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 2. ADMINISTRATION

CHAPTER 10. DEPARTMENT OF ADMINISTRATION
RISK MANAGEMENT SECTION

[R07-195]

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R2-10-207 — Amend

2. The specific statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rule is implementing (specific):
Authorizing statutes: A.R.S. § 41-703 (3)

Implementing statutes: A.R.S. §§ 41-621, 41-623(A)

3. The effective date of the rule:
August 4, 2007

4. A list of all previous notice appearing in the *Register* addressing the final rule:
Notice of Rulemaking Docket Opening: 12 A.A.R. 3242, September 8, 2006

Notice of Proposed Rulemaking: 12 A.A.R., 4218, November 17, 2006

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

Name:	Julie Cruse, Administrative Manager Risk Management Section
Address:	Arizona Department of Administration 100 N. 15th Ave., 3rd Fl., Ste. 301 Phoenix, AZ 85007
Telephone:	(602) 542-1492
Fax:	(602) 542-1473
or	
Name:	Rob Smook Rules Administrator
Address:	Arizona Department of Administration 1501 W. Madison Phoenix, AZ 85007
Telephone:	(602) 542-6161
Fax:	(602) 542-3125

6. An explanation of the rule, including the agency's reasons for initiating the rulemaking:
The purpose of this rulemaking is to address the issues identified in the previous five-year-review report approved by the Governor's Regulatory Review Council. The subject matter of R2-10-207 establishes the basis for the development of effective loss prevention programs within each state agency. The rule requires each agency to include certain specific elements and to develop procedures for investigating and reporting accidents, maintaining records and pre-

paring emergency plans for reasonably foreseeable perils. In addition, it clarifies and removes obsolete language and references.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The agency did not utilize a study for evaluating or justifying the rulemaking.

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:

A. Identification of Rule

Title 2, Chapter 10, Article 2, "Loss Prevention"

B. Background and Summary

The proposed rule amendment for R2-10-207 subsection (8) updates the language which references the Fire Protection Manual 1990 edition as this document is obsolete. Subsection (12) has been modified completely. The intent of the change is to guide the agencies and make recommendations for improved safety, security and loss prevention in a motor vehicle safety program area. The current language does not detail the specific program areas that are necessary for an effective loss prevention program within each state agency. The rule amendments are to provide specific direction and to assist the agencies in establishing an effective motor vehicle safety program.

C. Entities Directly Impacted

All state agencies could be impacted by these changes. Small business and consumers are not impacted by this rule.

D. Potential Costs and Benefits

Reduction of losses.

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

Based on suggestions from Council staff, minor, non-substantive changes were made in the rule to improve clarity. The suggestions included grammatical and other changes necessary to clarify the rule. Based on written comments received, a definition of an "authorized driver" was added in the rule for clarity and to address the concerns of effected parties.

11. A summary of the comments made regarding the rule and the agency response to them:

George Wendt, ADOT – Mr. Wendt requested an alternative to conducting annual motor vehicle record checks. He requested self-reporting for determining driver eligibility. He stated anyone who has a license suspended or revoked will be required to report this fact, failure to do will trigger disciplinary action. It would focus on the drivers that have a problem and identify the suspensions and notifications quicker than having to wait as long as a year to receive the information.

Risk Management response sent via letter: The proposed rule does not prevent ADOT from developing policy to require self-reporting and in fact includes language that states "An authorized driver shall promptly notify the authorized driver's immediate supervisor of any license suspension, revocation, or restriction placed on the driver's license or privilege to drive a motor vehicle by the Motor Vehicle Division (MVD) of the Arizona Department of Transportation (ADOT)."

ADOT may also establish a review period for MVRs that meets or exceeds the annual review, if the annual review does not provide the timely notification ADOT requires. The rule does not require ADOT to review MVRs for ALL employees, only those designated as authorized drivers. Identifying and screening authorized drivers is an essential component of any effective fleet safety program. The proposed rule adopts provisions of best practices established by the American National Standards Institute relative to Safe Practices for Motor Vehicle Operations – ANSI Z15.1. Section 15.3 of that standard states that "Organizations shall establish a program for periodically performing and reviewing each driver's state motor vehicle record, to assure that the driver remains qualified."

Risk Management believes the proposed rule requiring agencies to adequately screen, select and train drivers of state owned, leased or rented vehicles follows nationally recognized best practices and is in the best interest of the state.

Dona Markley, Department of Health Services – DHS had concerns regarding the applicability of this rule to all drivers. On December 21, 2006 they submitted a withdrawal of their comments regarding the applicability of this rule and are satisfied with the rule wording.

Risk Management response sent via letter: Definition of authorized driver explained. For the purpose of this Section, the definition of an authorized driver at a minimum is an employee whose job position description questionnaire or similar document requires the use of a vehicle or, an employee who operates a state vehicle or, an employee who operates a leased, rented or personal vehicle where the state provides 100% of that vehicle lease, rental or operational costs.

Ken Baldwin, Department of Economic Security – DES submitted a written request to change the rule reflecting that Arizona Department of Administration, Arizona Government University provides Defensive Driver/Van Safety training at no cost to state agencies or their employees.
Risk Management response sent via letter: The agency comments were taken into consideration and there will be no change to the rules in regards to providing training at no cost to the agencies. It is inappropriate to include language in our rule that commits us to a budgetary expenditure that is subject to legislative discretion.

Dennis Halachoff, ADOT Fleet Services – Mr. Halachoff asked at the oral proceedings how the rule will affect CDL drivers and will CDL drivers be required to take van training?
Risk Management response sent via letter: Risk Management will continue to encourage state agencies that have employees that operate a vehicle with an occupancy of nine to 15 passengers to attend the defensive driving course offered by the state. However, the CDL requirements currently meet or exceed the rule requirements. Each state agency has the flexibility in determining if current CDL holders attend 15 passenger van training.

Steve Holland, UofA – Fifteen passenger van training should be independent of any other training. If RMS is going exempt CDL drivers, then law enforcement should also be exempt as they also take defensive driving because they are operating a police vehicle and attend the specialized training.
Requested a continued push to implement the pull notice system, which is a notification system for traffic violations on an individual's license that Arizona Motor Vehicle Division does not have access into when new information is available on driver's license. UofA would pay for the subscription if that was available.
Response: The pull notice system is not currently available in Arizona.

Ken Baldwin, DES – If the rule becomes effective, 8,000-10,000 employees will be affected. Will AZGU be able to handle the training or will there be other options available?
Response: At this point in time, the training will be free and can be taken in sections. Training will be offered online and will make it more convenient and easier for all appropriate employees to take the required course in order to a drive a state vehicle. Risk Management is working with AZGU on the training, but we are not sure when the training will be available online.

Ceresa Stewart, ASU – Will ASU be able to utilize the same training program as that offered to the rest of the state agencies?
Response: Yes

Ceresa Stewart, ASU – Inquiry as to how employee insurance verification is to be conducted.
Response: Suggestions were made as to how to check knowing that an employee can terminate their insurance. But if they do, then that particular agency should have some method of corrective action in place. The travel reimbursement claim form has a clause at the bottom where the employee and supervisor sign which states the employee has liability insurance coverage and a valid driver license. In addition, other methods to validate insurance were encouraged.

Steve Holland, UofA – Mr. Holland made the following comments, which did not require a response. He commended ADOA – Risk Management for the rework and flexibility of the revised proposed rule. He noted that the challenge the UofA has with the MVRs is checking previous driver records from other states. When a person moves to Arizona they surrender the previous state license and when their record is checked there is no history associated with the new license. They are unable to get information as they do not have the old number. Also, out of country license checks are a concern. It is impossible to get information from other countries. So we ask all those with out of country licenses to obtain a U.S. license before they will be authorized to operate a state vehicle.

Brett Watson, Supreme Court – What time-frame will the new rule go into effect?
Response: At this point in time, estimated April 2007 at the earliest or the end of FY at the latest.

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 rule:

None

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

No

15. The full text of the rule follows:

TITLE 2. ADMINISTRATION

CHAPTER 10. DEPARTMENT OF ADMINISTRATION
RISK MANAGEMENT SECTION

ARTICLE 2. LOSS PREVENTION

Section
R2-10-207. Agency Loss Prevention Program Elements

ARTICLE 2. LOSS PREVENTION

R2-10-207. Agency Loss Prevention Program Elements

Each agency loss prevention committee or individuals designated by the agency head shall develop, implement, and monitor the following loss prevention program elements of an occupational health and safety program (as applicable to their agency):

1. The agency loss prevention policy statement;
2. New employee and continuous in-service training programs that include:
   a. Safety and loss prevention education regarding property protection, liability exposure, and workplace safety;
   b. Agency-specific safety training regarding emergency plans, actions, and first-aid; and
   c. Job-specific safety training to employees performing tasks where:
      i. Frequent or severe accidents have occurred; or
      ii. There is a potential for frequent or severe accidents.
3. Documentation and recordkeeping of employee training;
4. An emergency plan for each agency location that establishes procedures to follow in the event of serious injury, fire, or other emergency that can be reasonably foreseen at the specific agency location. The emergency plan shall:
   a. Designate an employee responsible for formulating, implementing, testing, and maintaining the emergency plan;
   b. Contain procedures for notification of emergency response personnel and safe evacuation of personnel from the location, including an evacuation diagram that shall be visibly posted throughout each location;
   c. Contain procedures for obtaining first-aid, medical treatment, and emergency transportation in the event of serious injury; and
   d. Require that the plan be periodically tested and evaluated and identified deficiencies corrected;
5. Procedures for scheduled safety inspections of buildings, grounds, equipment, and machinery. An agency shall document the results of each inspection and forward notice of any deficiencies to the loss prevention coordinator for corrective action. The agency loss prevention committee or coordinator shall follow-up on inspection recommendations to ensure action is taken to remedy a noted deficiency. The agency loss prevention committee or coordinator shall bring an uncorrected deficiency to the attention of the agency head;
6. Procedures for accident and incident investigations:
   a. An agency shall develop procedures for reporting an accident or incident involving personnel, property, automobile, liability, industrial injury, environmental damage, and a mishap or near miss to the agency's loss prevention coordinator or loss prevention committee. The loss prevention coordinator and loss prevention committee shall review the accident and incident reports and identify the corrective action necessary to prevent recurrence;
   b. Procedures for reporting, investigating, and recording maintenance of a work-related accident or incident shall include:
      i. Timely and accurate reporting of each work-related accident or incident;
      ii. Investigation of each accident or incident to gather pertinent information, determine cause, and recommend a solution to prevent recurrence of a similar accident or incident;
      iii. Compiling, analyzing, and evaluating all data derived from the investigation to determine the frequency, severity, and location of an accident or incident and communicating the information to appropriate agency personnel; and
      iv. Maintaining records of employee injury under ~~A.A.C. R20-5-631 through R20-5-636~~ A.A.C. R20-5-629;
7. A maintenance program for state-owned vehicles, equipment, and grounds under the control of that agency that includes:
   a. A preventive maintenance program with a written schedule of routine inspection, adjustment, cleaning, lubrication, and testing of equipment including boilers and machinery, fire protection, security and emergency equipment, and motor vehicles;
   b. Safety procedures such as "lock-out-tagout" and "buddy procedures" for jobs subject to a serious accident such as those involving working in a confined space, operating dangerous equipment and machinery, and working on electrical equipment; and
   c. Personal protective equipment for a specific job or area including training on proper fit, use, care, maintenance, inspection, cleaning, and storage;
8. A fire protection program that ~~meets the standards described in the Arizona State Fire Code contained in the Fire Protection Manual 1990 edition which is incorporated by reference and on file with the Department and the Office of the Secretary of State;~~ complies with the Arizona State Fire Code, located in A.A.C. Title 4, Chapter 36. This program shall incorporate best practices and standards that protect state of Arizona employees, the general public, and resources entrusted to the agency.
9. Systems and procedures to protect the personal security of each employee and prevent loss of or damage to state property, including:

a. Security escorts, exterior lighting, identification badges, and electronic access systems;
b. Labeling systems, inventory control procedures, property removal procedures, and key control systems; and
c. Building and ground security systems, alarms systems, electronic surveillance, perimeter fencing, and security patrol services.

10. A land, facility, equipment, or process environmental protection program that includes:
    a. Procedures to ensure compliance with all applicable local, state, and federal environmental laws;
    b. Identification of equipment, processes, and practices that may cause water pollution, air pollution, or land and property contamination;
    c. Procedures to prevent or control emissions and discharges in excess of local, state, and federal laws and rules; and
    d. Procedures to investigate, report, and remediate any discharge or contamination in excess of local, state, or federal laws and rules;
11. An industrial hygiene program that encompasses an existing or potential health hazard within an agency, or that agency personnel may be exposed to during the course of work. The program shall include a documented survey of agency facilities and work practices to identify areas of concern such as noise, air contamination, ergonomic factors, lighting and confined spaces. The program shall include procedures to notify employees of health hazards, medical monitoring when applicable, and personal protective equipment requirements including training, fit testing, and care. The industrial hygiene program shall include the following program elements as applicable:
    a. Hazard communication;
    b. Laboratory safety (Chemical Hygiene Plan);
    c. Hearing conservation;
    d. Confined space entry;
    e. Handling and disposing of hazardous waste;
    f. Back protection;
    g. Ergonomics;
    h. Asbestos management;
    i. Building air quality;
    j. Chemical exposure assessment;
    k. Personal protective equipment;
    l. Respiratory protection;
    m. Bloodborne pathogen protection; and
    n. Tuberculosis protection;

~~12. A motor fleet safety program for an employee operating a state or other vehicle on state business that includes:~~
~~a. Standards to ensure that an employee who drives on state business is capable of operating a vehicle in a safe manner and is currently licensed to operate a motor vehicle in Arizona;~~
~~b. Instruction in safe vehicle operation and defensive driving techniques;~~
~~c. Mandatory use of seat belts;~~
~~d. A log of the maintenance on each state vehicle.~~
~~e. Review of a vehicular accident by the agency loss prevention committee or by a committee appointed by the agency head to review vehicular accidents and recommend corrective action to prevent recurrence;~~
~~f. Review of the driving record of any agency employee who is authorized to drive state vehicles or other vehicles on state business. Each employee operating a state or other vehicle on state business shall upon request, provide the agency loss prevention coordinator, personnel representative, supervisor, fleet manager, or RM with the employees name, date of birth, driver's license number, and expiration date, and;~~
~~g. A training program for any driver of a passenger van designed for occupancy of 8 to 15 people. The program shall include classroom instruction, behind-the-wheel instruction (on the road or on a closed course), and a certificate of completion to be filed with the agency's fleet management.~~

12. Motor vehicle safety program. For the purpose of this Section, an authorized driver is an employee whose job position description questionnaire or similar document requires the use of a vehicle; an employee who operates a state vehicle; or an employee who operates a leased, rented or personal vehicle where the state provides 100% of that vehicle lease, rental or operational costs.
    a. Standards: Each agency shall develop standards to ensure that an authorized driver who drives on state business is capable of operating a motor vehicle in a safe manner. At a minimum, the program shall include the following standards:
        i. An authorized driver shall use and ensure use of seat belts by all occupants, as required by law.
        ii. An authorized driver shall possess a valid driver's license of the appropriate class with any required endorsements.
        iii. An authorized driver who operates a personally owned vehicle on state business shall maintain the statutorily required liability insurance.

b. Defensive driver training: The agency shall develop and implement programs and procedures to ensure that authorized drivers attend defensive driver training no later than three months from initial hire date or appointment to a position requiring the operation of a motor vehicle. All other authorized drivers who have not attended defensive driver training within the 36 months prior to August 5, 2007 shall attend defensive driver training within 12 months of this date. Defensive driver training and defensive driver refresher training shall cover, at a minimum, the following topics:
   i. Defensive driving techniques,
   ii. Traffic and vehicle regulations,
   iii. Driver and passenger restraints
   iv. Inclement weather and night-vision driving hazards,
   v. Dealing with emergencies,
   vi. Alcohol and drug use hazards and laws,
   vii. Vehicle insurance and financial responsibility, and
   viii. Motor Vehicle Record (MVR) Check.

   RM may provide Defensive Driver/Van Safety training assistance or coordination upon request of the agency or the agency may elect to develop and implement agency specific training.

c. Defensive driver refresher training: The agency shall have a designated responsible party to ensure that authorized drivers attend defensive driver refresher training at a minimum every four years.

d. Records: The agency shall ensure records are maintained regarding training under subsections (b), (c) and (e) that reflect topics, date of training, instructor name and qualifications of instructor, length of training, location of training, participant's name, and job title.

e. Passenger van and specialty vehicle training: In addition to subsection (b), the agency shall include a training element for drivers of passenger or cargo vans that are designed, modified, or could otherwise be configured for an occupancy of nine to 15 persons (including the driver). The training component for vans shall include: classroom instruction, behind-the-wheel instruction (on the road, on a closed course or using a driving simulator) and a certificate or card of completion. For a motorized specialty vehicle or specialty mobile equipment, the agency shall ensure that instruction is conducted before initial operation of the vehicle or equipment. The instruction shall be based on nationally recognized industry standards and training timelines or manufacturer's operator instructions. For the purpose of this subsection, a motorized "specialty vehicle" or "specialty mobile equipment" means a conveyance designed for the transport of people or cargo that is not licensed or intended for use on public roadways.

f. Vehicle maintenance and inspections: The agency shall develop and implement a preventive maintenance and inspection element for vehicles. At a minimum, the agency shall ensure that maintenance and inspection staff use preventive maintenance schedules and repair records. Vehicle inspections shall comply with all state and federal inspection standards for the vehicles being inspected. The agency shall ensure that all state-owned motor vehicles utilized for state business are inspected and maintained in a safe operating condition.

g. Vehicle incident review: An agency shall ensure that the motor fleet safety program includes a vehicle incident review element. A Vehicle Incident Review Committee shall conduct a review of each incident that involves collision or damage to determine the cause and preventability of the incident, and recommend any corrective action to prevent recurrence. If the committee determines the incident was preventable, the driver shall attend defensive driver refresher training within three months of committee determination. Based on the circumstances, the agency head may direct additional corrective action. An authorized driver involved in any motor vehicle collision on state business shall promptly notify the authorized driver's immediate supervisor.

h. Driving record review: An agency shall develop and implement procedures for the review of an authorized driver's record maintained by the Motor Vehicle Division (MVD) of the Arizona Department of Transportation (ADOT). The agency shall establish a schedule for reviewing driving records based on agency-specific exposures and RM claims history data. The agency shall ensure that the driving record of each authorized driver is reviewed at least annually. The review shall cover the most recent 39 month period. For driving record reviews, each authorized driver shall, upon request, provide, name, driver license number, expiration date and date of birth. A copy of a driving record release form is available upon request from RM. An authorized driver shall promptly notify the authorized driver's immediate supervisor of any license suspension, revocation, or restriction placed on the driver's license or privilege to drive a motor vehicle. If the license of an authorized driver is suspended or revoked, authorization to drive on state business is suspended on the date of driver's license suspension or revocation and remains suspended until the date of driver's license reinstatement. If a review of a driving record reveals one or more convictions totaling six or more points for the 39 month period, the appropriate agency management shall be notified. The driver shall attend defensive driver training or similar action designed to improve the person's driving skills. For the purpose of this Section, RM considers similar action to be successful completion of the MVD Traffic Survival School within 12 months of the record review.

i. Driving record review guidelines and criteria: Agencies may develop criteria that meet or exceed the requirements of this Section relating to accumulated MVD points or driving behavior. At a minimum, the following cri-

teria are to be followed when evaluating a 39-month driving record and recommending agency action:
i. 5 or fewer points = Acceptable record: Continue annual driving record and driver insurance status checks.
ii. 6 to 7 points = Conditional record: Conduct driving record and driver insurance status checks at least twice a year. Driver attends defensive driver training or similar action designed to improve driving skill.
iii. 8 or more points = High-risk record: Request that the agency head limit driving on state business. If an agency head allows the authorized driver to drive on state business, the agency head shall provide to the driver, in writing, the limitations and the duration of the authorization to drive. An agency head shall not circumvent an order or action of the Motor Vehicle Division or any court.

13. A safety and security standard for a construction site where state employees work, that ~~include~~ includes;
    a. Site-specific safety rules and procedures for the type of risks expected to be encountered on the site;
    b. Routine inspection of construction sites to ensure compliance with local, state, and federal safety laws and rules;
    c. Training of each employee in safe practices and procedures;
    d. Availability of first-aid, medical, and emergency equipment and services at the construction site, including arrangements for emergency transportation;
    e. Procedures to prevent theft, vandalism, and other losses at the construction site; and
    f. Periodic testing and evaluation of the plan and correction of identified deficiencies.

NOTICE OF FINAL RULEMAKING

TITLE 6. ECONOMIC SECURITY

CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY SOCIAL SERVICES

[R07-179]

PREAMBLE

1. Sections Affected | **Rulemaking Action**

R6-5-7401	Amend
R6-5-7437	Amend
R6-5-7447	Amend
R6-5-7465	Amend

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

Authorizing statute: A.R.S. § 41-1954(A)(3)

Implementing statute: A.R.S. § 8-503(A)(4)(a)

3. The effective date of the rules:

May 21, 2007

The rules will be effective immediately upon filing with the Secretary of State, under A.R.S. § 41-1032(A)(1). The Department has requested an immediate effective date for these rules under A.R.S. § 41-1032(A)(1). An immediate effective date is necessary to protect the safety and welfare of young adults in group care who will "age out" of foster care. Prior to the emergency rulemaking in this Article, child welfare licensees who offered services to young adults to prepare them for adult self-sufficiency were unable to comply with licensing regulations while meeting the needs of their young adult clients. An immediate effective date will enable licensees to continue providing these services as they have under the emergency rules.

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

Notice of Emergency Rulemaking: 12 A.A.R. 2233, June 23, 2006

Notice of Rulemaking Docket Opening: 12 A.A.R. 2570, July 21, 2006

Notice of Emergency Rulemaking: 12 A.A.R. 4732, December 22, 2006

Notice of Proposed Rulemaking: 12 A.A.R. 4657, December 22, 2006

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

Name: Beth Broeker

Address: 1789 W. Jefferson, Site Code 837A
Phoenix, AZ 85007

Telephone: (602) 542-6555
Fax: (602) 542-6000
E-mail: bbroeker@azdes.gov

6. An explanation of the rules, including the agency's reason for initiating the rules:
The Department of Economic Security initiated this rulemaking to give entities licensed under this Article a method for meeting the developmental needs of children and young adults who require preparation for adult self-sufficiency.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on in its evaluation of or justification for the rules or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, any analysis of each 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:
Not applicable

9. The summary of the economic, small business, and consumer impact:
This rulemaking will benefit young adults who require preparation for adult self-sufficiency. It will benefit entities licensed under this Article, by allowing them to accept and meet the needs of clients in this age group, while still complying with licensing standards and contractual obligations. It will also benefit other agencies that make placements in these licensed entities. It provides improved clarity regarding the Department's expectations for licensed entities serving a young adult population.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
Minor clarifications, as well as grammatical and typographical changes were made at the suggestion of G.R.R.C. staff.

11. A summary of the comments made regarding the rules and the agency response to them:
The Department did not receive any comments regarding these rules.

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 locations in the rules:
None

14. Were these rules previously made as emergency rules?
Yes, see item #4.

15. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY SOCIAL SERVICES

ARTICLE 74. LICENSING PROCESS AND LICENSING REQUIREMENTS FOR CHILD WELFARE AGENCIES OPERATING RESIDENTIAL GROUP CARE FACILITIES AND OUTDOOR EXPERIENCE PROGRAMS

Section
R6-5-7401. Definitions
R6-5-7437. Staff Coverage; Staff-child Ratios
R6-5-7447. Sleeping Arrangements
R6-5-7465. General Safety

ARTICLE 74. LICENSING PROCESS AND LICENSING REQUIREMENTS FOR CHILD WELFARE AGENCIES OPERATING RESIDENTIAL GROUP CARE FACILITIES AND OUTDOOR EXPERIENCE PROGRAMS

R6-5-7401. Definitions
In addition to the definitions contained in A.R.S. § 8-501, the following definitions apply in this Article:
1. "Abandonment" has the same meaning as A.R.S. § ~~8-546(A)(1)~~ 8-531(1).

2. *"Abuse" means the infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist pursuant to ~~Section 8-223~~ § 8-821 and which is caused by the acts or omissions of an individual having care, [physical] custody and control of a child. Abuse ~~shall include~~ includes:*
   (a) ~~inflicting~~ Inflicting or allowing sexual abuse pursuant to ~~Section~~ § 13-1404, sexual conduct with a minor pursuant to ~~Section~~ § 13-1405, sexual assault pursuant to ~~Section~~ § 13-1406, molestation of a child pursuant to ~~Section~~ § 13-1410, commercial sexual exploitation of a minor pursuant to ~~Section~~ § 13-3552, sexual exploitation of a minor pursuant to ~~Section~~ § 13-3553, incest pursuant to ~~Section~~ § 13-3608 or child prostitution pursuant to ~~Section~~ § 13-3212. ~~A.R.S. § 8-546(A)(2)~~
   (b) Physical injury to a child that results from abuse as described in § 13-3623, subsection C. A.R.S. § 8-201(2).
3. "Accredited" means the approval and recognition of an institution of learning as maintaining those standards requisite for its graduates to gain admission to other institutions of higher learning or to achieve credentials for professional practice. An example of an accrediting body is the North Central Association of Colleges and Universities.
4. *"Administrative completeness review time frame" means the number of days from [the Licensing Authority's] receipt of an application for a license until [the Licensing Authority] determines that the application contains all components required by statute or rule, including all information required to be submitted by other government agencies. The administrative completeness review time frame does not include the period of time during which an agency provides public notice of the license application or performs a substantive review of the application.* A.R.S. § 41-1072(1).
5. "Adverse action" means suspension or revocation of a license, denial of a renewal license, or making a material change in licensing status.
6. "After-care" means services provided to a child after the child is discharged from a licensee's care and may also include services for the child's family.
7. "Applicant" means a person who submits a written application to the Licensing Authority to become licensed or to renew a license to operate a child welfare agency or a residential group care facility.
8. "Barracks" means a building that:
   a. Is designed and constructed or remodeled for the specific purpose of housing large numbers of children of the same gender;
   b. Has wide, open sleeping areas for children, under one roof;
   c. Is identified and described as a barracks or dormitory in the agency's promotional and organizational materials; and
   d. Is made known as a barracks or dormitory to placing agencies and persons considering placement of a child.
9. "Behavior management" means the policies, procedures, and techniques a licensee uses to control conduct as prescribed in R6-5-7456.
10. "Child placing agency" means a person or entity that is licensed or authorized to receive children for care, maintenance, or placement in a foster home, because:
    a. The Department has licensed the person or entity as a child welfare agency pursuant to A.R.S. § 8-505; or
    b. It is an entity with statutory authorization to place children.
11. *"Child welfare agency" or "agency" ~~means:~~*
    a. Means:
       ~~a.i.~~ Any agency or institution maintained by a person, firm, corporation, association, or organization to receive children for care and maintenance or for 24-hour social, emotional, or educational supervised care or who have been adjudicated as a delinquent or dependent child.
       ~~b.~~ ii.Any institution that provides care for unmarried mothers and their children.
       ~~c.~~iii.Any agency maintained by the state, or a political subdivision thereof, person, firm, corporation, association, or organization to place children or unmarried mothers in a foster home. ~~"Child welfare agency" or "agency" does~~
    b. Does not include state operated institutions or facilities, detention facilities for children established by law, ~~camps operating less than 12 months per year or boarding schools which board children on a regular school year basis and where the child is off the grounds for at least 60 days or [a] health care institution which is~~ health care institutions that are licensed by the department of health services pursuant to Title 36, Chapter 4 or private agencies that exclusively provide children with social enrichment or recreational opportunities and that do not use restrictive behavior management techniques. A.R.S. § 8-501(A)(1).
12. "Corrective action" means a specific course of conduct an agency will follow to remedy violations of the licensing requirements prescribed in this Article, within a specified period of time.
13. "Corrective action plan" means a written document describing an agency's corrective action, as prescribed in ~~R6-5-7419~~ R6-5-7418.
14. "CPS" means Child Protective Services, a Department program responsible for investigating reports of child maltreatment.

15. "CPSCR" means the Child Protective Services Central Registry, a computerized database, which CPS maintains according to A.R.S. § ~~8-546.03~~ 8-804.
16. "De-escalation" means a method of verbal communication or non-verbal signals and actions, or a combination of signals and actions, that interrupt a child's behavior crisis and calm the child.
17. "Department" or "DES" means the Department of Economic Security.
18. "Developmentally appropriate" means an action ~~which~~ that takes into account:
    a. A child's age and family background;
    b. The predictable changes that occur in a child's physical, emotional, social, cultural, and cognitive development; and
    c. A child's individual pattern and timing of growth, personality, and learning style.
19. "DHS" means the Department of Health Services.
20. "Direct care staff" means the facility staff who provide primary personal care, guidance, and supervision to children in care.
21. "Discharge plan" means:
    a. A written description of:
        i. A program of action to prepare a child for release from a facility; and
        ii. After-care;
    b. That is developed by a licensee in cooperation with a child's service team.
22. "Discipline" means a teaching process through which a child learns to develop and maintain the self-control, self-reliance, self-esteem, and orderly conduct necessary to assume responsibilities, make daily living decisions, and live according to accepted levels of social behavior.
23. "Document" means to make and retain a permanent written or electronic record of a fact, event, circumstance, observation, contact, or communication.
24. "Exploitation" means the act of taking advantage of, or to make use of a child selfishly, unethically, or unjustly, for one's own advantage or profit, in a manner contrary to the best interests of the child, such as having a child panhandle, steal, or perform other illegal activities.
25. "Facility" or "residential group care facility" means a living environment operated by a child welfare agency, where children are in the care of adults unrelated to the children, 24 hours per day.
    a. "Facility" does not include a program licensed as a behavioral health service agency by the Department of Health Services under A.R.S. § 36-405 and 9 A.A.C. 20.
    b. "Facility" does include an outdoor experience program.
    c. When used in reference to an outdoor experience program, "facility" means the campsite at which or the mobile equipment in which children are housed.
26. "File" means a place where information is stored through written, electronic, or computerized means.
27. "Foot candles" means a unit of luminous intensity that can be measured with a light meter.
28. "Governing body" means an individual or group of individuals responsible for the policies, activities, and operations of a facility, as prescribed in R6-5-7424.
29. "Individual education plan" or "IEP" means a written document ~~which~~ that describes educational goals for a particular child and the services the child needs to attain those goals.
30. "Institution" as used in A.R.S. § 8-501(A)(1) means an entity meeting two or more of the following criteria:
    a. Solicits charitable contributions;
    b. Is organized as a profit or non-profit corporation with a board of directors and officers;
    c. Publishes and distributes information or promotional materials about its program or operations;
    d. Requires residents to formally apply for residency through use of application forms or other similar paperwork;
    e. Operates a structured program of care pursuant to written policies, procedures, guidelines, or rules; or
    f. Advertises itself or holds itself out in the community as an institution that provides care or social services.
31. "Institution for Unwed Mothers and Children" means a child welfare agency, as described in A.R.S. § 8-501(A)(1)(a)(ii), that is licensed to care for unmarried mothers who are under age 18 at the time of admission to the agency and the children of those mothers.
32. "License" means a document issued by the Licensing Authority to an individual or non-governmental business, which authorizes the individual or business to operate a child welfare agency in compliance with this Article.
33. "Licensee" means the person or entity holding a license. When used in reference to a duty, task, or obligation, the term "licensee" includes the staff who work at an agency or facility and who are responsible for doing the acts necessary to fulfill the requirements of this Article.
34. "Licensed medical practitioner" means a person who holds a current license as a physician, surgeon, nurse practitioner, or physician's assistant pursuant to A.R.S. §§ 32-1401 et seq., Medicine and Surgery; A.R.S. §§ 32-1800 et seq., Osteopathic Physicians and Surgeons; A.R.S. §§ 32-2501 et seq., ~~Physician's Assistant~~ Physician Assistants; and A.R.S. §§ 32-1601 et seq., Nursing and ~~A.A.C. R4-19-503~~ R4-19-501(A)(1), Registered Nurse Practitioner, respectively.

35. "Licensing Authority" means the Department administrative unit ~~which~~ that monitors and makes licensing determinations for agencies and facilities, including issuance, denial, suspension, and revocation of a license or operating certificate, and imposition of corrective action.
36. "Licensing representative" means a person employed by the Licensing Authority to investigate and monitor applicants and licensees.
37. "Licensing year" means a one-year time period that begins on the date an agency obtains its initial license to operate, and ends one year later.
38. "Living unit" means a specific grouping of children who are assigned to and share a distinct and common physical space within a facility.
39. "Maltreatment" means abuse, neglect, abandonment, or exploitation, of a child.
40. "Material change in licensing status" means, for the purpose of A.R.S. § 8-506.01,
    a. Any of the following actions:
        i. Denial, suspension, or revocation of an operating certificate;
        ii. At any time following issuance of an initial license, imposition of provisional license status, in lieu of a regular license as prescribed in R6-5-7419; or
        iii. A change in a term appearing on the face of a license or operating certificate, including: a.) Geographic area served; b.) Age, number, or gender of children served; or c.) Type of services offered;
    b. But does not include the act of placing an agency on a corrective action plan to bring the agency into compliance with licensing requirements as prescribed in R6-5-7418.
41. "Mechanical restraint" means:
    a. An article, device, or garment that:
        i. Restricts a child's freedom of movement or a portion of a child's body;
        ii. Cannot be removed by the child; and
        iii. Is used for the purpose of limiting the child's mobility;
    b. But does not include an orthopedic, surgical, or medical device ~~which~~ that allows a child to heal from a medical condition or to participate in a treatment program.
42. "Medication" means an agent, such as a drug or remedy, used to prevent or treat disease, illness or injury, including both prescribed and over-the-counter agents.
43. "Mobile dwelling" means a structure, such as a trailer or recreational vehicle as defined in A.R.S. § 41-2142(30). Mobile dwelling does not mean a mobile, manufactured, prefabricated, or modular home as defined in A.R.S. § 41-2142(14), (24), or (26).
44. "Neglect" has the same meaning ~~ascribed to it in A.R.S. § 8-546(A)(7)~~ as A.R.S. § 8-201(21).
45. "Non-ambulatory child" means a child who cannot walk due to a physical disability or impairment, rather than as a result of the child's normal age and developmental level.
46. "Onsite" means located on the physical property operated by the licensee for the purpose of the licensee's residential program and includes the contiguous area within:
    a. A single structure;
    b. A cluster of structures;
    c. A complex containing single or multiple family dwelling units with or without separate entrances for each unit; or
    d. A campus containing any combination of the residences listed in subsections (a) through (c), as approved by the Licensing Authority.

~~46.~~47. "Operating certificate" means a document that the Licensing Authority issues to a particular facility that is run by an agency holding a license, as prescribed in R6-5-7409.

~~47.~~48. "Outdoor experience program" means a child welfare agency that is located in a cabin or portable structure such as a tent or covered wagon and primarily uses the outdoors to provide recreational and educational experiences in group living, either in a fixed campsite or in a program with an unfixed site, such as a wagon train or wilderness hike.

~~48.~~49. *"Out-of-home placement" means the placing of a child in the custody of an individual or agency other than with the child's parent or legal guardian and includes placement in temporary custody pursuant to ~~Section~~ § ~~8-223~~ 8-821, subsection A or B, ~~paragraph 3 or subsection C, paragraph 2~~, voluntary placement pursuant to ~~Section~~ § 8-806 ~~8-546.05~~ or placement due to dependency actions.* A.R.S. § 8-501(A)(7).

~~49.~~50. *"Overall time frame" means the number of days after receipt of an application for a license during which* [the licensing authority] *determines whether to grant or deny a license. The overall time frame consists of both the administrative completeness review time frame and the substantive review time frame.* A.R.S. § 41-1072(2).

~~50.~~51. Paid staff means:
    a. A licensee's paid employees who work at a facility;
    b. Any temporary worker or independent contractor the licensee uses as a temporary replacement for an employee who is sick, on leave, or unavailable; and
    c. Any independent contractor that the licensee retains to provide children in care with direct services at the facility.

~~51.~~52. *"Parent or parents" means the natural or adoptive ~~parents~~ mother or father of ~~the~~ a child.* A.R.S. § 8-501(A)(8).
~~52.~~53. "Person" means an individual, partnership, joint stock company, business trust, voluntary association, corporation, or other form of business enterprise, including nonprofit or governmental organizations.
~~53.~~ 54. "Personally identifiable information" means any information which, when considered alone, or in combination with other information, identifies, or permits another person to readily identify the person who is the subject of the information, and includes:
a. Name, address, and telephone number;
b. Date of birth;
c. Photograph;
d. Fingerprints;
e. Physical description;
f. School;
g. Place of employment; and
h. Unique identifying number, including:
i. Social security number;
ii. Driver's license number;
iii. License number; and
iv. Court case number.
~~54.~~55. "Physical restraint" means the use of bodily force to restrict a child's freedom of movement, but does not include holding a child firmly enough to prevent the child from harming himself or herself, or others, but gently enough so that the child is not harmed by being held.
~~55.~~56. "Placing agency or person" means the child placing agency, parent, or guardian, having legal custody of a child and who makes the decision to send the child to reside at a particular agency.
~~56.~~57. "Potentially hazardous food" means a food that is:
a. Natural or synthetic and capable of rapid and progressive growth of infectious or toxigenic microorganisms or the growth and production of Clostridium botulinum;
b. Of animal origin and is raw or has been heated;
c. Of plant origin and is heated or consists of raw seed sprouts;
d. A cut melon; or
e. A garlic and oil mixture.
~~57.~~58. "Program director" means a person who meets the qualifications listed in R6-5-7432(B).
~~58.~~59. *"Relative" means a grandparent, great grandparent, brother or sister of whole or half blood, aunt, uncle, or first cousin*. ~~A.R.S. § 8-501(A)(11)~~ A.R.S. § 8-501(A)(12).
~~59.~~60. "Residential environment" means a facility building or any portion of a facility building that is used for living, sleeping, counseling, dining, or academic purposes.
~~60.~~61. "Restrictive behavior management" means a form of behavior control that is subject to limitations as prescribed in ~~R6-5-7456(D)~~ R6-5-7456(D) through (F).
~~61.~~62. "Safeguard" means to use reasonable and developmentally appropriate measures to minimize the risk of harm to a child in care and to ensure that a child in care will not be harmed by a particular object, substance, or activity. Where a specific method is not otherwise prescribed in this Article, safeguarding may include:
a. Locking up a particular substance or item;
b. Putting a substance or item beyond the reach of a child who is not mobile;
c. Erecting a barrier ~~which~~ that prevents a child from reaching a particular place, item, or substance;
d. Mandating the use of protective safety devices; ~~or~~
e. Providing staff supervision~~.~~; or
f. Providing a young adult with safety information and generalized instruction necessary to promote the safe and appropriate use of potentially dangerous objects.
~~62.~~63. "Seclusion" means placing a child alone in a room with closed, locked doors that cannot be opened from the inside as prohibited by ~~R6-5-7456(C)(5)~~ R6-5-7456(C)(6).
~~63.~~64. "Service plan," which is sometimes described as a "case plan," means a goal-oriented, time-limited individualized program of action ~~which~~ that:
a. Describes the plans for treating and providing services to a child and the child's family, and
b. Is developed by a licensee in cooperation with a child's service team.
~~64.~~65. "Service team" means the group of persons listed in ~~R6-5-7441(E)(1)~~ R6-5-7441(D)(1) who participate in development and review of a child's service plan and discharge plan.
~~65.~~66. "Shelter care facility" means an agency facility that receives children for temporary out-of-home care, 24 hours per day, when children request care, or are placed in care by a placing agency, a law enforcement agency, a parent, a guardian, or a court.
~~66.~~67. "Significant person" means a person who is important or influential in a child's life and may include a family mem-

ber or close friend.

~~67.~~68. "Sleeping area" means a single bedroom, or a cluster of two or more bedrooms, located in an adjacent area of a dwelling.

~~68.~~69. "Social worker" means a person with a bachelor's, master's, or doctoral degree in a field of organized work called social work, which is intended to advance the social conditions of a community through provision of counseling, guidance, and assistance, especially in the form of social services to individuals.

~~69.~~70. "Staff" means a licensee's paid staff and unpaid staff.

~~70.~~71. *"Substantive review time frame" means the number of days after the completion of the administrative completeness review time frame during which* [the licensing authority] *determines whether an application or applicant for a license meets all substantive criteria required by statute or rule. Any public notice and hearings required by law shall fall within the substantive review time frame.* A.R.S. § 41-1072(3).

~~71.~~72. "Swimming pool" means any on-grounds, natural or man-made body of water that is used for the purposes of swimming, recreation, or physical therapy, and includes spas and hot tubs.

~~72.~~73. "Threat" means an expression of intent to hurt, destroy, or take action prohibited by this Article or the licensee's policies, but does not include an expression of intent to impose a planned consequence for misbehavior if the consequence is not prohibited by this Article or the licensee's policies.

~~73.~~74. "Transitional program" means services provided to a child who is being emancipated as an adult, or a person who has reached the age of 18 and is considered an adult as a matter of law, in order to assist the child or person in becoming independent.

~~74.~~75. "Unpaid staff" means a licensee's volunteers, students, and interns who work, train, or assist at a facility.

~~75.~~76. "Unusual incident" means one or more of the events listed in R6-5-7434(C), (D), (E), or (G).

~~76.~~77. "Work day" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding Arizona state holidays.

78. "Young adult" means an individual, age 16 to 21, who has been assessed and determined to be appropriate for preparation for adult self-sufficiency. The assessment or determination shall be made by:
    a. The placing agency, if the young adult is in the care, custody, and control of the state of Arizona;
    b. A parent or legal guardian of the young adult, if subsection (a) does not apply;
    c. The licensee, if subsections (a) and (b) do not apply.

R6-5-7437. Staff Coverage; Staff-child Ratios

A. A licensee shall have a written plan to minimize the risk of harm to children. The written plan shall describe the staffing for each facility, for 24 hours per day, seven days per week. The staffing plan shall explain:
1. How staff coverage is assured:
    a. When assigned staff are absent due to illness, vacation, or other leaves of absence; and
    b. During emergencies when only one staff member is on duty; and
2. The methods the licensee uses to assure adequate communication and support among staff to provide continuity of services to children.

B. A licensee shall also have a written staffing schedule for each facility shift; the schedule shall document the staff actually on duty during each shift. The licensee shall retain the schedules in one designated location for at least two years.

C. A licensee shall have at least the paid staff to child ratios prescribed in this subsection.
1. Age 12 and above:
    a. At least one paid staff member for each 10 children when children are under the licensee's direct supervision and awake.
    b. During sleep hours, at least one paid staff member in each building where children in care are sleeping.
2. Age 6 through 11:
    a. At least one paid staff member for each eight children when children are under the licensee's direct supervision and awake.
    b. During sleep hours, at least one paid staff member in each building where children in care are sleeping.
3. Age 3 through 5:
    a. At least one paid staff member for each six children when children are under the licensee's direct supervision and awake.
    b. At least one paid staff member in each building where children in care are sleeping.
4. Under age 3:
    a. At least one paid staff member for each five children when children are under the licensee's direct supervision and awake.
    b. At least one paid staff member for each six children when children are sleeping.
5. Nonambulatory children, under age 6: At least one paid staff member for each four children at all times.
6. Young adults:
    a. At least one paid staff member onsite for each 10 young adults when young adults are under the licensee's direct supervision and awake.
    b. During sleep hours, at least one paid staff member onsite for each 20 young adults.

D. For the purpose of the paid staff-child ratios ~~set forth~~ in subsection (C) ~~above,~~:
1. Students and volunteers do not count as staff;
2. A child who ~~is not in care but~~ lives at the facility is counted as a child, unless the child is not in the care, custody, and control of the state of Arizona, and the child's parent is:
   a. In care, residing in the same facility; and
   b. Determined to be the child's primary caregiver by;
      i. The placing agency;
      ii. A court; or
      iii. The licensee, if subsections (i) and (ii) do not apply; ~~and~~
3. If a child resides with a parent in a facility licensed under this Article, the licensee shall provide, at the Department's request, documentation of:
   a. The custodial relationship between parent and child; and
   b. If applicable, the determination that the parent is an acceptable primary caregiver for the child; and

~~3.~~4. Any paid staff member counted in the ratio ~~must~~ shall be someone who is qualified to provide direct child care as prescribed in R6-5-7432(E).

E. A licensee shall not fall below the minimum paid staff-child ratios specified in subsection (C), and shall, notwithstanding those ratios, have paid staff:
1. Sufficient to care for children as prescribed in this Article and in the licensee's own program description, statement of purpose, and policies;
2. That take into account the following factors:
   a. The ages, capabilities, developmental levels, and service plans of the children in care;
   b. The time of day and the size and nature of the facility; and
   c. The facility's history and the frequency and severity of unusual incidents, including runaways, sexual acting-out behavior, disciplinary problems, and injuries.

F. A licensee shall have sufficient numbers of qualified staff to perform the fiscal, clerical, food service, housekeeping, and maintenance functions prescribed in this Article and in the licensee's own policies.

G. A licensee shall make a good faith effort to employ staff who reflect the cultural and ethnic characteristics of the children in care.

R6-5-7447. Sleeping Arrangements

A licensee shall comply with the sleeping arrangement provisions in this Section.
1. A child age 6 or older shall not share a bedroom with a child of the opposite gender.
2. A child shall not share a bedroom with an adult unless one of the conditions listed in this subsection is met.
   a. The child is younger than age 3.
   b. The child's service plan contains specific reasons and authorization from the placing agency or person for a shared bedroom.
   c. The child has a temporary need for special adult care during sleeping hours and the need is documented in the child's service plan.
   d. The child has regularly shared a bedroom with another child in the licensee's care; the other child has reached age 18; and the placing agency and licensee agree that continuing the shared arrangement is in the best interests of both the child and the adult.
   e. The child is sharing a room with his or her ~~mother~~ parent.
   f. The sleeping area at the facility is a barracks ~~which~~ that has been approved as described in R6-5-7461(B) and R6-5-7462(B), and a paid staff member sleeps in the same room to supervise the children in care.
3. Only children age 8 or older may sleep on the upper bed of a bunk bed.
4. If a child has a documented record of behavior that poses a risk to other children in care, the licensee, in consultation with the placing agency or person, shall develop special sleeping arrangements for that child, to minimize the risk of harm to other children. The licensee shall document the arrangements in the child's service plan.

R6-5-7465. General Safety

A. Ground Floor: A licensee shall house non-ambulatory children and children younger than 6 only on the ground floor.

B. Licensees that provide services to young adults:
1. A licensee that provides services to young adults shall provide adequate safety information and individualized instruction to promote the safe use of a substance or item that is:
   a. Required to be safeguarded under this Section, and
   b. Necessary for the young adult's self-sufficiency, such as laundry and cleaning supplies, tools, and kitchen knives.
2. A licensee that provides services to young adults placed in care with their own children shall safeguard substances and items in a manner appropriate to protect the youngest child in residence.

~~**B.**~~**C.** Dangerous objects: A licensee shall safeguard all potentially dangerous objects, including:
1. Firearms and ammunition;

2. Recreation and hunting equipment;
3. Household and automotive tools;
4. Sharp objects such as knives, glass objects, and pieces of metal;
5. Fireplace tools, matches, and other types of lighters;
6. Machinery;
7. Electrical wires, boxes, and outlets;
8. Gas appliances;
9. Chemicals, cleaners, and toxic or flammable substances;
10. Swimming pools, ponds, spas, and other natural or artificial bodies of water; and
11. Motorized vehicles.

~~C.~~**D.** Water Temperature: A licensee shall maintain water that is accessible to children for personal use at a temperature at or below 120° F.

~~D.~~**E.** Gas appliances:

1. A licensee shall have a licensed and bonded heating and cooling technician annually inspect all gas-fired devices at a facility. The licensee shall get a written report of the inspection for submission to the Licensing Authority at the time of license renewal.
2. A licensee shall equip all gas-fired devices with an automatic pilot gas shut-off control.
3. A licensee shall remove the valves from unused gas outlets and cap the disconnected gas line with a standard pipe cap.
4. A licensee shall not use unvented water heaters.
5. A licensee shall not use kerosene or gasoline for lighting, cooking, or heating.
6. If a licensee uses a natural or propane gas burning device inside a facility, the licensee shall:
   a. Install, test, and check carbon monoxide monitoring equipment in a facility's residential environment according to the manufacturer's instructions;
   b. Maintain the monitoring equipment in good working condition; and
   c. At the facility, keep a copy of the manufacturer's instructions, and, for one year, a record of the tests.

~~E.~~**F.** Finishes and surfaces:

1. A licensee shall not surface walls or ceilings with materials ~~containing~~ that contain lead except as allowed by law for protection from wood, pellet, or peat burning stoves.
2. A licensee shall not have any walls, equipment, furnishings, toys, or decorations surfaced with lead paint.
3. A licensee that accepts children who are under age 6, developmentally disabled, or severely emotionally disturbed, shall maintain the facility free of lead paint hazards, including permanent removal of any paint that a child may ingest.

~~F.~~**G.** Toxic and Flammable Substances:

1. A licensee shall ensure that any poisons and toxic or flammable substances used at a facility are used in a manner and under conditions that will not contaminate food or be hazardous to children.
2. A licensee shall ensure that containers of poisons and toxic or flammable substances are prominently and distinctly marked or labeled for easy identification of contents.
3. A licensee may burn trash only when:
   a. Local authorities and ordinances allow burning;
   b. The fire is at least 50 feet from any building used for children's residences; and
   c. An adult supervises any child involved in the burning.
4. A licensee shall not use charcoal or gas grills indoors or on covered porches.

~~G.~~**H.** Firearms, Weapons, and Recreational and Hunting Equipment:

1. A licensee shall ban firearms, explosives, and ammunition from a facility and grounds, except a licensee may allow the following:
   a. Firearms maintained and used exclusively by trained security guards; and
   b. Non-functional, permanently disabled firearms used for ceremonial purposes if such use is documented in the licensee's policy and procedures.
2. A licensee shall keep bows and arrows, knives, and other potentially hazardous hunting and recreational equipment in locked secure storage ~~which~~ that is not accessible to children.

~~H.~~**I.** Tools and Equipment: A licensee shall maintain lawn and garden equipment and maintenance tools and equipment safe and in good repair, and shall allow children to use them only under the supervision of staff. Depending on the developmental level of the child, the supervision need not be direct supervision.

~~I.~~**J.** Telephone service:

1. A licensee shall equip each living unit that does not house young adults with 24-hour telephone service or an intercom system linked to an outside telephone service~~.~~, or
2. A licensee that provides services to young adults shall provide a device in each living unit that allows a young adult to immediately summon on-duty staff or emergency services. In addition, the licensee shall provide a telephone

onsite. The licensee shall provide written and verbal information to each young adult, explaining how to summon assistance in the event of an emergency.

~~2.~~3. A licensee shall conspicuously post, adjacent to the telephone,
   a. The address and telephone number of the facility; and
   b. Emergency telephone numbers, including fire, police, physician, poison control, Child Protective Services, and ambulance.

~~J.~~**K.** Smoking:
1. A licensee shall not expose a child in care to tobacco products or smoke.
2. A licensee shall not allow any person to use tobacco products inside buildings.
3. A licensee shall not allow a child in care to use or possess tobacco products.

~~K.~~**L.** Animals:
1. The licensee shall not maintain, at a facility, any animal that poses a danger to children in care.
2. The licensee shall have written evidence that dogs kept at a facility have current vaccinations against rabies.

NOTICE OF FINAL RULEMAKING

TITLE 17. TRANSPORTATION

CHAPTER 4. DEPARTMENT OF TRANSPORTATION TITLE, REGISTRATION, AND DRIVER LICENSES

[R07-197]

PREAMBLE

1. Sections Affected — **Rulemaking Action**
R17-4-350 — New Section

2. The statutory authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):
Authorizing statute: A.R.S. § 28-366
Implementing statute: A.R.S. § 28-5810

3. The effective date of the rules:
August 4, 2007

4. A list of all previous notices appearing in the *Register* addressing the final rule:
Notice of Docket Opening: 13 A.A.R. 43, January 5, 2007
Notice of Proposed Rulemaking: 13 A.A.R. 84, January 12, 2007

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

Name:	Celeste M. Cook, Administrative Rules Analyst
Address:	Administrative Rule Unit Department of Transportation, Motor Vehicle Division 1801 W. Jefferson St., Mail Drop 530M Phoenix, AZ 85007
Telephone:	(602) 712-7624
Fax:	(602) 712-3081
E-mail:	ccook@azdot.gov

Please visit the ADOT web site to track progress of this rule and any other agency rulemaking matters at www.mvd.azdot.gov/mvd/MVDRules/rules.asp.

6. An explanation of the rule, including the agency's reason for initiating the rule:
The Arizona Department of Transportation, Motor Vehicle Division, engages in this rulemaking to prescribe the auditing procedures, reporting, and records maintenance requirements necessary to administer the rental surcharge reimbursement program.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting

material:
None

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 economic, small business, and consumer impact of these rules will be minimal as the rental business is currently required to maintain appropriate business related records for tax reporting purposes.

Small businesses and consumers are not adversely affected as the rental surcharge is already being collected by the rental business. There may be a small impact to rental businesses that have never submitted the vehicle license tax surcharge. However, these are taxes that the rental business is not legally permitted to retain.

The costs of this rulemaking to the Department, the Governor's Regulatory Review Council, and the Secretary of State are minimal clerical costs incurred in preparation, review, editing, and publishing of the rule.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):
Since the Division is authorized to cancel all registrations for nonpayment of any required fee, it was determined that the last portion of the statement in Section D(2), "Failure to respond to the Director's or agent of the Director's request for records will cause the Director to issue subpoenas for the production of records or allow seizure of records and will cause the Director to cancel all Arizona registration privileges." is redundant as it merely repeats the authority granted under A.R.S. § 28-2161. As a result, the following statement was removed from Section D(2) "and will cause the Director to cancel all Arizona registration privileges." An internal review of the proposed rule produced a request that the rule clarify who must submit an annual report and when an annual report is due immediately. For this reason, Section (B) was revised to add "**who has conducted a vehicle rental business for any time period during the previous year,**" and ", for the previous year," and Section (B)(2) was revised to add "If a rental business is closed before December 31, the annual report is due immediately." In addition, minor grammatical and style corrections were made to some Sections at the request of Governor's Regulatory Review Council staff.

11. A summary of the comments made regarding the rule and the agency response to them:
Not applicable

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

15. The full text of the rules follows:

TITLE 17. TRANSPORTATION

CHAPTER 4. DEPARTMENT OF TRANSPORTATION
TITLE, REGISTRATION, AND DRIVER LICENSES

ARTICLE 3. VEHICLE REGISTRATION

Section
R17-4-350. Rental Vehicle Surcharge Reimbursement

ARTICLE 3. VEHICLE REGISTRATION

R17-4-350. Rental Vehicle Surcharge Reimbursement

A. Definitions. In addition to the definitions prescribed under A.R.S. § 28-5810, the following definitions apply to this Section, unless otherwise specified:

"Division" means the Arizona Department of Transportation, Motor Vehicle Division.

"Person "means an individual, firm, partnership, joint venture, association, corporation, estate, trust, business trust, receiver or syndicate, this state, any county, city, town, district or other subdivision of this state, an Indian tribe, or any other group or combination acting as a unit.

"Previous year" means the prior calendar year, January 1 through December 31.

"Rental revenue" means the total contract amount stated in the retail contract less any taxes and fees imposed by A.R.S. §§ Title 42, Chapter 5, Article 1 and Title 48, Chapter 26, Article 2 and selected non-vehicle related charges (e.g., boxes, packing blankets, straps, tow bars, etc.).

"Surcharge" means the amount equal to five percent of the total contract amount stated in the rental contract less any taxes and fees imposed by A.R.S. Title 42, Chapter 5, Article 1 and Title 48, Chapter 26, Article 2 and selected non-vehicle related items (e.g., boxes, packing blankets, straps, tow bars, etc.).

"Vehicle License Tax" means the tax imposed by A.R.S. § 28-5801, less any fees credited under A.R.S. § 28-2356.

B. Reports. Each person subject to A.R.S. § 28-5810, who has conducted a vehicle rental business for any time period during the previous year, shall file an annual report, for the previous year, with the Division. The annual report is due no later than February 15 of each year, unless the rental business is closed before December 31, in which case the annual report is due immediately. The report shall be made on a form furnished by the Division and shall contain all of the following:

1. Address where business records are secured.
2. Authorized preparer's name, title, phone number, and mailing address.
3. Business name.
4. Business type (e.g., Individual, Partnership, Corporation, etc.).
5. Contact person's name, title, phone number, and mailing address.
6. Federal Employer Identification Number (FEIN)
7. Mailing address (if different from principal business address).
8. Principal business address.
9. Rental revenue, by county.
10. Total Arizona Vehicle License Tax paid on rental vehicles.
11. Total rental revenue.
12. Total surcharge collected.
13. Total surcharge due to the Division.
14. Type of rental business (e.g., passenger vehicle, semitrailer, trailer, truck, etc.).

C. Records. A person in the business of renting vehicles, as defined under A.R.S. § 28-5810, is required to maintain records in support of the required annual reports for a period of four years from the date of the filing of the required annual report or the due date of the report, whichever is longer. The records shall contain all information in support of:

1. The total amount of Vehicle License Tax paid during the previous year. Supporting Vehicle License Tax records shall include, but are not limited to:
   a. The Vehicle Identification Number.
   b. The Arizona vehicle license plate number.
   c. A copy of the Arizona registration.
   d. The amount paid for Vehicle License Tax minus any Vehicle License Tax fee credited under A.R.S. § 28-2356.
   e. The date on which the Vehicle License Tax was paid.
   f. The dates the rental vehicle was in and out of service.
2. The total gross amount of Arizona vehicle rental revenues collected for the previous year. Supporting Arizona vehicle rental revenue records shall include, but are not limited to:
   a. The rental contract.
   b. The amount of surcharge collected.
   c. Chart of accounts.
3. The amount of the surcharge collected during the pervious year. Supporting surcharge collection records shall include, but are not limited to:
   a. The rental contract.
   b. The total amount stated in the rental contract, supported by relevant documentation.
4. Failure to keep and maintain proper records or failure to provide records for audit purposes may result in an the Division making an assessment, against the rental business for the total surcharge amount estimated to have been collected, as determined from the best information available to the assistant Director.

D. Audits. Each audit of a person who collects the surcharge will be conducted in accordance with Generally Accepted Accounting Procedures and Government Auditing Standards (The Yellow Book, 2003 Revision).

1. Records shall be made available for audit during normal business hours at the rental business location in Arizona. Audits may be conducted at an out of state location, to be paid by the rental business. Audit expenses, per diem, and travel to be paid in accordance with the Arizona Department of Transportation expense guidelines in effect at the time of the audit.
2. The Division Director shall have appropriate subpoena powers to require records to be produced for examination and to take testimony. In accordance with A.R.S. § 28-5922, failure to respond to the Director's or agent of the Director's request for records will cause the Director to issue subpoenas for the production of records or allow seizure of records.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

[R07-200]

PREAMBLE

1. Sections Affected

Sections Affected	Rulemaking Action
R20-6-201	Amend
R20-6-201.01	New Section
R20-6-201.02	New Section
R20-6-202	Amend
R20-6-203	New Section
R20-6-204	Amend
R20-6-205	Renumber
R20-6-205	Amend
R20-6-206	Renumber
R20-6-206	Amend
R20-6-207	Renumber
R20-6-207	Amend
R20-6-208	Renumber
R20-6-208	Amend
R20-6-209	Renumber
R20-6-209	Amend
R20-6-210	Renumber
R20-6-210	Amend
R20-6-211	Renumber
R20-6-211	Amend
R20-6-212	Renumber
R20-6-212	Amend
R20-6-212.01	Renumber
R20-6-212.01	Amend
R20-6-213	Renumber
R20-6-213	Amend
R20-6-214	Renumber
R20-6-214	Amend
R20-6-215	Renumber
R20-6-215.01	Renumber
R20-6-216	Renumber
R20-6-217	Renumber

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

Authorizing statute: A.R.S. § 20-143

Implementing statutes: A.R.S. §§ 20-401.07, 20-413, 20-442, 20-443, 20-444, 20-445, 20-448, 20-449, 20-452, 20-826(T), 20-1018, 20-1057(X), 20-1110(E)

3. The effective date of the rules:

August 4, 2007

4. The list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Rulemaking Docket Opening: 12 A.A.R. 358, February 3, 2006

Notice of Proposed Rulemaking: 12 A.A.R. 2931, August 18, 2006

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

Name: Margaret McClelland

Address: Arizona Department of Insurance
2910 N. 44th St., Ste. 210
Phoenix, AZ 85018

Telephone: (602) 364-3471
Fax: (602) 364-3470
E-mail: mmclelland@id.state.az.us

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

This rulemaking repeals obsolete rules, improves clarity, conciseness, and understandability of all rules that are not being repealed and makes the rule consistent with statutory changes and model regulations of the National Association of Insurance Commissioners. New definitions are added to R20-6-201 to define terms used in this Article. Current Sections are revised and new Sections are added to clarify requirements regarding advertisement, and requiring insurers to provide an English translation of documents filed in a foreign language. The changes to the advertising rules are due to Laws 2000, Ch. 37, which eliminated the Department's prior review and approval of insurers' advertising materials. The Department proposes a new rule to specify the procedures for filing advertising materials and to facilitate the Department's timely review of filed materials. The new rule requiring translations will permit the Department to conduct required reviews of rules and forms.

7. A reference to any study relevant to the rules that the agency reviewed and either relied on in its evaluation of or justification for the rules or did not rely on in its evaluation of or justification for the rules, where the public may obtain or review each study, all data underlying each study, and any analysis of each 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:

Not applicable

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

The portions of this rulemaking that repeal or amend existing rules will have intangible benefits for the consumers by repealing obsolete provisions that might otherwise be confusing and simplifying the text of the remaining rules.

The new Section, R20-6-203, requiring insurers to provide the Department with English translations of foreign documents may pose some costs on insurers. Any cost to insurers is outweighed by the benefit to the insurance buying public by permitting the Department to conduct adequate regulatory review of documents written in a foreign language. The businesses directly impacted by this rulemaking are insurers that offer and sell insurance in Arizona. There are 548 disability insurers, 12 health care service organizations (HCSOs) and three service corporations licensed to transact business in Arizona. The companies most impacted will be the HCSOs that have not previously complied with the advertising rules. But, practically speaking, these insurers change their advertising materials regularly for their own purposes, so, there will not be a hardship to the companies to make required changes. This rulemaking will have very little impact on the disability insurers because they have already been complying with the advertising requirements of this Article. The Department expects the economic impact on insurers to be minimal to moderate.

The Department is not aware of small businesses that will be directly impacted by this rulemaking, therefore, the Department does not believe it is necessary to reduce the impact on small businesses.

The Department does not expect economic impacts to the Department or other governmental agencies aside from the costs of promulgating this rulemaking.

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

R20-6-201(A)(1)(b) is revised to add the following:

x. Press and news releases not intended to generate business.

This is added to clarify that this information is not considered an advertisement.

R20-6-201(C)(8) is revised to add "covered by (C)(7)" after "An advertisement" in the first sentence for clarity.

R20-6-201(E)(1) is revised to add the phrase "if the advertisement is filed with the Department or requested by the Department" at the end of the second sentence for clarity.

R20-6-202(D)(16) is revised to restore the language specifying the prohibitions for clarity. The format of the subsection is revised to make it clearer as follows:

~~c.~~16.Using a dollar amount in printed material to be shown to a prospective policyholder, unless that amount is accompanied by language ~~in such material indicating the~~ that:

a. States the nature of the ~~figure. (This is intended to~~ dollar amount;

b. ~~prohibit~~ Prohibits including the use of dollar ~~figures~~ amounts not ~~in relation~~ related to guaranteed values and properly projected dividend figures~~. It is intended to prohibit~~; and

c. Prohibits the use of figures showing growth of stock values, or other values not a part of the life insurance contract.~~)~~

R20-6-208(A)(1) is revised to add "all" after the word "meets" for clarity.

R20-6-208(A) is revised to correct subsection numbering.

R20-6-208(F)(2)(a) is revised to change "validly covered" to "eligible for coverage" for clarity.

R20-6-209(B)(3). The phrase "means the dividend that is" is deleted.

R20-6-209(B) is revised to delete the word "definitions" from the second sentence.

R20-6-209(D)(6) is revised to restore previously stricken language to read, "unless they are shown separately and in close proximity ~~thereto~~."

Other minor and technical changes were made at the suggestion of the staff of the Governor's Regulatory Review Council.

11. A summary of comments made regarding the rule and the agency response to them:

The Department held an oral proceeding on the proposed rulemaking on September 26, 2006. The Department did not receive oral comments, but the Department did receive written comments. The comments and responses are as follows:

COMMENT 1: R20-6-201(A)(1)(b). A commenter requests that the following be added to the section of material not considered an advertisement:

"Advertisement" does not include the following:

- Press/News releases not intended to generate business

For example, BCBSAZ issues press releases related to changes in corporate structure or personnel. This type of information should not be subject to Arizona Department of Insurance ("Department") filing and review."

Response: The Department agrees to add the requested language.

COMMENT 2: R20-6-201(C)(13). A commenter commented on the following provision:
"For the purpose of this rule,
An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised as exempt from approval or not subject to approval by order or statute."

The commenter requests the Department confirm that this rule is not meant to prohibit an insurer from making general statements about or references to a new product that hasn't yet been approved, so long as the advertisement does not include specific benefit or coverage information on the unapproved plan/form. For example, is the rule meant to prohibit a general statement such as: 'XXX plan, a new PPO plan'?

Response: The Department disagrees with making this change. The general statements and references referred to here are solicitations. An insurer may not solicit a product that has not yet been approved. The rule is meant to prohibit any type of advertising of a product that has not been approved by the Department or is exempt from filing. There can be a significant period of time between when an insurer files a product with the Department and when that product is approved. Sometimes there is a delay in getting a product or form approved when a company is unable or unwilling to make corrections or changes to the product or form to bring it into compliance with laws that would allow the Department to approve it. If an insurer is already advertising the product prior to approval, even without including specific benefit details, a delay can result in confusion and upset for consumers who are interested in purchasing the product and are unable to do so because it has not yet been approved. The consumers then often make inquiries or complain to the Department and the insurer resulting in time spent researching the issue and explaining the situation to the consumers. The Department cannot approve a product or form that does not comply with the law. There is also the possibility that the product will be disapproved. These problems are avoided if the insurer does not advertise prior to product or form approval.

COMMENT 3: R20-6-201.01(A) A commenter commented as follows:

BCBSAZ requests the following changes for better conformity with Department's language in R20-6-201 that an advertisement means "…materials **used** by an insurer…"

In addition, regarding an insurer's inability to control the conduct of third parties and the cost of imposing such burdens on the insurer, BCBSAZ believes that this Section should be divided into two separate Sections: (1) Responsibility and, (2) Records.

A. Responsibility:

An insurer shall establish, and at all times maintain, a system of control over the content, and form, ~~and method of dissemination~~ of all advertisements of its policies~~. The insurer whose policies are advertised shall be responsible for the advertisements, regardless of by whom the advertisement is written, created, designed, or presented, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement about an insurer or its products, a producer shall get written approval from the insurer for use of the advertisement. In the event that the Department does not make the above change, BCBSAZ requests that the Department clarify its position~~

~~regarding an insurer's obligation(s) for ensuring compliance with filing and record-keeping requirements by third parties and any third party materials.~~

Response: It is well settled that the insurer is responsible for the actions of its agents acting under actual or apparent authority of the insurer. The Department disagrees with this request to revise the rule.

COMMENT 4: R20-6-208(A) – Group Discontinuance and Replacement – The intent of the rule is that all the listed conditions in the subsection must be met in order for an insurance benefit to qualify as group insurance. It would be helpful to clarify this by adding the word "all" in paragraph (1) as follows: "….an insurance benefit that meets **all** the following conditions…"

Response: The Department agrees and has made this change.

COMMENT 5: R20-6-208 – "In subsection (A), both "Health insurance coverage" and "Health status related factor" are numbered as the second definition."

Response: The Department has corrected this typographical error.

COMMENT 6: R20-6-208 - **"**Subsection (E), which requires a group policy to include an extension of benefits provision, does not address the issue of payment of premium during the extension period. We would like to clarify that the insurer is not obligated to continue providing benefits during the extension period if there is no payment of premium."

Response: The Department disagrees with this comment. The language is correct and not in need of clarification. The insurer is obligated to provide benefits during this period without payment of premiums. This is a prior liability that insurers have reserves for because they have a continuing liability for these prior conditions. This is an extension of benefits only for the specific disabling condition for the individual who is disabled. It is not a general continuation of the insurance plan. It is for individuals who do not qualify for the new plan.

COMMENT 7: "It appears that some of the changes to R20-6-208(F) are conflicting. The current rule setting forth the obligations of the succeeding insurer separates those obligations into two separate categories: Those instances in which individuals are eligible for the succeeding insurer's plan of benefits and those instances when individuals are not eligible for the succeeding insurer's plan of benefits but are required to be covered anyway until the occurrence of certain events. R20-6-208(F)(5) appears to restate the same succeeding carrier coverage obligations already set forth in R20-6-208(F)(2). In both sections the succeeding insurer is required to cover an individual if the individual was validly covered under the prior plan on the date of discontinuance and is a member of the class or classes of individuals eligible for coverage."

Response: The Department agrees that a change is necessary for clarity. Subsection (F)(2) is revised to change "validly covered" to "eligible for coverage."

COMMENT 8: "There is an additional ambiguity in that the proposed R20-6-208(F)(5)(b)(i) provides that the succeeding insurer's obligations to cover the individuals defined in R20-6-208(F)(5) cease upon the individual becoming eligible under subsection (F)(2); however, this eligibility appears to already be a criteria they must meet within the scope of subsection (F)(5). This confusion may be due to the fact that subsection (F)(2) of the Department rule omits language found in the NAIC model regulation on which the rule is based. (See NAIC model regulation, "Group Coverage Discontinuance and Replacement," section F(C)(1)(a). The model regulation requires that the individual request enrollment in the plan, as well as meet the other criteria. The Department rule omits the request for enrollment. In the model regulation, subsection 7(2)(a) (which corresponds to subsection (F)(5) of the Department rule) addresses the insurer's obligation where the individual does not request enrollment."

Response: The Department disagrees with this comment. Enrollment is not always required because employers do not always require re-enrollment unless a change is being made. The requested change would also add a new burden on the member. However, the Department has made the clarification in the response to comment 7. While the Department intends to give consideration to adoption of the model regulation in the near future, to date, the Department has not adopted the model regulation.

COMMENT 9: These rules appear to require a succeeding health insurer to provide the same level of benefits provided by a prior health insurer to individuals (including those who are totally disabled), reduced by any benefits paid by the prior plan. BCBSAZ requests that the Department clarify that this rule does not require an insurer to change the benefits of any approved standard health insurer's plan if the prior health insurer has or had richer benefits.

Response: The rule does not require a change of plan, but the succeeding health insurer must calculate the benefits according to the prior health insurer's level of benefits. The goal is for an individual not to lose benefits the individual already had when their employer changes. This is an extension for someone who is not actively at work when the new plan takes effect. It does not prohibit an employer from making general changes the employer chooses to make. This is an extension of benefits only for the specific disabling condition for the individual who is disabled. It is not a general continuation of the insurance plan. It is for individuals who do not qualify for the new plan. This is not a new requirement.

COMMENT 10: R20-6-214. Coordination of Benefits – Rules for coordination of benefits ("COB") are designed to do three important tasks:

1. To establish a uniform order of benefit determination under which health plans pay claims;
2. To reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that pay benefits secondary rather than primary (as determined under the COB rule); and
3. To provide greater efficiency in processing claims when a person has coverage under more than one plan.

See, National Association of Insurance Commissioners (NAIC) Coordination of Benefits Model Regulation, Section 2.

The Department adopted its COB rule in 1982, based on the then-current, NAIC model COB regulation. The Department slightly modified its COB rule in 1987, nearly 20 years ago, and has not revised it since that time. In this rulemaking package, the Department is making only stylistic changes to its COB rule, R20-6-214.

In contrast to the Department, the NAIC has substantially revised its model regulation, most recently in March 2005. The revisions to the NAIC model regulation are designed to reflect changes in health care law and practice that have occurred since the 1980s. The current NAIC model regulation is materially different from the Department rule. The current NAIC model provides guidance on how to coordinate benefits in situations not covered under the rule because the rule was promulgated before the existence of certain insurance products and laws. The NAIC regulation covers the following: coordination for persons covered by high deductible health care plans used in conjunction with a health savings account (these products did not exist in the 1980s); coordination for persons with COBRA or state required continuation coverage; coordination for dependent children covered by a step-parent's policy; and coordination for dependent children whose parents have the same birthday. In this day of blended and restructured families, it is particularly problematic that the Department does not address the broader range of circumstances covered by the NAIC model, which also includes more detail on coordination in situations where a court order specifies dependent coverage.

The new model includes a revised definition of "allowable expense" for the purpose of computing how much a secondary insurer is required to pay. Specifically, the model says that if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense. See the NAIC model, section 3(A)(5)(c). This enables the secondary insurer to take advantage of the provider discounts negotiated by the primary insurer, without harm to the member or the provider who is assured of receiving the higher reimbursement amount that the provider negotiated to accept.

The NAIC model has important protections for policyholders. It does not allow a plan to shirk responsibility for coverage by including a provision that it is "always secondary." (The Department rule does not expressly prohibit such policy language.) It does not permit a plan to reduce benefits on the grounds that another plan exists in which the covered person chose not to enroll (a "phantom plan"). (NAIC model section 5(D) and (E).) The NAIC model includes a dispute resolution mechanism requiring coordinating plans that cannot agree on order of benefits to pay within 30 days and argue responsibility later. (Section 9(D).) These important protections are lacking in the Department rule.

The current COB rule is also inconsistent with the one-year adjustment limitation period in the Arizona timely pay law. R20-6-214(D)(1)(c) requires adjustment of claims without regard to the one year limitation period found in A.R.S. § 20-3102(I).

Because COB often involves coordination among carriers operating throughout the country, it is particularly important to have national consistency in how COB is administered. Adoption of the NAIC model would permit BCBSAZ and other carriers doing business in Arizona to adopt COB provisions in their policies that are consistent with those in other states. It would lessen confusion among insurers and insureds, which generally results in reduced administrative expenses. Reducing administrative expense and burden can help to minimize increases in premiums paid by consumers.

It has been almost 20 years since Arizona amended its COB rules. Insurers know that the Department has limited rulemaking resources and should not need to wait until the Department finds the time to return to Article 2. BCBSAZ urges the Department to repeal its current rule, in its entirety, and adopt the NAIC model regulation by reference.

Response: Adoption of the NAIC model regulation on coordination of benefits (COB) is a separate issue and process for the Department to consider. The current rulemaking is the result of the Department's commitment in a five-year review to revise Article 2. The Department chooses not to further delay revising Article 2 to address this issue of adopting the model regulation, which involves many complex issues and will require a stakeholder process to address those complex issues as they impact many types of carriers. The various types of carriers are not all likely to agree with this comment. In fact, the Department conducted an extensive two-year process seeking comments on the current rulemaking. The commenter was included in that process, and submitted comments to the Department over the course of that process. Prior to filing these formal comments after the Notice of Proposed rulemaking, neither the commenter nor any other insurer, raised the issue of adopting the NAIC model COB regulation. While the requested change might benefit this commenter, other insurers are likely to disagree.

Since this is a newly raised issue that will have a wide ranging impact on many insurers, it would not be appropriate for the Department to address that issue with a change to this rulemaking. Also, it would not be appropriate to abandon this rulemaking that has been long in the making and has the input and of many stakeholders who were involved in this two year process.

While the changes the Department submits to this rule are stylistic, these changes make this rule more clear, concise and understandable, as the Department committed to do in the five-year review. Additionally, the Department notes that while the NAIC revised its model regulation in 2005, the NAIC Model Regulation Service indicates that no states have adopted that revised model. Most states adopted the same birthday rule that the Department adopted in 1987. So, while that requirement was adopted some time ago, it remains the current standard in the industry, and Arizona remains in step with the national standard.

The Department is not opposed to considering this issue on its own merits for a possible later rulemaking.

COMMENT 11: This comment involves the removal of reference to "long-term care benefits" from the definition of "policy" in R20-6-201(A)(10). R20-6-201 is currently entitled "Advertisements of Disability Insurance." The term "disability" is being struck in the DOI proposal and the term "health" is being substituted therein. As a general matter, we agree with re-characterizing disability insurance to health insurance within the state of Arizona. However, the definition of "policy" in sub-paragraph (A)(10) references the term "long-term care benefits". We respectfully suggest that, that term be removed because of the possible confusion created by treating long-term care insurance as the same as health insurance in the state of Arizona.

Long-term care insurance does embody medically necessary services provided in a setting other than an acute care unit of a hospital. However, long-term care insurance also includes group and individual annuities and life insurance policies written as a supplement hereto (See A.R.S. § 20-1691(8)). In other words, long-term care insurance includes aspects of both health insurance and life insurance.

There is both a comprehensive statutory article governing long-term care insurance, Article 15, Title 20, § 20-1691, et seq., as well as a comprehensive regulation A.A.C. R20-6-1001 et seq., which provides a complete regulatory framework for long-term care insurance. Indeed, A.A.C. R20-6-1014 provides for the filing of advertising for long-term care insurance benefits in this state.

Simply, our concern is that placing long-term care insurance within the health insurance advertising regulation appears to be inconsistent with both the existing statutory and regulation framework for this important coverage because of the hybrid nature of this product. We believe it is more appropriate to address any specific concerns regarding long-term care insurance advertising within the context of the specific regulation relating to same. Therefore, we would ask that the reference to long-term care in R20-6-201(A)(10) be removed.

Response: The Department disagrees with this comment and believes that removal of this language will create confusion. The reference to long-term care was added to clarify that this provision applies all types of healthcare plans including health insurance and long-term care insurance. Long-term care insurance is a form of disability insurance as defined in A.R.S. § 20-253. This advertising rule has been applied to long-term care insurance since the rule was adopted.Compliance with the rule will not be new to companies that market long-term care products. The addition of the term long-term care benefits under the definition of "policy" was made only for clarification as was addition of the term "health insurance." Both are considered disability insurance under Title 20.

While there are other rules and statutes that are specific to long-term care, those do not contain details as to what is permitted or prohibited in practice when advertising material of all sorts is disseminated to the public. This rule contains clear requirements as to the acts and practices that are prohibited and contains important provisions that require disclosure of many insurance policy limitations and exclusions, without which the advertising would mislead the public.

COMMENT 12: R20-6-202(D)(16). One comment stated:
"The change proposed in this sub-paragraph would strike current language making it clear that a life insurance solicitation cannot include the use of dollar figures not related to guaranteed values and property projected dividend figures nor can it include figures showing growth of stock values or other values not a part of the life insurance contract. By striking the language indicating that these are prohibited practices, the Department is inadvertently condoning the use of such dollar figures which we submit is completely inconsistent with past and current regulatory practice.

We urge the Department not change the language in this sub-paragraph because it is not in the consumers' best interest."

Another comment stated the following regarding R20-6-202(D)(16):
"Due almost certainly to wording changes which have unintended effects, the Rule is proposed to be changed to mandate language that the existing version prohibits. We assume there is no change in the Department's attitude towards the prohibition itself. The existing Rule and proposed revision both say that an advertisement cannot use a dollar figure unless the figure is accompanied by language indicating what the dollar figure represents. The existing version then goes on to list irrelevant dollar figures which are prohibited. The proposed change runs the same list of irrelevant dollar figures after the "unless the figure is accompanied by language" phrase. The word "prohibited" is deleted and no comparable prohibitive language is introduced in its place. The consequence is that what was (and should be) prohibited is now proposed to become mandated language."

Response: The Department agrees with these comments. The language specifying the prohibitions is restored. The format of the subsection is revised to make it clearer.

COMMENT 13: The Department received comments on R20-6-209(B)(3) from two different commenters.

One comment stated that the definition of Equivalent Level Annual Dividends ("ELAD") seems to imply that the ELAD is a real dividend and not an illustrative example. An ELAD is not an actual dividend but is simply used for purposes of establishing a uniform benchmark for comparison purposes. The commenter believes the original language set for the in subparagraph (B)(3) should be preserved as being more accurate under the circumstances.

Another commenter stated that the proposal changes the definition of Equivalent Level Annual Dividends (ELADS) to say that the Equivalent Level Annual Dividend "is the dividend that is calculated…." The problem is that it "is" not a real dividend. It is an imaginary dividend that exists strictly for comparative purposes. This commenter believes it is inaccurate to say the ELAD "is" a dividend. The existing language is more accurate. Similarly the definition in R20-6-209(B)(4) for Equivalent Level Death Benefit is proposed to be changed to say it "is the death benefit.…" Again, it is not the death benefit but a pretend death benefit. The existing language is more accurate.

Response: The Department agrees with this comment. The phrase "means the dividend that is" is deleted. Additionally, the word "definitions" is deleted from the second sentence in R20-6-209(B).

COMMENT 14: R20-6-209(F)(6). The current regulation indicates that guarantees and non-guarantees cannot be shown as a single sum unless such guarantees are shown separately and given equal prominence in a life insurance illustration. The change proposed by this rewrite of the regulation eliminates the language permitting the use of a single sum for such guarantees so long as the guarantees are shown separately and with equal prominence. Frankly, prohibiting showing the guarantees and non-guarantees as a single sum would conflict with the NAIC Basic Illustration which is required for replacement purposes in Arizona and elsewhere (See A.R.S. § 20-1241.04), as well as creating a considerable administrative burden for life insurers doing business in the state requiring program changes that would only be relevant to Arizona on this point. All other states would be using the Basic Illustration approved by the NAIC and embodied in the NAIC Life Insurance Illustration Model Regulation which does permit a single sum so long as both guarantees are shown separately and with equal prominence. We would respectfully request that this change take place.

R20-6-209(F)(6) rewrites the current fairly common prohibition to create something unusual and, in our opinion, highly objectionable both from a cost and uniformity standpoint. The current version of the Rule conveys the general idea: it prohibits showing guarantees and nonguarantees as a single sum unless the guarantees are shown separately and with equal prominence. The idea is that if you show a total, be it a cash value or death benefit, the consumer should readily see that the guaranteed equivalent is lower, so you split out the guarantee separately. That is what all presentations and illustrations known to us are programmed to do. This new language says that guarantees and nonguarantees cannot be shown as a single sum, period. We do not believe this will result in more understandable illustrations or proposals. Indeed it would even seem to prohibit use of the tabular detail in an NAIC Basic Illustration, which is required in Arizona in cases of replacement (Az.Stat. Sec.20-1241.04) and provided in all sales by the many companies which voluntarily comply with the NAIC Life Insurance Illustration Model Regulation in Arizona. It would seem to mandate unique, and frankly not very clear, illustrations and proposals for use only in Arizona since no other state phrases its requirement in this manner. While the current language could perhaps be improved, this proposed change is highly objectionable.

Response: The Department agrees with this comment and has restored previously stricken language to read, "unless they are shown separately and in close proximity ~~thereto~~."

COMMENT 15: Last, we would ask that consideration be given to the adoption of the latest version of the NAIC Life Insurance Illustration Model Regulation in lieu of simply rewriting portions of the outdated Life Insurance Solicitation regulation currently on the books. This would be consistent with NAIC life insurance advertising disclosure requirements presently in place around the country. Indeed, we have enacted the life insurance replacement provisions of the NAIC which are completely consistent with the illustration model regulation which is intended to supplant the earlier life insurance solicitation regulation.

R20-6-209 is in large part the "old" NAIC life insurance solicitation regulation with confusing cost indexes and policy summary that the NAIC itself has determined are both inferior to the NAIC Basic Illustration in its disclosure. As stated above, we encourage the Department to consider adopting the newer NAIC Models.

R20-6-202(D)(9). Arizona has yet to adopt the NAIC Life Insurance Illustration Model Regulation, yet Arizona consumers benefit from its protections because national insurers use the same "disciplined current scale" in Arizona as in states that have the regulation. Thus, Arizona consumers are no longer experiencing the manipulation and "illustration games" that were common before the NAIC Model addressed them. Nonetheless we believe Arizona should continue to guard against these practices in its regulations. With respect to dividends, in theory the proposal opens up an illustration loophole by removing the phrase "being used" after "actual scale." The NAIC Model recognizes that some companies had an "actual scale" but which nonetheless was not a scale the company was currently using if the "actual scale" assumed future improvements over current scale in mortality, expenses, or investment earnings. Again, it is hard to imagine a national insurance company having a manipulated illustration or dividend scale just for Arizona to take advantage of this new loophole. But that is what the change in language seems to encourage.

Indeed we take this opportunity to respectfully urge the Arizona Department to adopt the NAIC Life Insurance Illustration Model Regulation as well as the newer versions of the NAIC's life insurance advertising and disclosure regulations which are part of the new generation of NAIC model regulations.

Modifying the outmoded solicitation regulation is less fruitful than would be adopting the Life Insurance Illustration Model Regulation, and then following the NAIC's suggestion in adopting the new NAIC life advertising and NAIC life insurance disclosure regulations, which are all meant to go together. The Arizona legislature has enacted the new NAIC life insurance replacement regulation, which is premised on the state having already adopted the Illustration Model Regulation.

Response: The Department is interested in adopting the NAIC Life Insurance Illustration Model Law has attempted legislation twice, but has been unsuccessful. The Department is again considering legislation to adopt the model law. The Illustration is a Model Law not intended to be adopted as a rule, but as a statute.

COMMENT 16: R20-6-201(C). The existing rule language tracks NAIC model rule language, in that words such as "all," "full," "complete," etc., are not to be used if the use has the effect of exaggerating the coverage advertised. The existing rule explicitly says use of such words is allowed provided it accurately describes the benefit. The rewording and reordering of words conveys instead that these words cannot be used because they exaggerate the coverage provided. What can be said if "full," "complete," or "all" are exactly the correct word is now left unaddressed. Assuming the Department means no change in the practical operation of the rule, we believe the existing wording is clearer: what is prohibited should be the false and misleading use of those words, not that they are always false or misleading perse.

Response: The Department believes that this language has been misinterpreted. There is not a prohibition on use of these terms. The rule requires that these words not be used to exaggerate a benefit beyond the terms of the policy.

COMMENT 17: R20-6-201(C)(7) to (C)(9). The common theme of these provisions is that an advertisement which gets very detailed about the coverage, or makes specific statements about benefits payable, has to include language about exclusions, waiting periods, pre-existing conditions, and other specific caveats on coverage. The concept is common to the NAIC Model as well as the advertising regulations of most states: if the upside specifics are advertised, then the downside specifics must be mentioned as well. This is accomplished in the current rules by way of a cross-reference ["an advertisement covered by (C)(2)"] to a subsection that talks about benefit-specific advertisements. That cross-reference is eliminated in the revision. To take its place, new language is introduced in (C)(7) and (C)(9) to preserve the central concept. For example, (C)(9) says that the advertisement has to talk about pre-existing conditions, but only if it gets specific about product information, benefit levels, or dollar amounts. However, there is no comparable language for (C)(8), which mandates disclosure about waiting periods and elimination periods, but is no longer tied to whether the advertisement is specific about claims, as is the current version. The practical consequence is that a very general ad with nothing specific in it about policy provisions, benefit payments, or claims would seemingly be mandated to include this very specific disclosure of waiting periods and elimination periods. As a consequence of this, very common advertising could not be used in Arizona. To preserve the current concept of the Rule, what is needed in (C)(8) is the same "however an insurer is not required to make disclosure if" language that is found in (C)(9).

Response: The Department agrees that a change needs to be made for clarity. R20-6-201(C)(8) is revised to add "covered by (C)(7)" after "An advertisement" in the first sentence.

COMMENT 18: R20-6-201(E). Testimonials. The proposal would add "The insurer shall provide the Department with the full name of the author and a full copy of the testimonial" to the current language. It is phrased as a stand-alone requirement; read literally, this must be sent to the Department in every instance of a testimonial. We assume the intent was to say "at the request of the Department" or "if the advertisement is filed with the Department." Otherwise this becomes an unusual and thus burdensome requirement.

Response: The Department agrees with this comment. The phrase "if the advertisement is filed with the Department or requested by the Department" is added to the end of this sentence.

COMMENT 19: R20-6-202(D)(2).This rule prohibits using any phrase as the name or title for a life insurance policy which does not include the words "life insurance." The current Rule is similar but has an important exception: unless other language "clearly indicates" the policy is a life insurance policy. The proposal changes this to "expressly provides." It is unclear to us what "expressly provides" can mean other than to use the words "life insurance." The effect of this change is to significantly change a practical and useful exception. If the other language says the policy will provide money to your family upon death, that "clearly indicates" that the policy is life insurance but does not, perhaps, "expressly provide" that it is life insurance. We believe the current language is more practical than the proposal and offers no less protection to consumers.

Response: The Department disagrees and believes this is an important disclosure to be made. It is a simple statement for purposes of clarity for insurance purchasers. Arizona has many insurance purchasers who are elderly and such a statement provides information to them that is clear, understandable, and necessary. The Department disagrees with the commenter's contention that if there is a benefit at death, this "clearly indicates" that this is a life insurance policy.This is not always true. For example, under a prepaid funeral contract arrangement sold by a funeral home, a consumer chooses the consumer's own funeral and burial arrangements and then prepays for those arrangements. The benefit here is that upon death, the consumer's funeral and burial arrangements are without cost to the consumer's family. What is not clearly indicated is that the contract is funded through a life insurance policy that the consumer-purchases as part of the contract with the funeral home under which the funeral home is the beneficiary. The life insurance policy in this arrangement must expressly provide that it is a life insurance policy, otherwise a consumer

could mistake it to be a part of the prepaid funeral contract.The Department believes that this is an important disclosure that must be made for consumer protection.

COMMENT 20: R20-6-203 relates to filing translations of documents in languages other than English. The mandatory format and mandated qualifications for the translator are very precise and prescriptive. We suggest the addition of some sort of safety valve wording that indicates that any other filing format or qualifications to the satisfaction of the Department are acceptable.

Response: It is important that the format and qualifications for the translator be precise and prescriptive. The standards need to be clear, concise and understandable. To include the type of "catch-all" language that the commenter suggests would provide a vague standard and would make it difficult for those making filings to know exactly what is required.

COMMENT 21: The Buyer's Guide which is an appendix to R20-6-209 is the "old" NAIC Buyer's Guide. This old version has to be used because it explains, or tries to explain, the various mandated cost indexes. The new Buyer's Guide from the NAIC omits that. On the other hand, the new Buyer's Guide is more useful for consumers because it discusses universal life insurance, while the old Buyer's Guide discusses endowment insurance instead — a product which has all but disappeared from the marketplace.

Response: The NAIC is currently reviewing the Buyer's Guide for possible revision in 2007. The Department will revise the appendix after the NAIC changes are finalized.

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 locations in the rules:

R20-6-212:

1. Life Insurance and Annuities Replacement Model Regulation, Appendix A - Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-11 through 613-12, July 2000.
2. Life Insurance and Annuities Replacement Model Regulation, Appendix B - Notice Regarding Replacement: Replacing Your Life Insurance Policy or Annuity?, Volume III, pp. 613-13, July 2000.
3. Life Insurance and Annuities Replacement Model Regulation, Appendix C - Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-14 through 613-15, 1998.

R20-6-212.01:

Annuity Disclosure Model Regulation, Appendix - Buyer's Guide to Fixed Deferred Annuities, Volume II, pp. 245-6 through 245-13, 1999, with attached Appendix I - Equity-Indexed Annuities, Volume II, pp. 245-14 through 245-20, 1999.

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

No

15. The full text of the rules follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 2. TRANSACTION OF INSURANCE

Section

R20-6-201. Advertisements of ~~Disability~~ Health Insurance
R20-6-201.01. Insurer Advertising Responsibility and Records
R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form
R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance
R20-6-203. ~~Repealed~~ Form Filings; Translations
R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers
~~R20-6-206.~~R20-6-205. ~~Repealed~~ Local or Regional Retaliatory Tax Information
~~R20-6-207.~~R20-6-206. Industrial Insureds
~~R20-6-209.~~R20-6-207. ~~Unfair Sex~~ Gender Discrimination
~~R20-6-210.~~R20-6-208. ~~Expired~~ Group Coverage Discontinuance and Replacement
~~R20-6-211.~~R20-6-209. Life Insurance Solicitation
~~R20-6-212.~~R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

~~R20-6-213.~~R20-6-211. ~~Unfair~~ Discrimination on the Basis of Blindness~~,~~ or Partial Blindness
~~R20-6-215.~~R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities
~~R20-6-215.01.~~R20-6-212.01. Forms for Buyer's Guide for Annuities
~~R20-6-216.~~R20-6-213. Life and Disability Insurance Policy Language Simplification
~~R20-6-217.~~R20-6-214. ~~Expired~~ Coordination of Benefits

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-201. Advertisements of ~~Disability~~ Health Insurance

A. Definitions. The following definitions apply to this Section and to R20-6-201.01, R20-6-201.02, and R20-6-203:

~~1. "An advertisement for the purpose of these rules shall include:~~

1. "Advertisement" means materials and information used by an insurer to generate insurance business.
   a. Advertisement includes the following information:
      ~~a.~~i. Printed and published material, audio visual material, or other forms of electronic communication that ~~and descriptive literature of~~ an insurer ~~used~~ uses or displays in direct mail, newspapers, magazines, radio, ~~and TV scripts,~~ television, billboards, Internet web sites, and similar ~~displays~~ media to inform the public about the insurer or its products; ~~and~~
      ~~b.~~ii. Descriptive literature and sales aids ~~of all kinds issued by~~ an insurer issues or releases for presentation to members of the public, including ~~but not limited to~~ circulars, leaflets, booklets, depictions, illustrations, and form letters; ~~and~~
      ~~c.~~iii. Prepared sales talks~~,~~ and presentations and material for use by an insurer or prepared by an insurer for use by authorized ~~agents and brokers~~ producers; and~~, and representations made by agents and brokers in accordance therewith~~.
      iv. Material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;
   b. "Advertisement" does not include the following:
      i. Material used solely for training and educating an insurer's employees or producers;
      ii. Material used in-house by insurers;
      iii. Communications within an insurer's own organization not intended for dissemination to the public;
      iv. Individual communications with current policy holders regarding a member's personal information other than material urging the policyholders to increase or expand coverages;
      v. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;
      vi. Court-approved material ordered by a court to be disseminated to policyholders;
      vii. Material in connection with promotion or sponsorship of a charitable event in which only the name of the insurer is displayed;
      viii. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged. The announcement shall clearly indicate that it is preliminary to the issuance of a booklet and that does not describe the specific benefits under the contract or program nor the advantages as to the purchase of the contract or program;
      ix. A general announcement by the sponsor that endorses the program;
      x. Health and wellness material with general health and wellness information; or
      xi. Press releases and news releases not intended to generate business.
2. "Disability insurance" has the same meaning prescribed in A.R.S. § 20-253.
3. "Elimination period" means the time between the date a loss occurs and the date that benefits begin to accrue for that loss.
4. "Exclusion" means a policy term stating a risk that an insurer has not assumed.
5. "Health insurance" means:
   a. Disability insurance;
   b. Insurance provided by a service corporation regulated under A.R.S. § 20-821 et seq.;
   c. Insurance provided by a prepaid dental plan organization regulated under A.R.S. § 20-1001 et seq.; and
   d. Insurance provided by a health care services organization regulated under A.R.S. § 20-1051 et seq.
6. "Insurance administrator" or "administrator" has the meaning prescribed in A.R.S. § 20-485(A)(1).
7. "Insurer" has the same meaning prescribed in A.R.S. § 20-104.
8. "Limitation" means a policy term, other than an exclusion or reduction, that decreases the risk assumed by the insurer or the insurer's obligation to provide benefits.
9. "Person" has the meaning in A.R.S. § 20-105.

~~2.~~10. "Policy" ~~for the purpose of these rules shall include~~ means any ~~policy,~~ plan, certificate, contract, agreement, statement of coverage, evidence of coverage, subscription contract, membership coverage, rider, or endorsement ~~which~~ that provides disability benefits, health insurance, ~~or~~ medical, surgical or hospital expense benefits, long-term care

benefits, or Medicare supplement benefits ~~whether on~~ in the form of a cash indemnity, reimbursement, or service ~~basis, except when other than life, and except disability and double indemnity benefits included in life insurance and annuity contracts~~.

11. "Reduction" means a policy term that reduces the amount of an insured's benefits. A reduction means that the insurer has assumed the risk of a particular loss, but the amount or period of the insurer's coverage is less than what the insurer would have paid for the loss without the reduction.
12. "Spokesperson" means a person making a testimonial about or an endorsement of an insurer's product who:
    a. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or independent contractor;
    b. Has been formed by the insurer, is owned or controlled by the insurer or its employees, or is a person who owns or controls an insurer;
    c. Is in a policy-making position and affiliated with the insurer in any capacity described in subsections (a) or (b); or
    d. Is directly or indirectly compensated for making the testimonial or endorsement.

~~3. "Insurer" for the purpose of these rules shall include any individual, agent, broker, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the advertisement of a policy as herein defined.~~

~~**B.** Advertisements in general. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.~~

~~**C.** Advertisements of benefits payable, losses covered or premiums payable~~

~~1. Deceptive words, phrases or illustrations. Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity and tendency to deceive as to the extent of any policy benefit payable, loss covered or premium payable. An advertisement relating to any policy benefit payable, loss covered or premium payable shall be sufficiently complete and clear as to avoid deception or the capacity and tendency to deceive.~~

~~a. Explanation:~~

B. Scope.

1. This Section applies to all advertisements for health insurance.
2. This Section applies to the conduct of insurers, producers, and third-party administrators.

C. General requirements. Insurers, producers, and third-party administrators shall ensure that health insurance advertisements meet the requirements of this Section.

1. Advertisements shall be truthful and not misleading. The insurer shall not use words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.
2. An advertisement shall not omit information or use words, phrases, statements, references, or illustrations if the omission of information or use of words, phrases, statements, references, or illustrations may mislead or deceive purchasers or prospective purchasers.

~~i.~~3. The words and phrases used to describe a policy shall accurately describe the benefits of the policy and not exaggerate any benefit through the use of phrases such as ~~the~~ "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills" or "this policy will replace your income," or similar words and phrases ~~shall not be used so as to exaggerate any benefit beyond the terms of the policy but may be used only in such manner as fairly to describe such benefit~~.

~~ii.~~4. ~~A~~ If a policy ~~covering~~ covers only ~~1~~ one disease or a list of specified diseases, any advertisement for the policy shall not ~~be advertised so as to~~ imply coverage beyond the ~~terms of the policy. Synonymous~~ specified diseases. ~~terms shall not be used to refer to any disease so as to imply broader coverage than is the fact~~.

~~iii.~~5. ~~The benefits of~~ If a policy ~~which~~ pays varying amounts for the same loss occurring under different conditions or ~~which~~ pays benefits only when a loss occurs under certain conditions, any advertisement for the policy shall ~~not be advertised without disclosing~~ disclose the limited conditions ~~under which the benefits referred to are provided by the policy~~.

~~iv.~~6. ~~Phrases such as "this policy pays $1,800~~ If an advertisement specifies payment of a particular dollar amount for hospital room and board expenses,~~"~~ the advertisement shall also include ~~are incomplete without indicating~~ the maximum daily benefit and the maximum time limit for ~~hospital room and board~~ which those expenses are covered.

~~2.~~7. ~~Exceptions, reductions and limitations. When an~~ An advertisement that refers to any dollar amount, period of time for which ~~any~~ a benefit is payable, cost of policy, or specific policy benefit or the loss for which ~~such~~ a benefit is payable~~, it~~ shall also disclose any related exclusions ~~those exceptions~~, reductions, and limitations ~~affecting the basic provisions of the policy~~ without which the advertisement would have the capacity and tendency to mislead or deceive.

~~a. Explanation:~~

~~i. The term "exception" shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.~~

~~ii. The term "reduction" shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would~~

~~be otherwise payable had such reduction clause not been used.~~

~~iii. The term "limitation" shall mean any provision which restricts coverage under the policy other than an exception or a reduction.~~

~~iv. Waiting, elimination, probationary or similar periods -- When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an An advertisement covered by (C)(2) shall disclose the existence of such any waiting or elimination periods.~~

8. An advertisement covered by subsection (C)(7) shall disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy. The advertisement shall disclose the existence of an elimination period.

~~3. Pre-existing conditions~~

~~a.~~9. An advertisement ~~covered by (C)(2)~~ shall disclose ~~the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy~~ any exclusion, reduction, or limitation applicable to a pre-existing condition; however, an insurer is not required to make disclosure in an advertisement that does not reference specific product information, benefit level, or dollar amounts.

~~b.~~10. ~~When~~ If a policy ~~does not cover losses traceable to~~ has an exclusion, reduction, or limitation applicable to a preexisting ~~conditions~~ condition, ~~no~~ an advertisement ~~of the policy~~ shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim ~~thereunder. This limits the~~ and shall not use ~~of~~ the phrase "no medical examination required" ~~and~~ or other similar phrase. ~~phrases of similar import.~~

~~**D.**~~11. ~~Necessity for disclosing policy provisions relating to renewability, cancellability and termination -- An~~ If an advertisement ~~which~~ refers to renewability, cancellation, or termination of a policy, or ~~which~~ states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, the advertisement shall disclose the provisions relating to renewability, ~~cancellability~~ cancellation, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner ~~which shall~~ that does not minimize or ~~render~~ obscure the qualifying conditions.

12. An advertisement shall not make any offer prohibited under A.R.S. § 20-452(4).

13. An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised is exempt from approval or not subject to approval by order or statute.

14. An advertisement shall not state or imply that a product being offered is an introductory, special, or initial offer that will entitle the applicant to receive advantages not described in the policy by accepting the offer.

15. An advertisement designed to produce leads either by use of a coupon, a request to write or call the company, or subsequent advertisement before contact, shall disclose that a producer may contact the potential applicant.

~~**E.**~~**D.** Method of disclosure of required information. ~~--~~ ~~All information~~ If an insurer is required by law to disclose particular information, the information ~~required to be disclosed by these rules~~ shall be ~~set out conspicuously~~ conspicuous and in close ~~conjunction with~~ proximity to the statements to which ~~such~~ the information relates, or under ~~appropriate~~ a prominent ~~captions~~ caption ~~of such prominence~~ so that ~~it shall~~ the required disclosure is not ~~be~~ minimized, ~~rendered obscure~~ obscured, ~~or~~ presented in an ambiguous fashion, or intermingled with the ~~context~~ content of the advertisement ~~so as to be confusing or misleading~~.

~~**F.**~~**E.** Testimonials. ~~--~~

1. Testimonials used in advertisements ~~must~~ shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer shall provide the Department with the full name of the author and a copy of the full testimonial if the advertisement is filed with the Department or requested by the Department. ~~The~~ If an insurer~~, in using~~ uses a testimonial, the insurer adopts ~~makes as its own all of~~ the statements ~~contained therein~~ in the testimonial as the insurer's own statements ~~and the advertisement including such statements is subject to all of the provisions of these rules~~. If a testimonial or endorsement is used more than one year after it is given, the insurer shall obtain a written confirmation from the author that the testimonial represents the current opinion of the author.
2. The insurer shall disclose that a spokesperson has a financial interest or the proprietary or representative capacity of a spokesperson in an advertisement in the introductory portion of a testimonial or endorsement in the same form and with equal prominence as the endorsement. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the insurer shall disclose that fact in the advertisement by language that states, "Paid Endorsement," or words of similar import in type, style, and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. For television or radio advertising, the insurer shall place the required disclosure prominently in the introductory portion of the advertisement.

~~**G.**~~**F.** ~~Use of statistics~~ Statistics. ~~--~~ An advertisement ~~relating to~~ with information on the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use facts that are irrelevant to the sale of insurance and shall ~~not be used unless it~~ accurately ~~reflects~~ reflect all of the relevant facts specific to the advertised policy or insurer. ~~Such an~~ An advertisement shall not state or imply that ~~such~~ statistics are derived from the

policy being advertised unless ~~such is the fact.~~ that is true. The insurer shall identify in the advertisement the source of any statistics used.

~~H.~~**G.** Inspection of policy. ~~—~~ An offer in an advertisement of free inspection of a policy or offer of a premium refund ~~is~~ does not ~~a~~ cure ~~for~~ misleading or deceptive statements ~~contained~~ in ~~such~~ the advertisement.

~~I.~~**H.** Identification of plan or number of policies.

1. ~~When~~ If an advertisement offers a choice ~~of~~ in the amount of benefits ~~is referred to, an~~ the advertisement shall disclose that the amount of benefits ~~provided~~ depends ~~upon~~ on the ~~plan~~ policy selected and that the premium will vary with the amount of the benefits.
2. ~~When~~ If an advertisement refers to ~~various~~ benefits ~~which may be~~ contained in ~~2 or~~ more than one ~~policies~~ policy, other than a group master ~~policies~~ policy, the advertisement shall disclose that ~~such~~ the benefits are provided only ~~through a combination of such~~ if multiple policies are purchased.

~~J.~~**I.** Disparaging comparisons and statements. ~~—~~ An advertisement shall not ~~directly or indirectly~~ make unfair, ~~or~~ incomplete, or unsubstantiated comparisons of other insurers' policies or benefits or ~~otherwise~~ falsely disparage ~~competitors, their~~ other insurers' policies, services, or business methods. A comparison is unsubstantiated if the insurer has no empirical study, analysis, or documentation supporting the comparative statement or comparison of policies or benefits.

~~K.~~**J.** Jurisdictional ~~licensing~~ limits.

~~1.~~ ~~An~~ If an insurer has an advertisement ~~which is intended~~ that is meant to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed, the advertisement shall ~~not imply licensing beyond those limits.~~

~~2.~~ ~~Such advertisements by direct mail insurers shall~~ indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of ~~some~~ language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."

~~L.~~**K.** Identity of insurer. ~~-- The identity of the insurer shall be made clear in all of its advertisements. An advertisement shall not use a trade name, service mark, slogan, symbol or other device which has the capacity and tendency to mislead or deceive as to the true identity of the insurer.~~ The insurer shall state the name of the actual insurer in all of its advertisements. An advertisement shall clearly identify the insurer and shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device ~~which has the capacity and tendency to~~ that may mislead or deceive the public as to the ~~true~~ insurer's identity ~~of the insurer~~.

~~M.~~**L.** Group ~~or quasi-group implications~~ insurance. An advertisement ~~of a particular policy~~ shall not state or imply that prospective policyholders become group or quasi-group members and ~~as such~~ enjoy special rates or underwriting privileges, unless ~~such is the fact~~ it is true. An advertisement to join an association, trust, or group that is also an invitation to contract for insurance coverage shall disclose that the applicant will be purchasing both membership in the association, trust, or group and insurance coverage.

~~N. Introductory, initial or special offers -- An advertisement shall not state or imply that a particular policy or combination of policies is an introductory, initial, or special offer and that the applicant will receive advantages by accepting the offer, unless such is the fact.~~

~~O. Approval or endorsement by third parties~~

~~1.~~**M.** Government approval. An advertisement shall not state or imply ~~that~~ any of the following:

1. ~~an~~ That a governmental agency or regulator is connected with or has provided or endorsed a policy or endorsed an insurer ~~or a policy~~;
2. That a governmental agency or regulator has examined ~~been approved or~~ an insurer's financial condition ~~has been examined~~ and found ~~to be~~ it satisfactory ~~by a governmental agency, unless such is the fact.~~ This subsection does not apply if an insurer is responding to a specific documented, public, false allegation about its financial condition.

~~2.~~**N.** Endorsements. An advertisement ~~shall not~~ may state ~~or imply~~ that ~~an insurer or a policy has been approved or endorsed by any~~ an individual, group ~~of individuals~~, society, association, or other organization has approved or endorsed the insurer or its policy~~, unless such is the fact~~ if the organization or group has done so in writing and if any proprietary relationship between the organization and the insured is disclosed.

~~P.~~**O.** ~~Service facilities~~ Claims handling. An advertisement shall not contain ~~untrue~~ false statements ~~with respect to~~ about the time within which claims are paid or statements ~~which~~ that imply that claim settlements will be liberal or generous beyond the terms of the policy.

~~Q.~~**P.** Statements about ~~an~~ the insurer. ~~—~~ An advertisement shall not contain false or misleading statements ~~which are untrue in fact or by implication misleading with respect to the~~ about an insurer's assets, corporate structure, financial standing, ~~age~~ length of time in business, or relative position in the insurance business.

~~R. Special enforcement procedures~~

~~1. Advertising file -- Each insurer shall maintain at its home or principal office a complete file containing every printed, published, recorded, or prepared advertisement of individual policies and typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to reg-~~

~~ular and periodical inspection by this Department. All such advertisements and shall be maintained in said file for a period of not less than 3 years.~~

~~2. Certificate of compliance -- Each insurer required to file an annual statement, which is now or which hereafter becomes subject to the provisions of this rule, must file with this Department, together with its annual statement, a certificate executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied, or were made to comply, in all respects with the provisions of the insurance laws of this state as implemented and interpreted by this rule.~~

~~3. Acknowledgment -- It is requested that the chief executive officer of each insurer to which this rule is addressed acknowledge its receipt and indicate its intention to comply therewith.~~

R20-6-201.01. Insurer Advertising Responsibility and Records

A. An insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements. The insurer whose policies are advertised is responsible for the advertisements, regardless of who writes, creates, designs, or presents the advertisement, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement about an insurer or its products, a producer shall get written approval from the insurer for use of advertisements that were not supplied by the insurer.

B. An insurer shall maintain, at its home or principal office, the following:

1. Advertisements disseminated by the insurer in Arizona or any other state, including:
   a. Each printed, published, recorded, or prepared advertisement of individual policies; and
   b. Typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies.
2. A notation attached to each advertisement specifying the manner and extent of distribution and the form number of any policy advertised; and
3. Documentation supporting any testimonials, statistical claims, or comparisons shown in the advertising.

C. An insurer shall maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination.

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

A. An insurer that is required to file a health insurance advertisement with the Department as specified in A.R.S. §§ 20-826(T), 20-1018, 20-1057(X), 20-1110(E), or 20-1662 shall file the advertisement with a transmittal form prescribed by the Department.

B. The transmittal form shall include the following information:

1. Identifying information of the insurer, including name, address, National Association of Insurance Commissioners' identification number, and type of insurer;
2. A contact person at the insurer with whom the Department can communicate about the advertisement;
3. Description of the type of advertisement being filed;
4. Planned use and dissemination of the advertisement, including date of first use, or a statement that the advertisement will not be used any earlier than a specified date;
5. Description of product being advertised;
6. Form number and name for the advertised product;
7. A certification from an officer of the insurer that the advertisement complies with applicable laws; and
8. The dated signature of the insurer's officer.

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

~~**A.** Authority and purpose -- This rule is adopted by the Director of Insurance pursuant to the rulemaking power of A.R.S. § 20-143, subject to the provisions of A.R.S. §§ 41-1001 through 41-1008. It is the purpose of this rule to implement the administration of the Arizona Insurance Code by defining acts and practices which are contrary to or would violate various sections of the Insurance Code, including but not limited to Title 20, Chapter 2, Articles 1, 2, 3 and 6, Chapter 5, Article 1 and Chapter 6, Article.~~

A. The definitions in R20-6-201(A) and the following definition apply in this Section:
"Life insurance" means a life insurance contract, including all benefits payable under the policy.

B. Applicability.

1. This ~~rule shall apply~~ Section applies to:
   a. ~~To any insurance company, agent, person, broker, or solicitor, as those terms are defined in the Insurance Code~~ All persons subject to regulation under A.R.S. Title 20; and
   b. ~~To acts and practices in the advertising~~ Advertising, promotion, solicitation, negotiation, ~~or effecting the~~ and sale of life insurance policies, regardless of the form of dissemination~~;~~.
   ~~c. To such acts and practices, whether they involve the use of language disseminated by means of sales kits, policy jackets or covers, letters, personal presentations, visual aids, or other sales media.~~
2. This ~~rule shall~~ Section does not apply to group insurance, franchise insurance, or to annuities without life contingen-

cies.

C. ~~Policy~~ General provisions.

1. ~~Misleading, through omissions, use of irrelevant material, or improper emphasis~~ The purpose of this rule essentially ~~is to assure the fair disclosure of relevant facts in the sale of life insurance. As used herein, the words "life insurance" shall mean the entire life insurance contract, including all benefits provided therein, and are not intended to be limited to the benefits payable on death. It is also designed to protect purchasers and prospective purchasers of life insurance policies against the use of sales methods which are misleading because of~~ A life insurance advertisement shall not mislead the public by:

~~a.~~1. ~~Omission of~~ Omitting information that ~~facts~~ fairly ~~describing both~~ describes the subject matter as a life insurance policy and the benefits ~~obtainable thereunder~~ available under the policy; ~~or~~

~~b.~~2. ~~An~~ Placing undue emphasis ~~upon~~ on facts ~~which~~ that, ~~however~~ even if true, are not relevant to the sale of life insurance; or

~~c.~~3. ~~An~~ Placing undue emphasis ~~upon~~ on features ~~which are~~ of incidental or secondary importance to the life insurance aspects of the policy.

2. ~~In considering possible the Department of Insurance will consider as relevant to a proposed sale, statements which are intended to:~~
   a. ~~Motivate the insured to purchase life insurance; or~~
   b. ~~Provide an explanation of the benefits provided by the life insurance policy; or~~
   c. ~~Present a picture of the company's ability to conduct a life insurance business.~~

3. ~~Specified acts and practices -- To assure such fair disclosure and to prevent the use of misleading sales methods, this rule provides advance interpretations as to the specific acts and practices which the Department of Insurance believes constitute a violation of such statutes; provided, however, it is recognized that whether particular conduct comes within the prohibition of such statutory provisions depends on the facts in each case.~~

4. ~~Acts and practices not specified -- Although this rule is intended to cover selected acts and practices which have been of serious concern to the Department of Insurance, this delineation is not a determination that any act of practice not specified herein is in conformance with the statutes. However, this rule will be read as a guide in considering whether any unspecified act or practice is of the kind or character which may be within the prohibitions of the statute and this rule.~~

D. ~~Prohibited acts and practices.~~ The Department deems the following acts misleading and deceptive:

1. ~~References to profits and investments -- In accordance with the authority, applicability and policy set out in subsections (A) through (C) above, the following is declared to be a violation of this rule:~~ ~~The~~ Using any statement, including ~~use of the word or words~~ phrases such as "investment," "investment plan," "founders plan," "charter plan," "expansion plan," "profit," "profits," or "profit sharing," in a context or under ~~such~~ circumstances or conditions ~~as to have the capacity and tendency to~~ that may mislead a purchaser or prospective purchaser to believe that ~~he will receive~~ the insurer is selling something other than a life insurance policy~~.~~ or will provide some benefit not ~~provided~~ included in the policy, or ~~some benefit~~ not available to other persons of the same class and equal expectation of life~~.~~; ~~This is not intended to prohibit appropriate presentation of the investment elements of a life insurance policy.~~

2. ~~Other limitations -- In accordance with subsections (A) through (C) above, the acts and practices set out in the following paragraphs are declared to be a violation of this rule in the sale of life insurance when used in a context or done under such circumstances or conditions as to have the capacity or tendency to mislead a purchaser or prospective purchaser to believe that he will receive, or that it is probable he will receive, something other than a life insurance policy, some benefit not provided in the policy, or some benefit not available to other persons of the same class and equal expectation of life. Each of said paragraphs will, therefore, be construed and applied in accordance with the provisions of this Section~~.
   a. Using any phrase as the name or title of a life insurance policy ~~which~~ if the phrase does not include the words "life insurance," unless ~~accompanied by~~ other language in the same document ~~clearly indicating~~ expressly provides that the contract ~~referred to~~ is a life insurance policy~~.~~;

~~b.~~3. Making any statement relating to the growth or earnings of the life insurance industry or to the tax status of life insurance companies in a context ~~which~~ that would reasonably be understood as attempting to interest a ~~prospect~~ prospective applicant in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy~~.~~;

~~c.~~4. Making any statement ~~which~~ that reasonably ~~gives rise to the belief~~ tends to imply that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by ~~virtue of the purchase of~~ purchasing the policy, unless ~~such~~ the statement is made with reference to policies of domestic life insurers engaged in a program ~~as set forth in the provisions of~~ allowed under A.R.S. § 20-453~~.~~;

~~d.~~5. Providing a policyholder with ~~any~~ a premium receipt book, policy jacket, return envelope, or other printed or electronic material ~~containing references to the company's~~ referring to the insurer's "investment department," "insured investment department," or similar terminology in a manner ~~as to imply~~ implying that the policy is sold, ~~or~~ issued, or ~~is~~ serviced by the insurer's investment department ~~of an insurance company.~~;

~~3. Referenced to special benefits~~

~~a.~~6. Making any statement ~~which~~ that reasonably tends to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive the payment of dividends, special advantages, benefits, or favored treatment unless ~~such is specifically provided in~~ the insurance contract specifically provides for the described payment of dividend, special advantages, benefits, or favored treatment; ~~This paragraph has no relation or applicability to policies under which insured persons of 1 class of risk may receive dividends of a higher rate than persons of another class of risk.~~

~~b. Stating that each stockholder is given the right to purchase or allocate a specific number of policies.~~

~~c.~~7. Stating or implying that only a limited number of persons or limited class of persons ~~will be eligible to~~ may buy a particular kind of policy, unless ~~such~~ the limitation is related to recognized underwriting practices~~,~~ or ~~unless such limitation is~~ specifically stated in the policy or rider ~~therefore.~~;

~~d. Stating that the policyholders who are to act as "centers of influence" for an insurance company in that capacity will share in the company's surplus earnings in some manner not available to other policyholders of the same class.~~

~~4. Coupons~~

~~a. Stating or implying that the principal amounts payable under the coupons represent interest, earnings, return on investments, a bonus, or anything other than benefits, the cost of which is included in the total premium.~~

~~b.~~8. Describing premium payments in language ~~which~~ that states the payment is a "deposit," unless:

~~i.~~a. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder~~.~~, or

~~ii.~~b. The term is used ~~in conjunction~~ with the word "premium" in a manner as to clearly indicate the true character of the payment~~.~~;

~~5.~~9. ~~References to dividends~~

~~a.~~ Providing any illustration or projection of future dividends ~~which~~ that:

a. ~~is~~ Is not based on the company's actual scale ~~being used by the company~~ for ~~the~~ payment of current dividends~~.~~, and

b. ~~Furthermore, such projection or illustration must~~ Does not clearly indicate that the dividends are not guarantees~~.~~;

~~b.~~10. Using the words "dividends," "cash dividends," "surplus," or similar phrases in ~~such~~ a manner ~~as to state~~ that states or ~~imply~~ implies that the payment of dividends is guaranteed or certain to occur~~.~~;

~~c.~~11. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the insurer's earnings ~~of the company.~~;

~~d.~~12. Making any statement that projected dividends under a participating policy will be or can be sufficient at any future time to assure the receipt of benefits such as a paid-up policy without further payment of premiums unless the statement ~~is accompanied by an adequate explanation as to~~ also explains:

~~i.~~a. ~~What~~ The benefits or coverage that would be provided at ~~such~~ the future time~~.~~, and

~~ii.~~b. ~~Under which~~ The conditions ~~this~~ under which the receipt of benefits without further payment of premiums would occur~~.~~;

~~6. Miscellaneous~~

~~a.~~13. Describing a life insurance policy or premium payments ~~therefor~~ in terms of "units of participation," unless accompanied by other language clearly indicating that the references are to a life insurance policy or to premium payments, as ~~the case may be~~ applicable.

~~b. Using the words "contract," "contract plan," or "plan" in describing a life insurance policy, unless accompanied by other language in the same document clearly indicating the reference is to a life insurance policy.~~

~~c.~~14. ~~Including in sales kits and prepared sales presentations proposed answers to a prospect's question as to whether life insurance is being sold, which are designed to avoid a clear and unequivocal statement that LIFE INSURANCE IS THE SUBJECT MATTER OF THE SOLICITATION~~. Advising producers to avoid disclosing that life insurance is the subject of the solicitation or sale;

~~d.~~15. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without ~~making an explanation of~~ explaining the non-forfeiture benefits~~.~~;

~~e.~~16. Using a dollar amount in printed material to be shown to a prospective policyholder, unless the amount is accompanied by language ~~in such material indicating the~~ that:

a. States the nature of the ~~figure. (This is intended to~~ dollar amount,

b. ~~prohibit~~ Prohibits including the use of dollar ~~figures~~ amounts not ~~in relation~~ related to guaranteed values and properly projected dividend figures~~. It is intended to prohibit~~, and

c. Prohibits the use of figures showing growth of stock values, or other values not a part of the life insurance contract.~~)~~

~~f.~~17. Stating that a policy provides ~~certain~~ features ~~which are~~ not found in any other insurance ~~policies~~ policy, unless ~~that in fact be true~~ the insurer can demonstrate that other policies do not have the same feature~~.~~;

~~g.~~18. ~~The making of~~ Making any statement or implication ~~in regard to~~ about an insurance policy that cannot be verified by reference to the policy contract, ~~itself, or~~ a ~~specimen copy~~ sample of the policy being described, or ~~to~~ the company's

officially published rate book and dividend illustrations.;

~~h.~~19. Stating that life insurance is "loss proof" or "depression proof," ~~but this shall not prohibit~~ except that an insurer may make statements that life insurance benefits, ~~(~~other than dividends~~)~~, are guaranteed by the company regardless of economic conditions.;

~~i.~~20. Making any statement that a company makes a profit as a result of policy lapses or surrenders.;

~~j.~~21. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience ~~of your company~~ for the company issuing the advertising.; and ~~This is intended to protect policyholders from being misled through presentations as to the probabilities of the policy being sold having the same results as that of other companies which successfully sold similar policies, without a fair disclosure of the fact that many companies have had unfavorable experience.~~

22. Conduct or statements designed to mislead a prospective applicant or purchaser.

~~**E.** Effective date. The provisions of this rule shall become effective on January 1, 1969.~~

~~**F.** Severability clause. If any provision of this rule is held invalid, such invalidity shall not affect other provisions of this rule which can be given effect without the invalid provision.~~

~~**G.** Company responsibility. Each company will be held responsible for disseminating this information to their representatives and assuring compliance.~~

R20-6-203. ~~Repealed~~ Form Filings; Translations

A. An insurer, rate service organization, or rating organization shall provide to the Department, at the time of filing, an English language translation of each form, advertisement, or other document or material that the insurer is required by statute or rule to file with the Department, if the filed document or material contains communication in a language other than English.

B. The translation filed under subsection (A) shall compare the foreign language version in a side-by-side format with the English language translation. An insurer, rate service organization, or rating organization shall ensure that the translation is performed by a person with formal college-level or specialized training in the foreign language, including training in grammar and sentence syntax.

C. With each translation, an insurer, rate service organization, or rating organization shall also provide to the Department a sworn statement signed by the translator who translated the document that includes the qualifications of the translator under subsection (B) and attests that the translation is identical in substance to the English document or material.

D. If an insurer, rate service organization, or rating organization files a foreign language version of a document or material that the insurer has previously filed in English, the insurer is not required to refile the English version, but shall identify the English version, provide the side-by-side comparison under subsection (B), and file the sworn statement required under subsection (C).

R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers

A. Definitions.

1. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
2. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.

~~1.~~2. "Listed insurer" means an unauthorized insurer who is on the list created by the Director under subsection (C)(1) and A.R.S. § 20-413.

~~2.~~3. "Surplus lines broker" means a person licensed under A.R.S. § 20-411.

~~3.~~4. "Surplus lines insurance" means the type of insurance described in A.R.S. § 20-407.

~~4.~~5. "Unauthorized insurer" means an insurer that does not have a certificate of authority to transact insurance in Arizona.

B. Filing requirements. ~~Unauthorized insurers~~ An unauthorized insurer writing surplus lines insurance in Arizona and each surplus line ~~brokers~~ broker shall comply with the filing requirements of this Section.

C. List of unauthorized insurers.

1. The Director shall create and maintain a list of unauthorized insurers that may write surplus lines insurance in this state under A.R.S. § 20-413. The list shall ~~include~~ contain the names of unauthorized insurers for which a surplus lines broker has made the filings required by this Section.
2. ~~A listed insurer shall remain~~ The Director shall retain a listed insurer on the list until:
   a. The Director removes the insurer from the list under A.R.S. § 20-413 or subsection (H) or (I) below, or
   b. The insurer requests the Director to remove its name from the list.~~, and the Director consents to the request.~~

D. Placing surplus lines insurance. A surplus lines broker shall ~~restrict~~ place all surplus lines business ~~placed by the surplus lines broker to listed~~ with insurers listed under subsection (C). An insurer's removal from the list does not affect the validity of any contract existing at the time of removal.

E. Requirements for ~~Initial Listing of Foreign Unauthorized Insurers and Insurance Exchanges~~ foreign unauthorized insurers and insurance exchanges. A surplus lines broker shall file the following documents for a foreign unauthorized insurer:

1. An original or a certified copy of the insurer's certificate of compliance from the supervisory official of the insurer's state of domicile;
2. A current Certificate of Deposit, Capital, and Surplus for Foreign Insurers from the public officials or other persons

who have supervision over the insurer in any other state;

3. A certification from the surplus lines broker of the insurer's compliance with the financial requirements of A.R.S. § 20-413;
4. The insurer's most recent report of financial examination, certified by the insurance supervisory official of its state of domicile; and
5. A certified copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) ~~convention blank~~ annual statement ~~(Form 2)~~ for the insurer as of December 31 of the preceding year.

F. Requirements for ~~Initial Listing of Alien Unauthorized Insurers~~ initial listing of alien unauthorized insurers. A surplus lines broker shall file a certification of the insurer's compliance with the financial requirements of A.R.S. § 20-413. For all alien insurers other than title insurers, the surplus lines broker may rely on the information contained in the most recent N.A.I.C. Financial Review of Alien Insurers as prima facie evidence of the insurer's compliance.

G. Filing ~~Requirements to Maintain Listing~~ requirements to maintain listing. To ensure that a foreign or alien unauthorized insurer remains on the Director's list, a surplus lines broker shall file, before June 1 of each year:

1. A copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) convention blank annual statement (Form 2) for the insurer, as of December 31 of the preceding year; and
2. An affidavit, on a form approved by the Director, that meets the following requirements ~~of this subsection.~~:
   a. The surplus lines broker and a duly authorized officer of the unauthorized insurer shall sign the affidavit.
   b. The insurer's officer shall state whether there have been any changes in the insurer's name, address, state of domicile, statutory ~~agent~~ producer, and any material changes in its operations since the insurer's initial qualification for listing or the last annual filing under this subsection. If there have been material changes in operations, the officer shall describe the changes. ~~In this subsection, material~~ Material changes under this subsection include a change in any ~~1~~ one or ~~a combination~~ more of the following:
      i. A director, officer, or controlling person;
      ii. The insurer's holding company or affiliates;
      iii. The insurer's charter documents, including its articles of incorporation, articles of agreement, or by-laws governing its conduct of business;
      iv. The insurer's marketing or administration plans, operations, or agreements with ~~3rd~~ third parties;
      v. Any other matter material to the insurer meeting its obligations to its policyholders; and
      vi. Any other matter that relates to any of the grounds for removal from the list as prescribed in A.R.S. § 20-413.
   c. The insurer's officer shall state whether the insurer is in good standing in all jurisdictions where it conducts insurance business and whether the insurer has been, since the date of initial listing or the last annual filing under this subsection, or currently is, the subject of any action or order by any regulatory official in any jurisdiction. If the insurer has been or is the subject of a disciplinary action or order, the insurer's officer shall describe the matter in the affidavit and shall attach a copy of any applicable official document regarding the disciplinary action or order. ~~In this subsection, regulatory~~ Regulatory action or order under this subsection includes any ~~1~~ one or a combination of the following:
      i. Denial, suspension, or revocation of a license, permit, or certificate of authority;
      ii. A corrective action or operation plan, consent order, memorandum of understanding, or cease and desist order;
      iii. Action against the insurer's bond or securities held in trust by a regulatory official; and
      iv. Supervision, conservatorship, receivership, or any other form of possession or control by a regulatory official in any jurisdiction.
   d. The insurer's officer shall state whether the report of examination, if any, previously filed with the Director under subsection ~~(E)(3)~~ (E)(4) or with a previous annual filing, remains the most current, filed report. If a more recent report of examination exists, the surplus lines broker shall file a copy of the report with the affidavit.

H. Supplemental information; removal. A surplus lines broker and an unauthorized insurer shall provide any additional information the Director requests to determine whether the insurer meets the requirements of A.R.S. § 20-413, or to clarify information in documents filed under this Section. The Director may remove an insurer from the list if the surplus lines broker or insurer does not submit the requested information within 30 days after the date of a written request for information.

I. Removal for failure to make annual filing. The Director shall remove an unauthorized insurer from the list if a surplus lines broker fails to timely file the documents required by subsection (G). The Director shall not restore the insurer to the list until a surplus lines broker files all applicable documents required under subsections (E) ~~and~~ or (F) and the insurer requalifies under A.R.S. § 20-413.

J. Organizations of surplus lines brokers; unauthorized insurer.

1. A surplus lines broker may file records or reports that are subject to examination by the director under A.R.S. § 20-408 with any voluntary organization of surplus lines brokers. The Director may examine the records or reports filed with an organization of surplus lines brokers to ascertain compliance with A.R.S. Title 20, Chapter 2, Article 5. An

examination performed under this authority shall not preclude examination of records of a surplus lines broker.

2. Nothing in this ~~rule~~ subsection requires that a surplus lines broker become a member of any surplus lines organization to file or ~~to~~ preserve or maintain any affidavit or statement.

~~R20-6-206.~~R20-6-205. ~~Repealed~~ Local or Regional Retaliatory Tax Information

A. Definitions.

1. "Addition to the rate of tax" means the tax rate determined under subsection ~~(E)~~ (D) to be applied under A.R.S. § 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state ~~having~~ that impose local or regional taxes.
2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state ~~under~~ within the meaning of A.R.S. § 20-254 or annuities ~~under~~ within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
4. "Department" means the Arizona Department of Insurance.
5. "Director" has the meaning prescribed in A.R.S. § 20-102.
6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.
7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their ~~agents~~ producers by any:
   a. City, county, or other political subdivision of a foreign country or other state; or
   b. ~~A combination~~ Combination of cities, counties, or other political subdivisions of a foreign country or other state.
10. "Other Arizona insurer" means a domestic insurer authorized to transact ~~a~~ one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact ~~a~~ one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
12. "Other state" means any state in the United States, the District of Columbia, and territories or possessions of the United States, ~~but~~ excluding Arizona.
13. "Premium Tax and Fees Report," ~~including~~ includes the ~~"~~Survey of Arizona Domestic Insurers~"~~ and the ~~"~~Retaliatory Taxes and Fees Worksheet,~"~~ and means the form prescribed by the Director and filed annually by insurers ~~pursuant to~~ under A.R.S. § 20-224.

~~C.~~B. Scope. This ~~rule~~ Section applies to all foreign, alien, and domestic insurers and to Premium Tax and Fees Reports filed by all insurers.

~~D.~~C. Data to be ~~Reported by Domestic Insurers~~ reported by domestic insurers. ~~Each~~ As a part of its Premium Tax and Fees Report, each domestic insurer shall file a Survey of Arizona Domestic Insurers ~~as part of its Premium Tax and Fees Report. The Survey shall report~~ that reports the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:

1. Total local or regional taxes paid; and
2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.

~~E.~~D. Computation of ~~Statewide and Foreign Countrywide Additions to the Rate of Tax~~ statewide and foreign countrywide additions to the rate of tax. For each foreign country or other state having ~~a~~ one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:

1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,
2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the other state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.

~~F.~~E. Publication of ~~Additions to the Rate of Tax~~ additions to the rate of tax. The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding calendar year ~~pursuant to~~ under subsection ~~(D)~~ (C). The Department shall publish the information annually on the Department web site, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.

~~G.~~F. Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a

foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes And Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:

1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.

~~H.~~G. ~~Contest of Computation~~ Contesting computation. A foreign or alien insurer subject to this ~~rule~~ Section may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.

~~I. Application. This rule applies to Premium Tax and Fees Reports filed by all insurers for the calendar year 1998 and all subsequent years.~~

~~R20-6-207.~~R20-6-206. Industrial Insureds

~~A. Authority -- This rule is adopted pursuant to A.R.S. §§ 20-106, 20-143 and 20-401.01 through 20-401.07.~~

~~B. Purpose -- The purpose of this rule is to implement the legislative intent, as expressed in Chapter 23, Laws of 1972, to regulate and control industrial insureds contracting with unauthorized insurers in this state.~~

~~C. Scope -- The scope of this rule is A.R.S. Title 20 and the information and returns required by this rule are declared necessary for the protection of residents of this state.~~

~~D. Repeal -- This rule does not repeal any known prior rule, memorandum, bulletin, directive, or opinion on this subject matter.~~

~~E.~~A. Definitions. ~~-- As used in~~ In this ~~rule~~ Section, unless the context otherwise requires:

1. "Admitted insurer" means an insurer to which the Director has issued a certificate of authority to transact insurance in this state under A.R.S. §§ 20-216 and 20-217.

~~1.~~2. "Director" means the Director of Insurance of the ~~State~~ state of Arizona;

~~2.~~3. "Gross premium" means the total premium charged, deducted or allocated, including membership fees, assessments, dues and any other consideration for insurance, less premiums returned on account of cancellation or reduction of premium;

~~3.~~4. "Industrial insured" has the same meaning ~~of~~ as in A.R.S. § 20-401.07(B) ~~and all of the qualifying attributes of such subsection. The term~~ and includes self-insureds ~~if~~ for any risk or partial risk of exposure ~~or partial risk or exposure is insured by a non-admitted insurer~~;

~~4.~~5. "Insurer" has the same meaning ~~of~~ prescribed in A.R.S. § 20-106(C);

~~5. "Reciprocal state" has the meaning of A.R.S. § 20-401;~~

6. "Transact" or "transaction" has the same meaning ~~of~~ as prescribed in A.R.S. § 20-106(A) and (B). ~~and the following provisions of subparagraph (a):~~

~~a. Any of the following acts in this state effected by mail or otherwise, by or on behalf of an unauthorized insurer, is deemed to constitute the transaction of an insurance business in this state:~~

~~i. The making of or proposing to make, as an insurer, an insurance contract.~~

~~ii. The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.~~

~~iii. The taking or receiving of any application for insurance.~~

~~iv. The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof.~~

~~v. The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state.~~

~~vi. Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state. The provisions of this subsection shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer.~~

~~vii. The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance.~~

~~viii. The transacting or proposing to transact any insurance business in substance equivalent to any provisions as provided in subdivisions (i) to (viii), inclusive, of this Section in a manner designed to evade the laws of this~~

~~state.~~

7. "Unauthorized insurer" ~~as used herein~~ means an insurer transacting business in this state who ~~has not qualified for a certificate of authority, approval to operate as a non-admitted insurer, or for~~ is not an admitted insurer, is not a listed qualified unauthorized insurer under R20-6-204(C), and has not been issued a certificate of exemption ~~and filed a tax return and paid the premium taxes made a condition of such qualification pursuant to R20-6-404~~ under A.R.S. § 20-401.05.

~~F.~~**B.** ~~Applicability of the rule~~

~~1.~~ A.R.S. § 20-401.07 and this ~~rule~~ Section apply to all insurance transacted by an unauthorized insurer with an industrial insured~~,~~ for which premiums, in whole or in part, are remitted directly or indirectly from within or outside this state and whether procured ~~through negotiation~~ by direct application, by mail, by an insurance producer on the industrial insured's behalf, or by ~~an application, in whole or in part, occurring or made within or outside this state~~ any other means.

~~2. A.R.S. § 20-401.07 and this rule apply to all insurance transacted by an unauthorized insurer with an industrial insured for which premiums, in whole or in part, are remitted directly or indirectly from within or outside this state.~~

~~G.~~**C.** ~~Return and premium required~~ Tax to be paid by industrial insureds contracting with an unauthorized insurer.~~—~~ Every industrial insured under a contract procured from an unauthorized insurer shall pay to the Director, before ~~April~~ March 1st ~~next following~~ after the calendar year in which the insurance was effectuated, continued, or renewed, a premium receipt tax of 3% of the gross premiums charged, deducted or allocated~~,~~ to persons, residents or property located in, or contracts to be performed in this state and ~~by~~ under A.R.S. § 20-401.07 deemed to be insurance effectuated or continued in this state. The return for premium receipts tax shall be prepared, executed and filed on ~~Form E-166 attached hereto and made part hereof~~ a form prescribed by the Director.

~~H.~~**D.** ~~Risks partly in this state~~

~~1.~~ If an industrial insured claims that ~~the~~ an insurance contract with an unauthorized insurer covers risks or exposures only partly in this state, the industrial insured shall file~~, in addition to and accompanying~~ with the Department on a form prescribed by the Director, the premium receipts tax return, and a certified statement ~~clearly disclosing information necessary for a determination of the criteria of percentage allocation of A.R.S. § 20-401.07, including but not limited to~~ containing the following information:

~~a.~~1. Percentage of physical assets in Arizona~~.~~,

~~b.~~2. Percentage of employee payroll in Arizona~~.~~,

~~c.~~3. Percentage of sales in Arizona~~.~~, and

~~d.~~4. Percentage of taxable income reportable in Arizona.

~~2. In addition to the statements required by (H)(1) hereof, each industrial insured shall file with the Director the computations by which the tax payable has been computed on the portions of the premium which are properly allocable to the risk or exposure located in this state.~~

~~I.~~**E.** ~~Exemptions -- Persons~~ A person contracting with an unauthorized ~~insurers~~ insurer claiming to be an ~~included in or exempt from the definition of "~~industrial insured~~"~~ ~~of~~ under A.R.S. § 20-401.07(B) shall file with the Department a certified statement ~~clearly disclosing~~ that discloses the following information for the person:

1. The ~~risk or risks insured other than life, disability and annuity contracts~~ insurance risks that are subject to the requirements of A.R.S. Title 20, Chapter 2, Article 4.1 and the identity of the insurer~~,~~;
2. ~~the identity, title and functions~~ The name of the ~~full time~~ full-time employee ~~acting as an insurance manager or buyer, or the identity, address and functions of a regularly and continuously retained qualified insurance consultant, and~~ or third-party consultant retained to act as risk manager and the third-party consultant's qualifications under A.R.S. § 20-401.07(B)(2);

~~2.~~3. The total aggregate annual gross premiums ~~of the insured and the total number of full time employees of the insured.~~ paid for insurance on all property and casualty risks that are subject to A.R.S. Title 20, Chapter 2, Article 4.1 as of the preceding fiscal year end;

4. Net worth as of the preceding fiscal year end, as verified by a certified public accountant; and
5. The total number of full-time employees or equivalent and if less than 80, the total number of full-time or equivalent employees of its holding company system, as of the date the policy was issued by the unauthorized insurer.

~~J.~~**F.** ~~Additional information -- In addition to the certified statements required by this rule, the~~ The Director may ~~and if requested the industrial insured or insured, shall furnish~~ require that the industrial insured provide the following additional information to the Director ~~additional information, including, but not limited to~~:

1. The mode of premium payment showing the percentage paid by employer and employee;
2. The amount of annual premium applied to life, disability, and annuity policies if additional risks are insured;
3. A statement of loss-claim ratio for the preceding year by policy type~~,~~; and
4. The amount of reserve for policies and contracts by type of policy.

~~K. Failure to pay claims -- Applications for classification as, or exemption from, the definition of the industrial insureds may be denied or rejected if the applicant has failed to pay any claims or loss within the provisions of an insurance contract issued by such applicant or by an unauthorized insurer for the applicant, or deemed to be insurance effectuated or contin-~~

~~ued in this state. The provisions of this Section may be waived by the Director upon a clear affirmative showing that the applicant is defending an action in law or equity in a court of this state.~~

~~**L.** Reciprocal state -- The list of the states and territories qualified as reciprocal states, and maintained by the Director pursuant to the authority and instruction of A.R.S. § 20-401.04 is by reference made part of this rule.~~

~~**M.** Effective date~~

~~1. This rule shall become effective April 1st, 1973. All reports and returns to be filed or filed on or after the effective date of this rule, except as herein provided, shall conform to the provisions of this rule as of the effective date, April 1st, 1973. Because of the fact that compliance with the provisions of A.R.S. § 20-401.07 and this rule involve complex matters that are not fully resolvable by the effective date, the time for filing initial returns and statements is hereby extended until July 1st, 1973, provided that the premium tax due accompanies the filing of such return or statement.~~

~~2. Any industrial insured wishing to comply with A.R.S. § 20-401.07 and this rule prior to such extended date may do so by filing with the Director the required return, statement and premium tax due.~~

~~**N.** Other approved dates -- For good cause shown the Director may authorize industrial insured to make, complete and file returns, statements and reports required by statute or this rule on dates other than those required, if applied for in writing not less than 10 days prior to the due date of such return, statement, report or accounting.~~

~~**O.** Severability -- If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.~~

~~**P.** Forms -- The filing of returns, reports, statements or accountings prescribed by this rule are not subject of a precise or specific form other than Forms A-1 and A-2 hereof. Filings shall adequately disclose the information required by statutes and this rule. If additional specific forms are hereafter adopted by the Department, such specific forms shall be prepared, executed and filed in accordance with such forms and the instructions attached thereto~~

~~**Q.** Adoption -- Notice of proposed adoption of this rule, together with a true copy thereof was filed in the Office of the Secretary of State on the 26th day of March, 1973, and a hearing thereof, pursuant to such notice, was held on the 24th day of April, 1973, when, pursuant to arguments made at such hearing and written memorandum filed thereafter, this rule was adopted on the 24th day of April, 1973. This rule shall become effective on the 1st day of April, 1973, pursuant to subsection (M) hereof.~~

~~R20-6-209.~~R20-6-207.~~Unfair Sex~~ Gender Discrimination

~~**A.** Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, and 20-448.~~

~~**B.** Purpose. The purpose of this rule is to eliminate the act of denying benefits or coverage on the basis of sex or marital status in the terms and conditions of insurance contracts and in the underwriting criteria of insurance carriers and to implement A.R.S. § 20-448, Unfair Discrimination.~~

~~**C.**~~**A.** ~~Definitions~~ The following definitions apply to this Section:

1. "Applicant" means a person who is applying for a policy.

~~1.~~2. ~~"Contracts" mean~~ "Policy" means ~~any~~ an insurance policy, plan, contract, certificate, evidence of coverage, subscription contract, or binder, including ~~any~~ a rider or endorsement ~~thereto~~ offered by an insurer.

~~2.~~3. "Insurer" ~~has the meaning of A.R.S. §§ 20-104 and 20-106(c)~~ means any company that issues a policy.

~~**D.**~~**B.** Applicability and scope. This ~~rule shall apply~~ Section applies to ~~all contracts~~ any policy or certificate delivered or issued for delivery in this state ~~by an insurer on or after the effective date of this rule and to all existing group contracts which are amended on or after the effective date of this rule~~.

~~**E.**~~**C.** Availability requirements.

1. ~~Availability~~ An insurer shall not deny availability of any insurance ~~contract shall not be denied to an insured or prospective insured~~ policy on the basis of the ~~sex~~ gender or marital status of the insured or prospective insured.
2. ~~The~~ An insurer shall not restrict, modify, exclude, reduce, or limit the amount of benefits payable, or any term, conditions or type of coverage ~~shall not be restricted, modified, excluded, or reduced~~ on the basis of an applicant's or insured's ~~sex~~ gender or marital status ~~of the insured or prospective insured,~~ except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S. Title 20~~, Arizona Revised Statutes~~.
3. ~~Nothing in this rule shall prohibit an~~ An insurer ~~from taking~~ may consider marital status ~~into account for the purpose of defining~~ to determine whether a ~~persons~~ person is eligible for ~~dependents~~ dependent coverage or benefits.

~~**F.**~~**D.** ~~Illustrations~~ Prohibited practices. ~~Illustrations of practices~~ The following practices and any other practice that treats similarly situated persons differently based on gender unless the different treatment is specifically allowed by law, is prohibited. ~~by this rule include, but are not limited to, the following:~~

1. Denying coverage to ~~persons~~ a person of one ~~sex gainfully employed at home~~ gender who is self-employed, employed part-time, or employed by relatives, ~~when~~ if coverage is offered to ~~persons~~ a person of the opposite ~~sex~~ gender who is similarly employed~~.~~;
2. Denying a policy ~~riders~~ rider to ~~persons of one sex when~~ a person of one gender if the ~~riders are~~ rider is available to ~~persons~~ a person of the opposite ~~sex~~ gender~~.~~;

3. Denying maternity benefits to ~~insureds or prospective insureds purchasing~~ an applicant or insured who buys a policy for ~~an~~ individual ~~contract~~ coverage if the insurer offers ~~when~~ comparable family coverage ~~contracts offer~~ policies with maternity benefits~~.~~;
4. Denying, under group ~~contracts~~ policies, dependent coverage to ~~a spouse of~~ an employee of one ~~sex~~ gender ~~when~~ if dependent coverage is available to an employee of the opposite ~~sex~~ gender~~.~~;
5. Denying a disability income ~~contracts~~ policy to an employed ~~persons~~ person of one ~~sex~~ gender ~~when~~ if ~~coverage~~ a policy is offered to ~~persons~~ a person of the opposite ~~sex~~ gender who is similarly employed~~.~~;
6. Treating complications of pregnancy differently from any other illness or sickness covered under ~~the contracts~~ a policy~~.~~;
7. Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one ~~sex~~ gender~~.~~;
8. Offering lower maximum monthly benefits to ~~persons~~ a person of one ~~sex~~ gender than to ~~persons~~ a person of the opposite ~~sex~~ gender who ~~are~~ is in the same classification under a disability income ~~contract~~ policy~~.~~;
9. Offering more restrictive benefit periods ~~and~~ or more restrictive definitions of disability to ~~persons of one sex~~ a person of one gender than to ~~persons~~ a person of the opposite ~~sex~~ gender who is in the same ~~classifications~~ classification under a disability income ~~contract~~ policy~~.~~;
10. Establishing different conditions ~~by sex under which the~~ for a policyholder of one gender to ~~may~~ exercise benefit options contained in the ~~contract~~ policy than for a person of the opposite gender~~.~~;
11. Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless ~~such~~ the limitation is for the purpose of defining persons eligible for dependent's benefits~~.~~; and
12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance ~~contracts~~ contract, the amount of benefits payable, or any term, condition or type of coverage on account of ~~sex~~ gender or marital status in all lines of insurance.

~~**G.** Severability. If any provision of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect the provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.~~

~~**H.** Effective date. This rule shall become effective immediately upon a certified copy of the same being filed in the office of the Secretary of State of the State of Arizona but not before April 1, 1977.~~

~~R20-6-210.~~R20-6-208. ~~Expired~~ Group Coverage Discontinuance and Replacement

A. ~~Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, and 20-1110.~~ Definitions. The following definitions apply in this Section:

1. "Group insurance" means an insurance benefit that meets all the following conditions:
   a. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;
   b. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group;
   c. Coverage is paid for by bulk payment of premiums to the insurer; and
   d. An employer, union, or association sponsors the plan.
2. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, but does not include the following:
   a. Coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
   b. Coverage issued as a supplement to liability insurance;
   c. Liability insurance, including general liability insurance and automobile liability insurance;
   d. Workers' compensation or similar insurance;
   e. Automobile medical payment insurance;
   f. Credit-only insurance;
   g. Coverage for onsite medical clinics; and
   h. Other insurance coverage similar to the coverage specified in subsections (2)(a) through (g), of the Health Insurance Portability and Accountability Act of 1996 (Pub.L.No. 104-191) (HIPAA), under which benefits for medical care are secondary or incidental to other insurance benefits.
   i. The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the coverage:
      i. Limited-scope dental or vision benefits;
      ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits;

iii. Other similar, limited benefits specified in federal regulations issued under HIPAA.

j. The following benefits if provided under a separate policy, certificate, or contract of insurance with no coordination between provision of benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and if the benefits are paid for an event regardless of whether the benefits are provided under a group health plan maintained by the same plan sponsor:

i. Coverage only for a specified disease or illness, or

ii. Hospital indemnity or other fixed indemnity insurance.

k. The following benefits if the benefits are offered as a separate policy, certificate, or contract of insurance:

i. Medicare supplemental policy as defined under § 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss;

ii. Coverage supplemental to the coverage provided under, 10 U.S.C. Title 10, Chapter 55; or

iii. Similar supplemental coverage provided to coverage under a group health plan.

3. "Health status-related factor" means any of the following:

a. Health status;

b. Medical condition, including a physical or mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including conditions arising out of acts of domestic violence; or

h. Disability.

4. "Insurer" means an insurer that offers or provides group health insurance coverage, and includes an insurer that issues disability insurance as defined in A.R.S. § 20-253, a medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, and a health care services organization as defined in A.R.S. § 20-1051.

B. ~~Scope.~~This ~~rule~~ Section ~~is applicable~~ applies to all group insurance ~~policies and subscriber contracts~~ issued ~~or provided~~ by an ~~insurance company or a non-profit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions (or associations)~~ insurer.

~~**C.** Definition. The term "group-type basis" means a benefit plan, other than "salary budget" plans utilizing individual insurance policies or subscriber contracts, which meets the following conditions:~~

~~1. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.~~

~~2. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group.~~

~~3. There are arrangements for bulk payment of premiums or subscription charges to the insurer or non-profit service corporation.~~

~~4. There is sponsorship of the plan by the employer, union (or association).~~

~~**D.**~~**C.** Effective date of discontinuance for non-payment of premium. ~~or subscription charges~~

1. If a group insurance policy ~~or contract subject to these rules and regulations~~ provides for automatic discontinuance of the policy ~~or contract~~ after a premium ~~or subscription charge has remained~~ remains unpaid through the grace period allowed for ~~such~~ payment, the ~~carrier shall be~~ insurer is liable for valid claims for covered losses incurred ~~prior to~~ before the end of the grace period.

2. If the insurer's actions ~~of the carrier~~ after the end of the grace period indicate that ~~it~~ the insurer considers the group insurance policy ~~or contract~~ as continuing in force beyond the end of the grace period ~~(such as, by continuing to recognize claims subsequently incurred),~~ the ~~carrier shall be~~ insurer is liable for valid claims for losses beginning ~~prior to~~ before the effective date of written notice of discontinuance to the policyholder or other entity responsible for ~~making payments or submitting subscription charges to the carrier~~ paying premiums. ~~The effective date of discontinuance shall not be prior to midnight at the end of third scheduled work day after the date upon which the notice is delivered.~~

a. The following actions indicate that the insurer considers the policy in force:

i. Continued recognition, acknowledgement, or payment of subsequently incurred claims, or

ii. Continued enrollment of employees or dependents.

b. The following actions shall not indicate that the insurer considers that policy in force:

i. Recognition, payment, or acknowledgement of a claim by an insurer or processing a denial based on eligibility or other denial reasons set forth in the group benefit plan booklet; or

ii. Recognition, payment, or acknowledgement of claims due to the group's failure to notify the insurer that the employee or member is no longer eligible for coverage or the group policy is terminated.

3. The effective date of discontinuance shall not be before midnight at the end of the third scheduled work day after the date on which the notice of discontinuance is delivered.

~~**E.**~~**D.** Requirements for notice of discontinuance.

1. ~~Any~~ An insurer's notice of discontinuance ~~so given by the carrier~~ shall include a request to the group policyholder ~~or other entity involved~~ to notify covered employees ~~covered under the policy or subscriber contract~~ of the date ~~as of~~

~~which~~ when the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the ~~carrier shall~~ insurer is not ~~be~~ liable for claims for losses incurred after ~~such~~ the date of discontinuance. ~~Such~~ If the plan involves employee contributions, the notice of discontinuance shall also advise~~, in any instance in which the plan involves employee contributions,~~ that if the policyholder ~~or in any instance in which the plan involves employee contributions, that if the policyholder or other entity~~ continues to collect employee contributions ~~for the coverage~~ beyond the date of discontinuance, the policyholder ~~or other entity may be held~~ is solely liable for ~~the~~ benefits ~~with respect to~~ for the period which ~~the~~ contributions ~~have been~~ were collected.

2. The ~~carrier will~~ insurer shall also ~~prepare and furnish to~~ provide the policyholder ~~or other entity at the same time~~ with a supply of ~~a~~ notice ~~form to be distributed~~ forms that the policyholder can distribute to the covered employees. ~~or members concerned indicating such~~ The notice forms shall explain the discontinuance and the effective date ~~thereof~~, and ~~urging~~ advise ~~the~~ employees ~~or members~~ to refer to their certificates or contracts ~~in order~~ to determine ~~what~~ their rights~~, if any, are available to them upon such~~ on discontinuance.

~~F.~~**E.** Extension of benefits.

1. ~~Every~~ A group policy ~~or other contract subject to these rules and regulations hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must~~ shall provide a reasonable provision for extension of benefits ~~in the event of~~ for an employee or dependent who is ~~total disability at~~ totally disabled on the date of discontinuance ~~of the group policy or contract,~~ as ~~required by the following paragraphs of this subsection.~~ follows:
   ~~2.~~a. ~~In the case of~~ For a group life plan ~~which contains~~ with a disability benefit extension of any type ~~(e.g.,~~ such as a premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability~~)~~, the discontinuance of the group policy shall not ~~operate to~~ terminate ~~such~~ the benefit extension.
   ~~3.~~b. ~~In the case of~~ For a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability or hospital confinement shall ~~have no~~ not effect ~~on~~ benefits payable for that disability or hospital confinement.
   ~~4.~~c. ~~In the case of~~ A hospital or medical expense ~~coverages~~ coverage, other than dental and maternity expense, shall include a reasonable extension of benefits or accrued liability provision ~~is required~~. ~~Such a~~ A provision ~~will be considered~~ is ~~"~~reasonable~~"~~ if:
      i. ~~it~~ It provides an extension of at least 12 months under "major medical" and "comprehensive medical" type ~~coverages,~~ coverage; ~~and~~ or
      ii. ~~under~~ Under other types of hospital or medical expense ~~coverages~~ coverage, it provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event ~~which~~ that occurred while coverage was in force. ~~(e.g.,~~ such as an accident~~)~~.

~~5.~~2. ~~Any applicable extension of benefits or accrued liability shall be described in any~~ An insurer shall ensure that the policy ~~or contract involved as well as in~~ and group insurance certificates includes a description of the extension of benefits or accrued liability provision.

3. ~~The~~ An insurer shall ensure that benefits payable during ~~any~~ a period of extension or accrued liability ~~may be~~ are subject to the policy's ~~or contract's~~ regular benefit limits. ~~(e.g.,~~ such as benefits ceasing at exhaustion of a benefit period or of maximum benefits~~)~~.

4. For hospital or medical expense coverage, an insurer may limit benefit payments to payments applicable to the disabling condition only.

~~G.~~**F.** Continuance of coverage in situations involving replacement of one ~~carrier~~ plan by another.

1. ~~This Section shall indicate the carrier responsible for liability in those instances in which one carrier's contract~~ When a group policyholder secures replacement coverage with a new insurer, self-insures, or foregoes provision of coverage, ~~replaces a plan of similar benefits of another.~~

~~2.~~ ~~Liability of prior carrier. The prior carrier remains~~ the replaced insurer is liable only to the extent of its accrued liabilities and extensions of benefits after the date of discontinuance. ~~The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.~~

~~3.~~2. ~~Liability of~~ The succeeding ~~carrier.~~ insurer shall cover each individual who:
   a. ~~Each person who~~ Was eligible for coverage under the prior plan on the date of discontinuance, and
   b. ~~is~~ Is eligible for coverage ~~in accordance with~~ according to the succeeding ~~carrier's~~ insurer's plan of benefits ~~(in respect of~~ with respect to a class ~~classes~~ of individuals eligible for coverage. ~~and activity at work and non-confinement rules) shall be covered by that plan of benefits~~.

3. For the purpose of successive health insurance coverage under subsection (F)(2), a succeeding insurer's plan of benefits shall:
   a. Not have any non-confinement rules; and
   b. Provide, as to any actively-at-work rules, that absence from work due to a health status-related factor is treated as being actively-at-work.

4. Nothing in subsection (F)(2) prohibits an insurer from performing coordination of benefits.

~~b.~~5. A succeeding insurer shall cover each individual ~~Each person~~ not covered under the succeeding ~~carrier's~~ insurer's plan of benefits ~~in accordance with subparagraph (a) above must nevertheless~~ under subsection (F)(2) ~~be covered by the succeeding carrier in accordance with the following rules~~ according to subsections (a) and (b) if ~~such~~ the individual was validly covered, ~~(~~including benefit extension~~)~~, under the prior plan on the date of discontinuance and ~~if such individual~~ is a member of ~~the~~ a class ~~or classes~~ of individuals eligible for coverage under the succeeding ~~carrier's~~ insurer's plan. Any reference in ~~the following rules~~ subsection (a) or (b) to an individual who was or was not totally disabled is a reference to the individual's status immediately ~~prior to~~ before the effective date of coverage for the succeeding ~~carrier's coverage becomes effective~~ insurer.

~~i.~~a. The minimum level of benefits to be provided by the succeeding ~~carrier~~ insurer shall be the ~~applicable~~ level of benefits of the prior ~~carrier's~~ insurer's plan reduced by any benefits payable by the prior plan.

~~ii.~~b. The succeeding insurer shall provide coverage ~~Coverage must be provided by the succeeding carrier~~ until at least the earliest of the following dates:

~~(1)~~i. The date the individual becomes eligible under the succeeding ~~carrier's~~ insurer's plan as described in ~~subparagraph (a) above.~~ subsection (F)(2);

~~(2)~~ii. ~~For each type of coverage, the~~ The date the individual's coverage would terminate ~~in accordance with~~ according to the succeeding ~~carrier's~~ insurer's plan provisions applicable to individual termination of coverage ~~(e.g.~~, such as at termination of employment or ceasing to be eligible dependent~~, as the case may be).~~; or

~~(3)~~ iii. ~~In the case of~~ For an individual who was totally disabled, and ~~in the case of~~ covered by a type of coverage for which subsection ~~(F)~~ (E) requires an extension of accrued liability, the end of any period of extension of benefits or accrued liability ~~which~~ that is required of the prior ~~carrier by~~ insurer under subsection ~~(F)~~ (E), or~~,~~ if the prior ~~carrier's~~ insurer's policy ~~or contract~~ is not subject to ~~that~~ subsection (E), would have been required of ~~that carrier~~ the insurer had its policy ~~or contract~~ been subject to subsection ~~(F)~~ (E) at the time the prior plan was discontinued and replaced by the succeeding ~~carrier's~~ insurer's plan~~.~~;

c. For health insurance coverage, if an individual who was totally disabled at the time the prior insurer's plan was discontinued and replaced by the succeeding insurer's plan, and if subsection (E) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer's plan, reduced by any benefits paid by the prior plan.

~~c.~~d. ~~In the case of a preexisting conditions limitation included in~~ If the succeeding ~~carrier's~~ insurer's plan has a preexisting conditions limitation, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding ~~carrier's~~ insurer's plan ~~in accordance with~~ according to ~~this~~ subsection ~~(G)~~ (F) during the period ~~of time this~~ the limitation applies under the new plan shall be the ~~lessor~~ lesser of:

i. The benefits of the new plan determined without application of the preexisting conditions limitation~~;~~, ~~and~~ or

ii. The benefits of the prior plan.

~~d.~~e. The succeeding ~~carrier~~ insurer, in applying any deductibles, coinsurance amounts applicable to out-of-pocket maximums, or waiting periods ~~in its plan~~, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. ~~In the case of~~ For ~~deductible provisions~~ deductibles or coinsurance amounts applicable to out-of-pocket maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior ~~carrier's~~ plan during the 90 days ~~preceding~~ before the effective date of the succeeding ~~carrier's~~ insurer's plan but only to the extent these expenses are recognized under the terms of the succeeding ~~carrier's~~ insurer's plan and are subject to similar deductible or coinsurance ~~provision~~ provisions.

~~e.~~f. ~~In any situation where~~ If the succeeding insurer is required under this Section to make a determination ~~of~~ about the benefits in the prior ~~carrier's benefit is required by the succeeding carrier, at~~ plan, the succeeding ~~carrier's~~ insurer may ~~request~~ ask the prior ~~carrier shall furnish~~ plan to provide a statement of the benefits available or other pertinent information~~,~~ sufficient to permit the succeeding insurer to ~~verification of~~ verify the benefit determination ~~or the determination itself by the succeeding carrier~~. For the purposes of this Section, ~~benefits of the prior plan will be determined in accordance with~~ all ~~of the~~ definitions, conditions, and covered-expense provisions of the prior plan shall govern the benefit determination ~~rather than those of the succeeding plan~~. The benefit determination ~~will be~~ is made as if the succeeding insurer had not replaced coverage ~~had not been replaced by the succeeding carrier~~.

~~**H.** Effective date. This rule shall become effective 120 days after a certified copy of this rule is filed in the office of the Secretary of State of the State of Arizona.~~

~~R20-6-211.~~R20-6-209. Life Insurance Solicitation

~~**A.** Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110 and 20-1111.~~

~~**B.** Purpose~~

~~1. The purpose of this rule is to require insurers to deliver to purchasers of life insurance information which will improve the buyer's ability to select the most appropriate plan of life insurance for his needs, improve the buyer's~~

~~understanding of the basic features of the policy which has been purchased or which is under consideration and improve the ability of the buyer to evaluate the relative costs of the similar plans of life insurance.~~

~~2.~~ ~~This rule does not prohibit the use of additional material which is not in violation of this rule or any other state statute or rule.~~

~~C.~~**A.** Scope.

1. ~~Except as hereinafter exempted, this rule shall apply~~ This Section applies to any solicitation, negotiation, or procurement of life insurance occurring ~~within this state~~ in Arizona. This ~~rule shall apply~~ Section applies to any issuer of life insurance contracts, including fraternal benefit societies.
2. Unless otherwise specifically included, the ~~rule shall~~ Section does not apply to:
   a. Annuities~~.~~,
   b. Credit life insurance~~.~~,
   c. Group life insurance~~.~~,
   d. Life insurance policies issued in connection with a pension and welfare ~~plans~~ plan as defined by and ~~which are~~ subject to the ~~Federal~~ federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq.; or
   e. Variable life insurance under which the death benefits and cash values vary ~~in accordance with~~ according to unit values of investments held in a separate account.

~~D.~~**B.** ~~Definitions. For the purpose of this rule~~ In this Section, the following ~~definitions shall~~ apply:

1. "Buyer's Guide~~.~~" ~~A Buyer's Guide is~~ means a document ~~which~~ that contains~~, and is limited to,~~ the language ~~contained~~ in the Appendix to this ~~rule~~ Section or language approved by the Director ~~of Insurance~~.
2. "Cash dividend~~.~~" ~~A cash dividend is~~ means the current illustrated dividend ~~which~~ that can be applied toward payment of the gross premium.
3. "Equivalent Level Annual Dividend~~.~~" ~~The Equivalent Level Annual Dividend~~ is calculated ~~by applying the following steps~~ as follows:
   a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the ~~tenth~~ 10th and ~~twentieth~~ 20th policy years~~.~~;
   b. Divide each accumulation ~~of Step~~ in subsection (a) by an interest factor that converts ~~it onto~~ the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in ~~Step~~ subsection (a) over the ~~respective~~ periods stipulated in ~~Step~~ subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
   c. Divide the results ~~of Step~~ in subsection (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the "Equivalent Level Annual Dividend."
4. "Equivalent Level Death Benefit~~.~~" ~~The Equivalent Level Death Benefit~~ means the amount of benefit of a policy or term life insurance rider ~~is an amount~~ calculated as follows:
   a. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for 10 and 20 years at 5% interest compounded annually to the end of the ~~tenth and twentieth~~ 10th and 20th policy years, respectively.
   b. Divide each accumulation ~~of Step~~ in subsection (a) by an interest factor that converts ~~it~~ the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in ~~Step~~ subsection (a) over the ~~respective~~ periods stipulated in ~~Step~~ subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
5. "Generic ~~Name.~~ name" ~~Generic Name~~ means a short title ~~which is~~ that is descriptive of the premium and benefit patterns of a policy or a rider.
6. ~~"Life Insurance Cost Indexes."~~
   ~~a.~~ "Life Insurance Surrender Cost Index." ~~The Life Insurance Surrender Cost Index~~ means the cost index that is calculated ~~by applying the following steps~~ as follows:
   ~~i.~~a. Determine the guaranteed cash surrender value, if any, available at the end of the ~~tenth and twentieth~~ 10th and 20th policy years.
   ~~ii.~~b. For policies participating ~~policies~~ in dividends, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at 5% interest compounded annually to the end of the period selected and add this sum to the amount determined in ~~Step~~ subsection ~~(i)~~ (a).
   ~~iii.~~c. Divide the result ~~of Step ii.~~ in subsection ~~(ii)~~ (b) ~~(Step~~ subsection ~~(i)~~ (a) for guaranteed-cost policies) by an interest factor that converts into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in ~~Step ii~~ subsection ~~(ii)~~ (b)~~.~~ ~~(Step~~ or subsection ~~(i)~~ (a) for guaranteed cost policies~~)~~, over the ~~respective~~ periods stipulated in ~~Step~~ subsection ~~(i)~~ (a)). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
   ~~iv.~~d. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5% interest compounded annually to the end of the period stipulated in ~~Step~~ subsection ~~(i)~~ (a) and dividing the result by the respective factors stated in ~~Step~~ subsection ~~(iii)~~ (c). ~~(this~~ This amount is the annual premium

payable for a level premium plan~~)~~.

~~v.~~e. Subtract the result of ~~Step~~ subsection ~~(iii)~~ (c) from ~~Step~~ subsection ~~(iv)~~ (d).

~~vi.~~f. Divide the result of ~~Step~~ subsection ~~(v)~~ (e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.

~~b.~~7. "~~Life Insurance Net Payment Cost Index.~~" The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.

~~7.~~8. "Policy Summary~~.~~" ~~For the purposes of this rule, Policy Summary~~ means a written statement describing elements of the policy, including ~~but not limited to~~:

a. ~~A~~ The following prominently placed title ~~as follows~~: Statement of Policy Cost and Benefit Information.

b. The name and address of the insurance ~~agent~~ producer, or, if no ~~agent~~ producer is involved, a statement of the procedure to be followed ~~in order~~ to receive responses to inquiries regarding the Policy Summary.

c. The full name and home office or administrative office address of the company ~~in~~ by which the life insurance policy is to be or has been written.

d. The generic name of the basic policy and each rider.

e. ~~The following amounts, where applicable, for~~ For the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including~~, but not necessarily limited to,~~ the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier~~.~~, the following amounts, where applicable:

i. The annual premium for the basic policy~~.~~;

ii. The annual premium for each optional rider~~.~~;

iii. Guaranteed amount payable upon death~~,~~ at the beginning of the policy year regardless of the cause of death ~~other than~~ except for suicide, or other specifically enumerated exclusions~~, which is~~ provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately~~.~~;

iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider~~.~~;

v. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. ~~(~~Dividends need not be displayed beyond the ~~twentieth~~ 20th policy year~~.~~;~~)~~ and

vi. Guaranteed endowment amounts payable under the policy ~~which~~ that are not included under guaranteed cash surrender values ~~above~~ in subsection (iv).

f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether ~~this~~ the rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary ~~includes~~ shall include the maximum annual percentage rate.

g. Life Insurance Cost Indexes for 10 and 20 years but ~~in no case~~ not beyond the premium-paying period. Separate indexes ~~are~~ shall be displayed for the basic policy and for each optional term life insurance rider. ~~Such~~ The indexes need not be included for optional riders ~~which~~ that are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months, and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life.

h. The Equivalent Level Annual Dividend in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.

i. ~~A~~ If the Policy Summary ~~which~~ includes dividends, ~~shall also include~~ a statement that dividends are based on the ~~company's~~ insurer's current dividend scale and are not guaranteed ~~in addition to~~ and a statement in close proximity to the Equivalent Level Annual Dividend as follows: "An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide."

j. A statement in close proximity to the Life Insurance Cost Indexes as follows: "An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide."

k. The date on which the Policy Summary is prepared. The Policy Summary ~~must~~ shall consist of a separate document. All information required to be disclosed ~~must~~ shall ~~be set out in such a manner as to not minimize or render any portion thereof~~ not be minimized or obscure. Any amounts ~~which~~ that remain level for two or more years of the policy may be represented by a single number ~~if it is clearly indicated what~~ that clearly indicates the amounts that are applicable for each policy year. Amounts in subsection ~~(7)~~(8)(e) ~~of this subsection~~ shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

~~E.~~**C.** Disclosure requirements.

1. The insurer shall provide~~,~~ to all prospective purchasers, a Buyer's Guide and a Policy Summary ~~prior to~~ before

accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains ~~such~~ an unconditional refund offer, in which ~~event~~ case the Buyer's Guide and Policy Summary ~~must~~ shall be delivered with the policy or ~~prior to~~ before delivery of the policy.

2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.
3. ~~In the case of policies whose~~ If the Equivalent Level Death ~~Benefits do~~ Benefit of a policy does not exceed $5,000, the requirement for providing a Policy Summary ~~will be~~ is satisfied by delivery of a written statement containing the information described in ~~subsection (D), paragraph (7), subparagraphs (b)~~ subsections (D)(8)(b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).

~~F.~~**D.** General rules.

1. Each insurer shall maintain at its home office or principal office for at least three years after its last authorized use a ~~complete file containing one~~ copy of each ~~document authorized by the insurer~~ form the insurer authorized for use ~~pursuant to this rule. Such file shall contain one copy of each authorized form for a period of three years following the date of its last authorized use~~.
2. ~~An agent~~ A producer shall inform ~~the~~ a prospective purchaser, ~~prior to~~ before commencing a life insurance sales presentation, that ~~he~~ the producer is acting as a life insurance ~~agent~~ producer and inform the prospective purchaser of the full name of the insurance company ~~which he~~ that the producer is representing. ~~to the buyer. In sales situations in which an agent is not involved~~ If an insurance producer is not involved in the sale, the insurer shall ~~identify its~~ inform the prospective purchaser of the insurance company's full name.
3. ~~Terms~~ An insurer or producer shall not use terms such as financial planner, investment advisor, financial consultant, or financial ~~counselling shall not be used in such a way as~~ counseling to imply that the insurance ~~agent~~ producer is generally engaged in an advisory business in which compensation is unrelated to sales unless ~~such~~ that is ~~actually the case~~ true.
4. ~~Any reference to~~ If an insurer or producer refers to policy dividends, the reference ~~must~~ shall include a statement that dividends are not guaranteed.
5. ~~A~~ An insurer shall not use a system or presentation ~~which~~ that does not recognize the time value of money through the use of appropriate interest adjustments ~~shall not be used~~ for comparing the cost of two or more life insurance policies. ~~Such a~~ unless the system or presentation is used to demonstrate ~~may be used for the purpose of demonstrating~~ the cash flow pattern of a policy ~~if such~~ and the presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.
6. ~~A~~ In a presentation of benefits, an insurer shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately and in close proximity ~~thereto~~.
7. ~~A~~ An insurer shall include with a statement regarding the use of the Life Insurance Cost Indexes ~~shall include~~ an explanation ~~to the effect~~ that the indexes are useful only for the comparison of the relative costs of two or more similar policies.
8. ~~A~~ An insurer shall include with a Life Insurance Cost Index ~~which~~ that reflects dividends or an Equivalent Level Annual Dividend ~~shall be accompanied by~~ a statement that it is based on the company's current dividend scale and is not guaranteed.
9. ~~For the purposes of this rule, the annual premium for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.~~ If an insurer reserves the right to change the premium for a basic policy or rider, the annual premium shall be the maximum annual premium.

~~G.~~**E.** ~~Failure to comply. Failure of an insurer~~ An insurer's failure to provide or deliver a Buyer's Guide~~,~~ or a Policy Summary as provided in subsection ~~(E)~~ (C) ~~shall constitute~~ constitutes an omission ~~which~~ that misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

~~H. Effective date. This rule shall become effective immediately upon a certified copy of the same being filed in the Office of the Secretary of State of the State of Arizona but not before January 1, 1979.~~

APPENDIX

Life Insurance Buyer's Guide

The face page of the Buyer's Guide shall read as follows:

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,
- Decide what kind of life insurance policy you need, and
- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

Buying Life Insurance

When you buy life insurance, you want a policy ~~which~~ that fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes ~~which~~ that are described in this guide. A good life insurance ~~agent~~ producer or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds ~~which~~ that are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance ~~agent~~ producer or company or books on life insurance in your public library.

This guide does not endorse any company or policy.

The remaining text of the buyer's guide shall begin on page 3 as follows:

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment Insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the ~~agent~~ producer or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection of a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these poli-

cies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money ~~which~~ that you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance

An endowment insurance policy pays a sum or income to you – the policyholder – if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "non participating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance ~~agents~~ producers and companies:

1. Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
   Life Insurance Net Payment Cost Index. This Index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare

total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

(1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

(2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "Shopper's Guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

(3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its ~~agent~~ producer. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

(4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or ~~agent~~ producer will provide service in the future, to you as a policyholder.

(5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company ~~which~~ that issued the old policy before you take action.

Important Things To Remember - A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums must closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance ~~agent~~ producer can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the ~~agent~~ producer or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

~~R20-6-212.~~R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

~~**A.** Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110, 20-1110.01 and 20-1111.~~

~~**B.** Purpose. The purpose of this rule is to provide an orderly procedure for complying with the provisions of A.R.S. § 20-1110.01.~~

~~**C.**~~**A.** Definitions. ~~As used~~ The following definitions apply in this ~~rule, unless the context otherwise requires~~ Section:

1. ~~A "readable~~ "Readable insurance policy" ~~is~~ means a ~~contract~~ policy ~~designed to~~ that can be read and reasonably understood by a person without special knowledge or training.
2. "Policy" means a contract or agreement for ~~or effecting~~ insurance, or ~~the~~ an insurance certificate ~~thereof, by whatever name called~~ regardless of the name used, and includes all clauses, ~~riders,~~ endorsements, and papers attached ~~thereto and a part thereof~~ or incorporated.

~~**D.**~~**B.** Scope.

~~1.~~ This ~~rule~~ Section applies to ~~individual and personal line~~ private passenger ~~automobile~~ motor vehicle policies, homeowner policies, ~~and individual and~~ personal line dwelling policies, for ~~(4~~ four family units or less~~)~~, and mobile homeowner policies delivered or issued for delivery in Arizona. ~~or amended on or after January 1, 1979. This rule shall not apply to any such dwelling policy covering a mobile home until after December 31, 1979~~.

~~2. This rule applies to individual and personal line automobile policies and individual and personal line dwelling policies (4 family units or less) that are renewed on or after January 1, 1982.~~
~~3. The Director reserves the right to extend the scope of this rule to other kinds of insurance in the future.~~

~~E.~~**C.** Compliance.
1. ~~Each~~ An insurer ~~is required to~~ shall test the readability of its policy by use of the Flesch Readability Formula as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974).
2. ~~A~~ An insurer shall not use a policy unless the policy has a total readability score of 40 or more on the Flesch scale ~~is required~~.
3. ~~All policies, outlines of coverage or brochures within the scope of this rule shall be filed with the Director accompanied by a sworn affidavit setting forth the Flesch score and a sworn statement of compliance with the guidelines set forth in this rule.~~ An insurer shall include with each policy form filing required to be filed with the Director a checklist for the line of insurance setting forth the Flesch score.

~~F.~~ ~~Readable policy guidelines~~

D. Readability guidelines.
~~1. The policy as a legal document. Revision of the insurance policy to make it more readable must not lead to its devaluation as a legal document. The policy must comply with all statutory and regulatory requirements.~~
~~2. Arizona standard fire policy. A.R.S. § 20-1110.01 modifies the provisions of Article 7, Chapter 6, Title 20, Arizona Revised Statutes, relating to the Arizona standard fire policy. All policies within the scope of the rule, including any policy that contains, in whole or in part, the provisions of the Arizona standard fire policy, shall comply with all requirements of this rule.~~
~~3.~~1. General organization of text.
   a. A ~~readable~~ policy shall be divided into logically arranged sections for ease of locating ~~desired~~ content.
   b. Each section shall be self-contained as to provisions relating solely to that section (for example, an exclusion section shall not be mixed with other parts of a policy).
   c. General policy provisions applying to all or several like coverages ~~alike~~ shall be located in a common area.
   d. ~~Non-essential~~ The policy shall not contain non-essential provisions ~~shall be eliminated~~.
   e. Defined words and terms shall be ~~selected with care and placed in a separate definition section to appear early in the~~ placed in a separate section at the beginning of the policy ~~format~~.

~~4.~~2. Visual aids to readability. The insurer shall ensure that each policy meets the following format requirements:
   a. Type size shall ~~not~~ be ~~smaller than 8~~ at least eight point ~~and type style shall be selected with legibility as the primary consideration~~.
   b. The font shall be block print rather than script, and legible.
   ~~b.~~c. Captions and headings shall be ~~clearly~~ distinguishable from the general text.
   ~~c.~~d. White space separating coverages, policy sections, and columns shall be sufficient to make a distinct separation.
   ~~d.~~e. Defined words and terms shall be ~~clearly~~ distinguishable from the general text.

~~5.~~3. Language usage ~~suggestions~~. The insurer shall ensure that each policy:
   a. ~~The policy should be~~ Is written in everyday, conversational language~~.~~;
   b. ~~Use~~ Uses short, simple sentences and words in common usage ~~wherever possible~~.
   c. ~~Use a~~ Uses ~~personal~~ an easy-to-read style, personal pronouns, and present tense~~,~~ active verbs~~, wherever possible~~.

~~G.~~ ~~Outline of coverage. The requirements for a readable insurance policy contained in this rule may be complied with by an insurer providing to the policyholder an outline of coverage or brochure which accompanies the policy. Such an outline of coverage or brochure must comply with the readability requirements contained in this rule for a policy. If an insurer elects to use such an outline of coverage or brochure, the policy that is provided to the policyholder and accompanied with the outline of coverage or brochure need not comply with the readability requirements of this rule. If an insurer elects to use such an outline of coverage or brochure, the outline of coverage or brochure must contain all provisions of the policy.~~

~~H.~~ ~~This rule shall become effective immediately upon a certified copy of the same being filed in the Office of the Secretary of State of the State of Arizona.~~

~~R20-6-213.~~R20-6-211. ~~Unfair~~ Discrimination on the Basis of Blindness~~,~~ or Partial Blindness

~~A.~~ ~~Authority. This rule is adopted pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110 and 20-1111.~~

~~B.~~ ~~Purpose. The purpose of this rule is to ensure that individuals who are blind, partially blind, or have a physical disability will not be unfairly discriminated against in the rates charged for or the availability of any contract of life insurance or life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract; and will not be unfairly discriminated against in the amount of premium, policy fees or rates charged for or the availability of any policy or contract of insurance other than life or in the benefits payable thereunder or in any of the terms or conditions of such contract, or in any manner whatever.~~

~~C.~~**A.** Definitions. The following definitions apply in this Section:
1. ~~"Contract"~~ "Policy" means ~~any policy of~~ a contract or agreement for or effecting insurance, or ~~the~~ a certificate ~~thereof~~ of insurance, ~~by whatever name called~~ regardless of the name used, and includes all clauses, riders, endorsements, and attached papers ~~attached thereto and a part thereof~~.

2. "Person" ~~shall mean "person" as defined~~ has the same meaning prescribed in A.R.S. § 20-105.

~~**D.**~~**B.** Scope. This ~~rule shall apply~~ Section applies to all ~~contracts~~ policies delivered or issued for delivery in this state ~~by a person on or after the effective date of this rule. This rule shall also apply to any group or blanket contract which has been delivered or issued for delivery in this state before the effective date of this rule, but not until such contract is amended or renewed at or after the later of the following times:~~

~~1. The effective date of this rule, or~~

~~2. If the contract provides benefits in connection with or pursuant to the provisions of a collective bargaining agreement which is in force on the effective date of this rule, when such collective bargaining agreement expires~~.

~~**E.**~~**C.** Prohibition. ~~The~~ An insurer shall not engage in the following prohibited ~~are hereby identified as~~ acts or practices ~~which~~ that constitute unfair discrimination between individuals of the same class:

1. ~~Refusing~~ Refusal to insure~~,~~ or ~~refusing~~ refusal to continue to insure, or limiting the amount, extent, or kind of coverage available to an individual solely because of blindness or partial blindness~~,~~, or ~~charging~~
2. Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

~~**F.**~~**D.** In this subsection, ~~Refusal~~ "refusal to insure" includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed ~~in the event that~~ if the insured loses ~~his/her~~ eyesight. ~~However, an~~ An insurer may exclude from coverage disabilities~~,~~ consisting solely of blindness or partial blindness~~, when such condition existed at the time~~ if the insured was blind or partially blind when the policy was issued.

~~**G.**~~**E.** ~~With respect to~~ For all other conditions, including the underlying cause of the blindness or partial blindness, ~~persons who are~~ a person who is blind or partially blind ~~shall be~~ is subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as ~~are~~ a sighted ~~persons~~ person.

~~R20-6-215.~~R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities

~~The Department adopts, incorporates, and approves as its own~~ An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference~~, on file with the Office of Secretary of State,~~ and ~~copies~~ available ~~from~~ at the Department of Insurance, 2910 ~~North~~ N. 44th ~~Street~~ St., Phoenix, ~~Arizona~~ AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

1. For the purpose of meeting the requirements of A.R.S. § 20-1241.03(C): Life Insurance and Annuities Replacement Model Regulation, Appendix A - Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-11 through 613-12, July 2000.
2. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(A): Life Insurance and Annuities Replacement Model Regulation, Appendix B - Notice Regarding Replacement: Replacing Your Life Insurance Policy or Annuity?, Volume III, pp. 613-13, July 2000.
3. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(B)(2): Life Insurance and Annuities Replacement Model Regulation, Appendix C - Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-14 through 613-15, 1998.

~~R20-6-215.01.~~R20-6-212.01. Forms for Buyer's Guide for Annuities

~~The Department adopts, incorporates, and approves as its own~~ An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference~~, on file with the Office of Secretary of State,~~ and ~~copies~~ available ~~from~~ at the Department of Insurance, 2910 ~~North~~ N. 44th ~~Street~~ St., Phoenix, ~~Arizona~~ AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

For the purpose of meeting the requirements of A.R.S. § 20-1242.02 regarding a Buyer's Guide: Annuity Disclosure Model Regulation, Appendix - Buyer's Guide to Fixed Deferred Annuities, Volume II, pp. 245-6 through 245-13, 1999, with attached Appendix I - Equity-Indexed Annuities, Volume II, pp. 245-14 through 245-20, 1999.

~~R20-6-216.~~R20-6-213. Life and Disability Insurance Policy Language Simplification

~~**A.** Authority. This rule is adopted and promulgated by the Director of Insurance pursuant to A.R.S. §§ 20-142, 20-143, 20-441 through 20-460, 20-1110, 20-1110.01 and 20-1111.~~

~~**B.** Purpose. The purpose of this rule is to establish minimum standards for language used in policies, contracts and certificates of life insurance, disability insurance, credit life insurance and credit disability insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds.~~

~~**C.**~~**A.** Definitions. ~~As used in this rule, unless the context otherwise requires~~ The following definitions apply in this Section:

1. "Company" or "insurer" means any life or disability insurance company, benefit insurer, benefit stock insurer, prepaid dental plan organizations, health care service organizations, and all similar type organizations.
2. "Director" means the Director of Insurance of Arizona.
3. "Policy" or "policy form" means any policy, contract, plan or agreement of life or disability insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in the state by any company subject to this rule; and any certificate issued ~~pursuant to~~ under a group insurance policy delivered or issued for delivery in this state.

~~D.~~**B.** Applicability.

1. This ~~rule~~ Section and R20-6-212 ~~shall~~ apply to all life and disability insurance policies delivered or issued for delivery in this state by any company ~~on or after the date such forms must be approved under this rule, but nothing in this rule shall apply~~ but do not apply to:
   a. Any policy ~~which~~ that is a security subject to federal jurisdiction;
   b. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy~~;~~ however, this shall not exempt any certificate issued ~~pursuant to~~ under a group policy delivered or issued for delivery in this state; or
   c. Any group annuity contract ~~which~~ that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
   ~~d. Any form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under this rule; or~~
   ~~e. The renewal of a policy delivered or issued for delivery prior to the dates such forms must be approved under this rule.~~
2. Except as provided in ~~A.C.R.R. R20-6-212~~ R20-6-210, no other rule of this state setting language simplification standards shall apply to any policy forms.

~~E.~~**C.** Minimum policy language simplification standards.

1. ~~In addition to any other requirements of law, no policy forms, except as stated in subsection (D), shall be delivered or issued for delivery in this state on or after the dates such forms must be approved under this rule~~ Except as stated in subsection (B), an insurer shall not deliver or issue for delivery a policy form that has not been approved by the Director unless:
   a. The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in ~~paragraph~~ subsection (3) ~~of this subsection~~;
   b. It is printed, except for specification pages, schedules, and tables, in ~~not less~~ no less than 10 point type, one point leaded;
   c. The style, arrangement and overall appearance of the policy do not give ~~no~~ undue prominence to any portion of the text of the policy or to any endorsements or riders; and
   d. ~~It~~ The policy, if the policy has more than 3,000 words printed on three or fewer pages of text or if the policy has more than three pages regardless of the number of words, contains a table of contents or an index of the principal sections of the policy~~, if the policy has more than 3,000 words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.~~
2. ~~For the purposes of this subsection, a~~ An insurer shall measure a Flesch reading ease test score ~~shall be measured by the following method~~ as follows:
   a. For policy forms containing 10,000 words or less of text, an insurer shall analyze the entire form ~~shall be analyzed~~. For policy forms containing more than 10,000 words, an insurer may analyze the readability of two, 200-word samples per page ~~may be analyzed~~ instead of the entire form. The ~~samples shall be separated~~ insurer shall separate the samples by at least 20 printed lines.
   b. ~~The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied~~ The insurer shall count the number of words and sentences in the text, then divide the total number of words by the total number of sentences, then multiply that figure by a factor of 1.015.
   c. ~~The total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied~~ The insurer shall count and divide the total number of syllables by the total number of words, then multiply that figure by a factor of 84.6.
   d. The sum of the figures computed under subsections (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
   e. For ~~purposes of subparagraphs~~ subsections (b), (c), and (d), the insurer shall use the following procedures ~~shall be used~~:
      i. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as ~~1~~ one word~~,~~;
      ii. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence~~,~~; and
      iii. A syllable means a unit of spoken language consisting of ~~1~~ one or more letters of a word as divided by an accepted dictionary. ~~Where~~ If the dictionary shows ~~2~~ two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
   f. The term "text" as used in this subsection shall include all printed matter except the following:
      i. The name and address of the insurer~~,~~, the name, number or title of the policy, the table of contents or index, captions and subcaptions~~,~~, specification pages, schedules or tables; and

ii. ~~Any policy~~ Policy language ~~which~~ that is drafted to conform to the requirements of ~~any~~ a federal law, regulation, or agency interpretation~~;~~, ~~any~~ policy language required by ~~any~~ a collectively bargained agreement~~;~~, ~~any~~ medical terminology, ~~any~~ words ~~which are~~ defined in the policy~~;~~, and ~~any~~ policy language required by law or regulation~~;~~, ~~provided, however,~~ if the insurer identifies the language or terminology excepted by this ~~subdivision~~ subsection ~~(ii)~~ and certifies, in writing, that the language or terminology is entitled to be excepted by this ~~subdivision~~ subsection.

3. Any other reading test may be approved by the Director for use as an alternative to the Flesch reading test if it is comparable in result to the Flesch reading ease test.
4. Filings subject to this subsection shall be accompanied by a certificate signed by an officer of the insurer stating that ~~it~~ the filing meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved ~~in accordance with~~ under subsection (G) of this ~~rule~~ Section. To confirm the accuracy of any certification, the Director may require the submission of further information to verify the certification in question.
5. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

~~**F.** Construction. Nothing in this rule shall be construed to negate any law of this state permitting the issuance of any policy form after it has been on file for the time period specified.~~

~~**G.**~~**D.** ~~Powers of the Director~~. The Director may authorize a lower score than the Flesch reading ease score required in ~~subparagraph~~ subsection (E)(1)(a) ~~whenever, in his sole discretion, he finds that~~ if a lower score:

1. ~~Will provide~~ Provides a more accurate reflection of readability of a policy form;
2. Is warranted by the nature of a particular policy form or type or class of policy forms; or
3. Is caused by certain policy language ~~which is~~ drafted to conform to the requirements of any state ~~law regulation~~ statute, rule, or agency interpretation of law.

~~**H.** Effective dates. Except as provided in subsection (D), this rule applies to all policy forms filed on or after January 1, 1982. No new policy form shall be delivered or issued for delivery in this state on or after January 1, 1982, unless it has been filed pursuant to A.R.S. § 20-1110 and is in compliance with this rule. All other policy forms which have been approved or permitted to be issued prior to January 1, 1982, shall meet the standards set by this rule by January 1, 1984.~~

~~R20-6-217.~~R20-6-214. ~~Expired~~ Coordination of Benefits

A. Applicability.

1. This ~~rule~~ Section applies to all:
   a. ~~group~~ Group disability insurance policies~~;~~,
   b. ~~group~~ Group subscriber contracts of hospital and medical service corporations and ~~of~~ health care services organizations~~;~~, ~~and~~
   c. ~~group~~ Group disability policies of benefit insurers~~;~~; and
   d. ~~as well as such group~~ Group-type contracts ~~as~~ that contain a coordination of benefits provision, are not available to the general public, and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization ~~or group which contain a coordination of benefits provision~~. Group-type contracts ~~answering~~ that meet this description are included regardless of whether denominated as "franchise," ~~or~~ "blanket," or some other designation.
2. This ~~rule~~ Section does not apply to:
   a. Individual or family policies or individual or family subscriber contracts except as provided for in ~~paragraph~~ subsection (A)(1) ~~above~~.;
   b. Group or group-type hospital indemnity benefits, ~~(~~written on a non-expense incurred basis~~)~~, of $30 per day or less unless ~~they are~~ characterized as reimbursement-type benefits ~~but are~~ and designed or administered ~~so as~~ to give the insured the right to elect indemnity-type benefits, ~~in lieu~~ instead of ~~such~~ the reimbursement type benefits~~;~~ at the time of claim~~;~~ or
   c. School accident-type coverages, written on ~~either~~ a blanket, group, or franchise basis.

B. Definitions. In this Section, the following definitions apply:

1. "Allowable expense" means any necessary, reasonable, and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.
   a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered ~~shall be~~ is deemed to be both an allowable expense and a benefit paid.
   b. A plan ~~which~~ that takes "Medicare" or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.
2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.
3. "Plan," within the coordination of benefits provisions of a group policy or subscriber contract, means the types of coverage ~~which~~ that the insurer may consider in determining whether overinsurance exists with respect to a specific claim.

4. "School accident-type ~~coverages~~ coverage" means coverage ~~covering~~ of grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to-and-from school," for which the parent pays the entire premium.

C. Order-of-benefit determination.

1. When a claim under a plan with a coordination of benefit provision involves another plan ~~which~~ that also has a coordination of benefit provision, the insurer shall make the order-of-benefit determination ~~shall be made~~ as follows:
   a. The ~~benefits of a~~ plan that covers the person claiming benefits other than as a dependent shall ~~be determined~~ determine benefits before those of the plan ~~which~~ that covers the person as a dependent.
   b. The ~~benefits of a~~ plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year. The word "birthday" as used in this ~~paragraph~~ subsection refers only to month and day in a calendar year, not the year in which the person was born.
   c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in ~~this~~ the following order~~;~~:
      i. ~~first~~ First, the plan of the parent with custody of the child;
      ii. ~~then~~ Then, the plan of the spouse of the parent with custody of the child; and
      iii. ~~finally~~ Finally, the plan of the parent not having custody of the child.
   d. Notwithstanding ~~paragraph~~ subsection (c) above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
2. The benefits of a plan ~~which~~ that covers a person as an employee (or as that employee's dependent) are determined before those of a plan ~~which~~ that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this ~~paragraph shall not~~ subsection does apply.
3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan ~~which~~ that covered a claimant longer are determined before those of the plan ~~which~~ that covered that person for the shorter time.
4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

D. Excess and other nonconforming provisions.

1. A plan with an order of benefit determination provision ~~which~~ that complies with this ~~rule, herein called~~ Section, a complying plan, may coordinate its benefits with a plan ~~which~~ that is "excess" or "always secondary" or ~~which~~ that uses an order-of-benefit determination provision ~~which~~ that is inconsistent with ~~that contained in~~ this ~~rule~~ Section, ~~herein called,~~ a noncomplying plan, on the following basis:
   a. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
   b. If the complying plan is the secondary plan, it shall~~, nevertheless,~~ pay or provide its benefits first, as the secondary plan. ~~In such a situation, such~~ The payment shall be the limit of the complying plan's liability, except as provided in ~~subparagraph~~ subsection (d).
   c If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay ~~its~~ benefits accordingly. ~~However, the~~ The complying plan ~~must~~ shall adjust any payments it makes based on ~~such~~ the assumption whether information becomes available as the actual benefits of the noncomplying plan.
   d. If the noncomplying plan pays benefits so that the claimant receives less in benefits than ~~he or she~~ the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, ~~then~~ the complying plan shall advance to or on behalf of the claimant an amount equal to ~~such~~ the difference. ~~Which advance~~ The complying plan shall not ~~include~~ have a right to reimbursement from the claimant.

~~**E.** Severability. If any provision of this rule or the application thereof to any person or circumstances is held invalid, the remainder of the rule and the application of such provision to other persons and circumstances shall not be affected.~~