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 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

Editor's Note: The following Notice of Final Rulemaking was reviewed per the Governor's Regulatory Review Plan memorandum, January 22, 2009 and the continuation issued April 30, 2009. (See a copy of the memoranda in this issue on pages 1002 and 1003.) The Governor's Office authorized the notice to proceed through the rulemaking process on April 1, 2009.

[R09-57]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R20-5-106	Amend
R20-5-164	Amend

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

Authorizing statute: A.R.S. §§ 41-1003; 23-107(A)(1); 23-921(B)

Implementing statute: A.R.S. § 23-1043.04

3. The effective date of the rules:

June 2, 2009

The Commission requests that the rule become effective immediately upon filing with the Secretary of State. An immediate effective date is allowed under A.R.S. § 41-1032(A)(4), which allows a rule to become effective immediately to provide a benefit to the public and a penalty is not associated with a violation of the rule. The amendments made in this rule package are a benefit to the public because it codifies A.R.S. § 23-1043.04, a statute recently enacted that adds methicillin-resistant *Staphylococcus aureus*, spinal meningitis, and tuberculosis to the Industrial Commission's notification and reporting requirements and no penalty is associated with a violation of the rule. This is squarely within the meaning of A.R.S. § 41-1032(A)(4).

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 1146, April 11, 2008

Notice of Proposed Rulemaking: 14 A.A.R. 4040, October 24, 2008

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

Name: Rachel C. Morgan, Legal Division

Address: Industrial Commission of Arizona
800 W. Washington St.
Phoenix, AZ 85007

Telephone: (602) 542-5906

Fax: (602) 542-6783

E-mail: rmorgan@ica.state.az.us

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

During the 48th Legislature, First Regular Session, 2007, the legislature amended Arizona Revised Statutes Title 23, Chapter 6, Article 8 by adding § 23-1043.04, Methicillin-resistant *Staphylococcus aureus*; spinal meningitis; tuberculosis; establishing exposure; definitions. R20-5-106(A)(11) is being amended to reflect the change in the title of the form and the information included in the form used for reporting exposure to diseases listed in A.R.S. §§ 23-1043.02, 23-1043.03 and the new 23-1043.04. R20-5-164 is being amended to include the diseases listed in A.R.S. § 23-

1043.04, methicillin resistant *Staphylococcus aureus*, spinal meningitis and tuberculosis, to the Industrial Commission's notification and reporting requirements.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on 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 authority of a political subdivision of this state:

Not applicable

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

Annual costs/revenues changes are designated as minimal when less than $1,000, moderate when between $1,000 and $10,000, and substantial when $10,000 or greater in additional costs or revenues.

The Commission will bear minimal to moderate costs for promulgating and enforcing the rules. Costs for promulgating the rules include staff time to write, review, and direct the rules through the rulemaking process.

There is negligible cost to employers to add methicillin resistant *Staphylococcus aureus*, spinal meningitis and tuberculosis, to the diseases they must post in the work place and report to the Industrial Commission. Employers will need to print and post an additional notice. No additional reporting form is needed, as the current reporting form will be amended to include methicillin resistant *Staphylococcus aureus*, spinal meningitis and tuberculosis.

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

None

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

No comments were received regarding the rule.

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. Incorporation 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 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 5. INDUSTRIAL COMMISSION OF ARIZONA

ARTICLE 1. WORKERS' COMPENSATION PRACTICE AND PROCEDURE

Section

ARTICLE 1. WORKERS' COMPENSATION PRACTICE AND PROCEDURE

R20-5-106. Commission Forms ~~Prescribed by the Commission~~

A. The following forms shall be used when applicable:

1. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
2. No change

a. No change
b. No change
c. No change
d. No change
e. No change

3. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
4. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
5. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
6. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
7. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
8. No change
   a. No change
   b. No change
   c. No change
   d. No change
9. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
10. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
11. Report of significant work exposure to bodily fluids or other infectious material shall contain:

a. The requirements set forth in A.R.S. §§ 23-1043.02(B), ~~and~~ 23-1043.03(B), and 23-1043.04(B);
b. Employee identification;
c. Employer identification;
d. Source of exposure person identification (if known);
~~d.~~ e. Details of the exposure including:
i. Date of exposure;
ii. Time of exposure;
iii. Place of exposure;
iv. How exposure occurred;
v. Type of bodily fluid or fluids;
vi. Source of bodily fluid or fluids;
vii. Part or parts of body exposed to bodily fluid or fluids;
viii. Presence of break or rupture in skin or mucous membrane; and
ix. Witnesses (if known); and
~~e.~~ f. Dated signature of employee or the employee's authorized representative.

B. No change
1. No change
a. No change
b. No change
c. No change
2. No change
a. No change
b. No change
c. No change
d. No change
e. No change
f. No change
g. No change
h. No change
i No change
j. No change
3. No change
a. No change
b. No change
c. No change
d. No change
4. No change
a. No change
b. No change
c. No change
d. No change
5. No change
a. No change
b. No change
c. No change
d. No change
e. No change
f. No change
6. No change
a. No change
b. No change
c. No change
d. No change
7. No change
a. No change
b. No change
c. No change
d. No change
e. No change

8. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
   g. No change
   h. No change
   i. No change
      i. No change
      ii. No change
      iii. No change
      iv. No change
      v. No change
   j. No change
      i. No change
      ii. No change
      iii. No change
   k. No change
      i. No change
      ii. No change
      iii. No change
   l. No change
9. No change
   a. No change
   b. No change
   c. No change
   d. No change
   e. No change
   f. No change
10. No change
    a. No change
    b. No change
    c. No change
    d. No change
    e. No change
11. No change
    a. No change
    b. No change
    c. No change
    d. No change
12. No change
    a. No change
    b. No change
    c. No change

C. Optional use of a form described in subsection ~~(C)~~ (B) does not affect any requirement under the Act or this Article.
D. No change
E. No change

R20-5-164. Human Immunodeficiency Virus, ~~and~~ Hepatitis C, Methicillin-resistant *Staphylococcus Aureus*, Spinal Meningitis and Tuberculosis; Significant Exposure; Employee Notification; Reporting; Documentation; Forms

A. An employer subject to the Act shall notify its employees of the requirements of A.R.S. §§ 23-1043.02, ~~and §~~ 23-1043.03, and 23-1043.04 by posting the Commission ~~notice~~ notices titled "Work Exposure to Bodily Fluids" and "Work Exposure to methicillin-resistant *Staphylococcus Aureus* (MRSA), Spinal Meningitis, or Tuberculosis (TB)" in a conspicuous place immediately next to the "Notice to Employees" notice required under A.R.S. § 23-906(D).
B. ~~A properly~~ Properly posted "Work Exposure to Bodily Fluids" and "Work Exposure to Methicillin-resistant *Staphylococcus Aureus* (MRSA), Spinal Meningitis, or Tuberculosis (TB)" ~~notice constitutes~~ notices constitute sufficient notice to employees of the requirements of a prima facie case under A.R.S. §§ 1043.02(B), ~~and §~~ 23-1043.03(B), and 23-

1043.04(B).

C. An employer's insurance carrier, claims processor, or workers' compensation pool shall provide the ~~"Work Exposure to Bodily Fluids" notice~~ notices specified in subsection (A) to the employer. ~~This notice is~~ These notices are also available from the Commission upon request.

D. An employer shall make readily available to its employees the Commission form described in R20-5-106 titled "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material." An employer's insurance carrier, claims processor, or workers' compensation pool shall provide the "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" to the employer. This form is also available from the Commission upon request.

E. If an employee sustains a significant exposure as defined in A.R.S. §§ 23-1043.02(G), ~~or §~~ 23-1043.03(G), or 23-1043.04(H)(2), the employee shall complete, date, and sign a "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" form. The employee or employee's authorized representative shall give to the employer the completed, dated, and signed form. The employer shall return one copy of the completed form to the employee or to the employee's authorized representative. Nothing in this subsection limits the requirements to report an injury or file a claim under the Act.

F. If an employee submits a written report of a significant exposure to an employer, but does not use the Commission form titled "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material," the employer shall provide the employee the Commission form within five calendar days after receiving the employee's initial written report.

G. The date of the receipt by the employer or its authorized representative of the employee's initial report is the date used to compute the time period prescribed in A.R.S. §§ 23-1043.02(B)(2), ~~and §~~ 23-1043.03(B)(2), and 23-1043.04 (B)(2) if:

1. The initial report contains the information required in the "Report of Significant Work Exposure to Bodily Fluids or Other Infectious Material" form; or
2. The employee gives to the employer the completed Commission form within 10 calendar days after the employee's receipt of the Commission form.

H. Failure or refusal by the employer to provide the Commission form to the employee shall not be a defense to a prima facie claim under A.R.S. §§ 23-1043.02(B), ~~and §~~ 23-1043.03(B), and 23-1043.04(B).

I. In investigating the circumstances and facts surrounding an employee's report to an employer of a significant exposure ~~to bodily fluids~~ under A.R.S. §§ 23-1043.02(C), ~~and §~~ 23-1043.03(C), and 23-1043.04(C), the employer, or its carrier, or any employees, agents or contractors of either the employer or carrier, shall not disclose to any person, except as authorized or required by law, that the reporting employee, or any witness or alleged source of exposure, may have or did contract the human immunodeficiency virus, acquired immune deficiency syndrome, ~~or~~ hepatitis C, methicillin-resistant *Staphylococcus aureus*, spinal meningitis, or tuberculosis. However, an employer, its carrier or their respective attorneys, may:

1. Direct an agent to investigate the employee's report of significant exposure ~~to bodily fluids~~; and
2. Communicate with the investigating agent about the conduct and results of the investigation.

J. As required under the federal Occupational Safety and Health Standard for Bloodborne Pathogens, 29 CFR 1910.1030, an employer shall pay for the testing required by A.R.S. § 23-1043.02.

NOTICE OF FINAL RULEMAKING

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

Editor's Note: The following Notice of Final Rulemaking was reviewed per the Governor's Regulatory Review Plan memorandum, January 22, 2009 and the continuation issued April 30, 2009. (See a copy of the memoranda in this issue on pages 1002 and 1003.) The Governor's Office authorized the notice to proceed through the rulemaking process on May 18, 2009.

[R09-59]

PREAMBLE

1.	Section Affected	Rulemaking Action
	R20-6-1101	Amend

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

Authorizing statute: A.R.S. §§ 20-143 and 20-1133

Implementing statutes: A.R.S. §§ 20-142, 20-143, and 20-1133

3. The effective date of the rules:

June 2, 2009

Upon filing with the Secretary of State, under A.R.S. § 41-1032(A)(2), the Department requests immediate effectiveness to meet the federally mandated deadline in P.L. 110-233 of July 1, 2009 for state effectiveness.

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

Notice of Rulemaking Docket Opening: 14 A.A.R. 4935, December 26, 2008

Notice of Proposed Rulemaking: 15 A.A.R. 129, January 9, 2009

Notice of Public Information: 15 A.A.R. 500, March 13, 2009

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

Name:	Margaret McClelland
Address:	Department of Insurance 2910 N. 44th St., Suite 210 Phoenix, AZ 85018
Telephone:	(602) 364-3471
Fax:	(602) 364-3470

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

The Arizona Department of Insurance (ADOI) intends to amend R20-6-1101 to conform Arizona's Medicare supplement insurance rules with the 2008 revisions adopted by the National Association of Insurance Commissioners (NAIC) to the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (Model Regulation). Authority for revisions to the Medigap model was granted by Congress in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Public Law 108-175) and these changes are made throughout the Model Regulation. Additionally, Congress enacted the Genetic Information Nondiscrimination Act of 2008 (GINA) on May 21, 2008 (Public Law 110-233), which also calls for changes to the NAIC Medigap model. The changes are contained in the revised Section 24 of the Model Regulation.

This proposed rulemaking incorporates by reference the Model Regulation with some modifications that are necessary to address Arizona standards. Revisions were made to the rule to delete unnecessary language and to add language as required by the Model Regulation. The overall purpose of the Model Regulation and this rulemaking is to benefit consumers by providing for the standardization of coverage and simplification of terms and benefits of Medicare supplement policies, as well as to facilitate public understanding and comparison of the policies. GINA prohibits issuers from denying or conditioning the issuance or effectiveness of a policy (including the imposition of any exclusion of benefits based on a preexisting condition) or discriminating in the pricing of the policy (including the adjustment of premium rates) based on an individual's genetic information. This rulemaking will also provide uniformity with other states that will also adopt this Model Regulation making compliance easier for insurers who will not have to meet different requirements for each state.

There are federally mandated deadlines for implementation by states of these revisions. The deadline for states to conform their statutes or regulations to the NAIC revisions for GINA requirements is July 1, 2009. The deadline for states to adopt NAIC Medigap model changes required by MIPPA is September 24, 2009. The Department intends to request that this rulemaking become effective upon filing with the Office of the Secretary of State under A.R.S. § 41-1032(2) and (3) to meet the federally mandated deadlines.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on 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 consumers who will be impacted are consumers of Medicare supplement insurance who will benefit from uniformity and simplification of terms and benefits of Medicare supplement policies, as well as a better ability to compare and understand such policies. The businesses that will be directly impacted are insurers who offer Medicare supplement insurance. There are approximately 107,837 Medicare supplement insurance policyholders in Arizona. There are 53 companies actively marketing Medicare Supplement insurance in Arizona.

The Department is not aware of small businesses that will be directly impacted by this rule.

There will be a minimal economic impact on the Department associated with the rulemaking process.

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

R20-6-1101 is revised to add the following:

4. Section 8.1(A)(7)(c) is revised to read as follows:
Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

This change is not a substantial change. The language already exists in the Model Regulation that is incorporated by reference. This is simply a clarification that the footnote language that follows Section 8(A)(7)(c) is incorporated, as is suggested in the footnote.

Subsections after R20-6-1101(B)(4) are renumbered for chronology.

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

Comment

The Department is modifying NAIC Model § 8(A)(7)(c) (which governs 1990 standardized plans) to add language from a drafting note regarding payment of premium. Blue Cross Blue Shield of Arizona agrees with this change, but thinks that a parallel change should be made in section 8.1(A)(7)(c) (governing 2010 standardized plans). This latter section includes the same drafting note and should also be modified for consistency and fairness.

Response

The Department agrees with this comment and subsection (B) is revised to add this language from the drafting note to section 8.1(A)(7)(c) for consistency.

Comment

BCBSAZ would like clarification as to whether it can require individuals enrolled in 1990 standardized plans to convert to comparable 2010 standardized plans, so long as the conversion complies with the requirements of NAIC model section 8(A)(8).

Response

The answer to this question is no. The rule only permits companies to offer all their existing policyholders the **option** to switch to a newer plan, if they so choose.

Comment

AHIP recommends the use of the phrase "for effective dates on or after June 1, 2010" when referencing the new 2010 Medicare Supplement policies or certificates that may be marketed, delivered or issued *with an effective date* on or after June 1, 2010 (emphasis added). Similarly, we recommend the use of the phrase "for effective dates before June 1, 2010" in all references to the 1990 Medicare Supplement policies and certificates. The adoption of this language would provide the necessary clarification that Medicare Supplement policies or certificates with an effective date on or after June 1, 2010, must contain the new benefit package, but carriers are not precluded from issuing or delivering such policies or certificates to consumers prior to that date to ensure that the consumer does not experience a lag or break in coverage.

Response

The Department agrees with this clarification, but does not believe that it is necessary to revise the rule. The NAIC, drafters of the Model Regulation, at the March 2009 Spring National Meeting identified a technical language issue in the Model Regulation that was recently revised to conform to the Medicare Improvements for Patient and Providers Act (MIPPA) and the Genetic Information Protection Act (GINA). The issue involves transition language in the Model Regulation in Section 4, Section 8, Section 8.1, Section 9 and Section 9.1, and in the benefit chart in the final draft that currently references policies "issued for delivery on or after June 1, 2010." The NAIC issued to all state insurance regulators the following statement in a clarifying memorandum dated March 20, 2009:

> Section 104(a)(2)(C) of the "Medicare Improvements for Patients and Providers Act of 2008" (Public Law 110-275) provides that a carrier may issue a new or revised Medigap policy if coverage is effective on or after June 1, 2010. Accordingly, the revisions to the Model Regulation reflect this provision of federal law.
>
> The intention of the transition language was to make sure that issuers could sell policies to seniors with the new benefit packages prior to June 1, 2010, providing that those policies have an effective date on or after June 1, 2010. For example, this language allows seniors who are aging-in to Medicare and shopping for Medigap policies prior to June 1, 2010, to purchase policies with the new benefit design instead of being forced to purchase the 1990 policies. However, these policies would not be effective until on or after June 1, 2010.

> It was suggested that use of transition language that references policies "with an effective date for coverage on or after June 1, 2010" would more clearly convey the intention to permit the sale of policies prior to June 1, 2010 with an effective date after June 1, 2010. This suggested transition language was discussed prior to the adoption of the Medicare Supplement model act by the B Committee, but was inadvertently left out of some sections in the final model.
>
> Because the intended meaning of both phrases: policies "issued for delivery on or after June 1, 2010" and policies "with an effective date for coverage on or after June 1, 2010" is exactly the same, and that this intended meaning is also part of the federal law, the task force does not think that the model regulation needs to be revised nor are changes necessary in those states that have already taken action to enact the revisions.

While the Department does not believe it is necessary to revise the rule to address this matter, the Department will issue, a regulatory bulletin in support of the NAIC Task Force position at the time of effectiveness of this rule.

Comment

The proposed amendments to sections 23(A) and (B) of R20-6-1101 omit important language from the NAIC Model Regulation regarding similar benefits for Medicare supplement policies and certificates.

Response

The Department disagrees with this comment. R20-6-1101(B)(7) which incorporates sections 23(A) and (B) of the Model are consistent with the drafting note of the Model for Section 23 which states:

> Although NAIC is restricted from making revisions to its models that do not conform to the Omnibus Budget Reconciliation Act of 1990, states are encouraged to consider deletion of the words "for similar benefits" in Subsection (A) and the words "for benefits similar to those contained in the original policy or certificate" in Subsection (B).

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

Not applicable

13. Incorporation by reference and its location in the rules:

R20-6-1101, Model Regulation to Implement the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act, October 2008 (Model Regulation)

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

No

15. The full text of the rule follows:

TITLE 20. COMMERCE, FINANCIAL INSTITUTIONS, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section
R20-6-1101. Incorporation by Reference and Modifications~~; Applicability~~

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

R20-6-1101. Incorporation by Reference and Modifications~~; Applicability~~

A. The Department incorporates by reference the Model Regulation to Implement the National Association of Insurance Commissioners (NAIC) Medicare Supplement Insurance Minimum Standards Model Act, October ~~2004~~ 2008 (Model Regulation), and no future editions or amendments, which is on file with the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and available from the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108.

B. The Model Regulation is modified as follows:

1. In addition to the terms defined in the Model Regulation, the following definitions apply:
   a. "Agent" means an insurance producer as defined in A.R.S. § 20-281(5).
   b. "Commissioner" means the Director of the Arizona Department of Insurance.
   c. "HMO" and "health maintenance organization" mean a health care services organization as defined in A.R.S. § 20-1051(7).
   d. "Regulation" means Article.
2. Section 8A(7)(c) reads:
   c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder

or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss of the group health plan and pays the premium attributable to the supplemental policy period, effective as of the date of termination of enrollment in the group health plan.

3. Section 8.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:
   The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.
4. Section 8.1(A)(7)(c) is revised to read as follows:
   Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 186(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.
5. Section 9.1 is revised to insert the citation to A.R.S. § 20-1133 as follows:
   The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of A.R.S. § 20-1133.

~~3.~~6. ~~A new subsection~~ Subsection G ~~is added to~~ of Section 15 is revised as follows:

G. An insurer shall not file or request approval of a rate structure for its Medicare supplement policies or certificates based upon attained-age rating as a structure or methodology ~~after September 13, 2005~~.

~~4. The heading for the table for "PLAN E, MEDICARE (PART B) MEDICAL SERVICES PER BENEFIT PERIOD" is revised to "PLAN E, MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR."~~

~~5.~~7. Tables for PLAN F or HIGH DEDUCTIBLE PLAN F are revised as follows:

a. For the table entitled "PARTS A & B" a column heading is revised from "AFTER YOU PAY ~~$[1690]~~ $[2000] DEDUCTIBLE,** PLAN PAYS" to "[AFTER YOU PAY ~~$[1690]~~ $[2000] DEDUCTIBLE,**] PLAN PAYS."
b. For the table entitled "PARTS A & B" a column heading is revised from "IN ADDITION TO ~~$[1690]~~ $[2000] DEDUCTIBLE,** YOU PAY" to ["IN ADDITION TO ~~$[1690]~~ $[2000] DEDUCTIBLE,**] YOU PAY."
c. For the table entitled "OTHER BENEFITS - NOT COVERED BY MEDICARE" a column heading is revised from "AFTER YOU PAY ~~$[1690]~~ $[2000] DEDUCTIBLE,** PLAN PAYS" to "[AFTER YOU PAY ~~$[1690]~~ $[2000] DEDUCTIBLE,**] PLAN PAYS."
d. For the table entitled "OTHER BENEFITS - NOT COVERED BY MEDICARE" a column heading is revised from "IN ADDITION TO ~~$[1690]~~ $[2000]] DEDUCTIBLE,** YOU PAY" to ["IN ADDITION TO ~~$[1690]~~ $[2000] DEDUCTIBLE,**] YOU PAY."

~~6. Tables for PLAN J or HIGH DEDUCTIBLE PLAN J are revised as follows:~~

~~a. For the tables entitled "MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD" and "MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR," the last sentence of the second paragraph under the title is revised to: "This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible."~~
~~b. For the table entitled "MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR," all information for "HOSPICE CARE" is moved to the bottom of the table for "MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD."~~
~~c. For the table entitled "PARTS A & B" a column heading is revised from "AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS" to "[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS."~~
~~d. For the table entitled "PARTS A & B" a column heading is revised from "IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY" to ["IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY."~~
~~e. For the table entitled "PARTS A & B OTHER BENEFITS - NOT COVERED BY MEDICARE" a column heading is revised from "AFTER YOU PAY $[1690] DEDUCTIBLE,** PLAN PAYS" to "[AFTER YOU PAY $[1690] DEDUCTIBLE,**] PLAN PAYS."~~

~~f. For the table entitled "PARTS A & B OTHER BENEFITS - NOT COVERED BY MEDICARE" a column heading is revised from "IN ADDITION TO $[1690] DEDUCTIBLE,** YOU PAY" to ["IN ADDITION TO $[1690] DEDUCTIBLE,**] YOU PAY."~~

8. Section 23 is revised as follows:
   A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.
   B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

~~C. This Section is applicable to Medicare supplement insurance policies issued on or after January 1, 2006.~~