

NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by 1st submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication.

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

NOTICE OF PROPOSED RULEMAKING

TITLE 3. AGRICULTURE

CHAPTER 4. DEPARTMENT OF AGRICULTURE - PLANT SERVICES DIVISION

PREAMBLE

- | | |
|-----------------------------|---------------------------------|
| 1. Sections Affected | <u>Rulemaking Action</u> |
| R3-4-244 | Amend |
| R3-4-245 | Amend |
- 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. § 3-107

Implementing statute: A.R.S. §§ 3-202, 3-203, 3-204, 3-205, 3-205.01, 3-206, 3-207, 3-209, 3-210
- The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Shirley Conard, Rules Specialist

Address: Arizona Department of Agriculture
1688 West Adams, Room 124
Phoenix, Arizona 85007

Telephone: (602) 542-0962

Fax: (602) 542-5420
- The explanation of the rule, including the agency's reasons for initiating the rules:**

This rulemaking corrects a duplication of the species name in R3-4-244(A)(2)(d), moves a restricted pest to the regulated pest category, clarifies the definitions of specific pests, and, in R3-4-245, removes and adds a plant to the prohibited noxious weed list. Several of the noxious weeds that have been added to the prohibited list also appear on the regulated and restricted noxious weed list. Although we recognize that these weeds already exist in Arizona, the inclusion on the prohibited list will ban further entry of these weeds in the state.

The floating water hyacinth listed in R3-4-244, has not been a problem in Arizona for 60 years. This plant is sold by nurseries for fish ponds and decorative water areas. Since the plant is not likely to survive Arizona's colder winters and doesn't grow well enough for propagation to occur that would close a waterway, there is no reason to keep the plant on the restricted list. The floating water hyacinth will still remain an ornamental, but the Department won't be responsible for controlling or eradicating the plant. There may be a demand for the floating water hyacinth as a component in a sewage system.

Kikuyu grass, R3-4-245(A)(2)(x) is being removed from the prohibited list. This plant is being grown commercially in California and Hawaii as a forage crop and, under controlled conditions, is not a serious weed. The Department has already given a Yuma farmer permission to grow 125 acres of Kikuyu grass as a scientific experiment and believes that this plant can be a source of revenue.

The Tropical Soda Apple (TSA), a common weed in Paraguay, Argentina, Uruguay and southern Brazil, now exists in North America, Africa, India, the West Indies, Honduras, and Mexico. Since 1990, TSA has become a serious weed problem in many perennial grass pastures and natural areas of Florida, and has spread to Texas, Alabama, South Carolina, Mississippi, Georgia, Tennessee and Pennsylvania. Infestations of TSA in Florida were estimated to be 25,000 acres in 1990 and 150,000 acres in 1992. According to the TSA census by beef producers, the TSA infestation was 388,000 acres in 1993 and is currently estimated at 500,000 acres. If all land systems (natural and developed) were included in estimating the TSA infestation in Florida, the acres of infestation would probably approach a million acres. This rapid spread over 3 years is cause for concern among people

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in agriculture and those that manage natural systems.

How has this species, which is native to Brazil and Argentina, become a problem in Florida so rapidly? There are approximately 413 seeds per fruit and 125 berries per plant with germination at approximately 70% (40,000 to 50,000 seeds per plant). During 1 year, a single plant could supply enough viable seed to produce 28,000 to 35,000 new TSA plants. Although cattle and wildlife avoid eating the prickly vegetation, their long tongues can reach into the foliage to pluck off the fruits. They are good carriers for spreading the seeds through their digestive tracts.

TSA spreads rapidly and is highly competitive. It invades fields, roadsides, citrus groves, watermelon fields, rangeland and woodlands. The weed is a menace to natural areas. Its competitive nature will displace native plant species and forage plants essential to wildlife and livestock. Once introduced, there is a real possibility of TSA becoming a serious problem in the fragile riparian (streamside) communities in the Southwest. TSA's ability to form large, dense, and spiny stands within woodlands and water edges makes it a potential pest of recreational areas.

Researchers have discovered that TSA is a threat to vegetable crops and interferes with melon harvests. The weed is a competitor for space, nutrients and moisture, and serves as a host for cucumber mosaic virus, potato leafroll virus, potato virus, tomato mosaic virus, tomato mottle virus and tobacco etch virus.

The foliage of TSA is spiny and not palatable for domestic livestock and wild grazers/browsers. The berry contains the glycoalkaloid solasodine and is toxic to humans. Symptoms of poisoning could occur following the consumption of about 10 fruit. TSA is disseminated primarily by humans by grass seed, sod and contaminated hay.

Control of this perennial weed is difficult because of its prickly nature; ability to form large, dense stands; and its rapidly expanding range. This suggests that TSA will have a major economic impact in agricultural fields, orange groves and pastures. The spread of TSA is associated with major soil disturbance. This includes the plowing of fields, disking, cleaning ditch banks, or herds of cattle around waterholes or feeding stations. Cleaning of roadsides and ditchbanks encourages invasion and spread of this pest. In the south, rooting by wildlife, such as raccoons, deer and feral pigs, creates a favorable environment for TSA development. Mechanical control has limited effectiveness. Mowing alone leads to poor control due to the emergence of many seedlings, spreading of seed and regrowth of mowed plants. Mowing is most effective during the summer when few fruits are produced. University of Florida researchers have discovered that the herbicides Remedy (triclopyr), Tordon (pichloram) and Roundup (glyphosate) can be used to combat this weed. A control program combining mowing and herbicide treatment appears to be the most effective.

TSA is presently regulated under the Federal Noxious Weed Act (FNWA) and is listed as a noxious weed by Florida and other southeastern states. Although the FNWA is enforced by the Department, we feel that TSA represents enough of a threat to Arizona that it is imperative to include this weed on the prohibited noxious weed list.

5. 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.

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

Tropical Soda Apple negatively impacts pasture grass production and its utilization by cattle. TSA also infests wooded areas (hammocks) and thereby interferes with the ability of cattle to use these areas for shade. Without use of these areas for shade, the cattle will suffer additional production losses due to increased heat stress. The total value of annual cattle production loss in Florida from TSA has been estimated at \$11,000,000.

TSA also negatively impacts vegetable production. It has been identified as a host for several viruses that cause economic damage to vegetables, such as cucumber mosaic virus, potato leafroll virus, potato virus, tobacco etch virus, tomato mosaic virus, and tomato mottle virus. TSA was the 1st weed in Florida identified to be a host of the geminivirus, a virus that is causing millions of dollars in damage to tomato growers. In addition, TSA has also interfered with watermelon harvest efficiency.

A. Estimated Costs and Benefits to the Arizona Department of Agriculture.

It is unknown what the costs would be if this noxious weed were to infest the state. The Department would set up a quarantine program and mount an aggressive campaign to monitor the borders and eradicate the pest.

B. Estimated Costs and Benefits to Political Subdivisions.

Political subdivisions of this state are not directly affected by the implementation and enforcement of this proposed rulemaking.

C. Businesses Directly Affected By the Rulemaking. (Agricultural industry in Arizona)

Arizona's farmers and land owners, whether private, federal, or state would have to take whatever remedy necessary to eradicate the pest. Using research based on Florida's infestation, that includes a combination of mowing and using specific herbicide treatments and spot treatments, the combination of different methods appears to control the development of seedlings. It is expected, that, unless the pest is prevented from entering the state, Arizona would experience the same economic damage and financial loss as Florida.

D. Estimated Costs and Benefits to Private and Public Employment.

This rulemaking will have no impact on private and public employment.

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E. Estimated Costs and Benefits to Consumers and the Public.

This rulemaking will regulate the Tropical Soda Apple in Arizona and prevent it from becoming a garden weed.

F. Estimated Costs and Benefits to State Revenues.

This rulemaking will have no impact on state revenues.

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

Name: Shirley Conard, Rules Specialist
Address: Arizona Department of Agriculture
1688 West Adams, Room 124
Phoenix, Arizona 85007
Telephone: (602) 542-0962
Fax: (602) 542-5420

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

Date: Friday, February 13, 1998
Time: 10 a.m.
Location: Arizona Department of Agriculture
1688 West Adams, Room 206
Phoenix, Arizona 85007
Nature: Oral Proceeding

Written comments on the proposed rules or preliminary economic, small business, and consumer impact statement must be received by 4:00 p.m., February 17, 1998. The Department is committed to complying with the Americans with Disabilities Act. If any individual with a disability needs any type of accommodation, please call (602) 542-4316, at least 72 hours before the hearing.

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

None.

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

None.

11. The full text of the rules follows:

TITLE 3. AGRICULTURE

**CHAPTER 4. DEPARTMENT OF AGRICULTURE
PLANT SERVICES DIVISION**

ARTICLE 2. QUARANTINE

Section

R3-4-244. Regulated and Restricted Noxious Weeds
R3-4-245. Prohibited Noxious Weeds

ARTICLE 2. QUARANTINE

R3-4-244. Regulated and Restricted Noxious Weeds

A. Definitions. In addition to the definitions provided in A.R.S. § 3-201, the following shall apply to this rule:

1. "Infested area" means each individual container in which the pest is found or the specific area which that harbors the pest.
2. "Regulated pest" means when any of the following plant species, including viable plant parts (stolons, rhizomes, cuttings and seed, except agricultural, vegetable and ornamental seed for planting purposes), which are regulated noxious weeds are found within the state, it may be controlled to prevent further infestation or contamination:
 - a. *Cenchrus echinatus* L. -- Southern sandbur

- b. *Cenchrus incertus* M.A. Curtis -- Field sandbur
 - c. *Convolvulus arvensis* L. -- Field bindweed
 - d. *Eichhornia crassipes* (Mart.) Solms -- Floating waterhyacinth
 - e. *Medicago polymorpha* L. -- Burclover
 - f. *Portulaca oleracea* L. -- Common purslane
 - g. *Tribulus terrestris* L. -- Puncturevine
3. "Restricted pest" means when any of the following plant species, including viable plant parts (stolons, rhizomes, cuttings and seed, except agricultural, vegetable and ornamental seed for planting purposes), which are restricted noxious weeds are found within the state, it shall be quarantined to prevent further infestation or contamination:
- a. *Acroptilon repens* (L.) DC. -- Russian knapweed
 - b. *Aegilops cylindrica* Host. -- Jointed goatgrass
 - c. *Alhagi pseudalhagi* (Bieb.); Desv. -- Camelthorn
 - d. *Cardaria draba* (L.) Desv. -- Globed-podded hoary cress (Whitetop)
 - e. *Centaurea diffusa* L. -- Diffuse knapweed
 - f. *Centaurea maculosa* L. -- Spotted knapweed

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- g. *Centaurea solstitialis* L. -- Yellow starthistle (St. Barnaby's thistle)
- h. *Cuscuta* spp. -- Dodder
- i. ~~*Eichhornia crassipes* (Mart.) Solms -- Floating waterhyacinth~~
- j-i. *Elytrigia repens* (L.) Nevski -- Quackgrass
- k-j. *Halogeton glomeratus* (M. Bieb.) C.A. Mey -- Halogeton
- l-k. *Helianthus ciliaris* DC. -- Texas blueweed
- m-l. *Ipomoea triloba* L. -- Three-lobed morning glory
- n-m. *Linaria genistifolia* var. *dalmatica* -- Dalmation toadflax
- o-n. *Onopordum acanthium* L. -- Scotch thistle
- B. No change.
- C. No change.
- D. No change.
- E. No change.
- F. No change.
- G. No change.
- R3-4-245. Prohibited Noxious Weeds**
- A. Definition. In addition to the definitions provided in A.R.S. § 3-201, the following shall apply to this rule:
- "Infested area" means each individual container in which the pest is found, the specific area which that harbors the pest, or any shipment which that has not been released to the receiver and is found to be infested with a pest.
 - "Pest" means any of the following plant species, including viable plant parts (stolons, rhizomes, cuttings and seed, except agricultural, vegetable and ornamental seed for planting purposes), which that are prohibited noxious weeds from entering the state:
 - Acroptilon repens* (L.) DC. -- Russian knapweed
 - Aegilops cylindrica* Host -- Jointed goatgrass
 - Alhagi pseudalhagi* (Bieb.) Desv. -- Camelthorn
 - ~~a-d. *Alternanthera philoxeroides* (Mart.) Griseb. -- Alligator weed~~
 - e-e. *Cardaria pubescens* (C.A. Mey) Jarmolenko -- Hairy whitetop
 - b-f. *Cardaria chalepensis* (L.) Hand-Muzz -- Lens podded hoary cress
 - g. *Cardaria draba* (L.) Desv. -- Globed-podded hoary cress (Whitetop)
 - d-h. *Carduus acanthoides* L. -- Plumeless thistle
 - i. *Cenchrus echinatus* L. -- Southern sandbur
 - j. *Cenchrus incertus* M.A. Curtis -- Field sandbur
 - e-k. *Centaurea calcitrapa* L. -- Purple starthistle
 - f-l. *Centaurea iberica* Trev. ex Spreng. -- Iberian starthistle
 - h-m. *Centaurea squarrosa* Willd. -- Squarrose knapweed
 - g-n. *Centaurea sulphurea* L. -- Sicilian starthistle
 - o. *Centaurea solstitialis* L. -- Yellow starthistle (St. Barnaby's thistle)
 - p. *Centaurea diffusa* L. -- Diffuse knapweed
 - q. *Centaurea maculosa* L. -- Spotted knapweed
 - i-r. *Chondrilla juncea* L. -- Rush skeletonweed
 - j-s. *Cirsium arvense* L. Scop. -- Canada thistle
 - t. *Convolvulus arvensis* L. -- Field bindweed
 - k-u. *Coronopus squamatus* (Forsk.) Ascherson -- Creeping wartress (Coronopus)
 - l-v. *Cucumis melo* L. var. *Dudaim* Naudin -- Dudaim melon (Queen Anne's melon)
 - w. *Cuscuta* spp. -- Dodder
 - m-x. *Drymaria arenarioides* H.B.K. -- Alfombrilla (Lightningweed)
 - y. *Eichhornia crassipes* (Mart.) Solms -- Floating waterhyacinth
 - n-z. *Eichhornia azurea* (SW) Kunth. -- Anchored waterhyacinth
 - aa. *Elytrigia repens* (L.) Nevski -- Quackgrass
 - e-bb. *Euphorbia esula* L. -- Leafy spurge
 - cc. *Halogeton glomeratus* (M. Bieb.) C.A. Mey -- Halogeton
 - dd. *Helianthus ciliaris* DC. -- Texas blueweed
 - p-ee. *Hydrilla verticillata* Royale -- Hydrilla (Florida-elodea)
 - e-ff. *Ipomoea* spp. -- Morning glory. All species except *Ipomoea carnea*, Mexican bush morning glory; *Ipomoea triloba*, Three-lobed morning glory (which is considered a restricted pest); and *Ipomoea aborescens*, morning glory tree.
 - gg. *Ipomoea triloba* L. -- Three-lobed morning glory
 - f-hh. *Isatis tinctoria* L. -- Dyers woad
 - ii. *Linaria genistifolia* var. *dalmatica* -- Dalmation toadflax
 - s-ji. *Lythrum salicaria* L. -- Purple loosestrife
 - kk. *Medicago polymorpha* L. -- Burclover
 - l-ll. *Nassella trichotoma* (Nees.) Hack. -- Serrated tussock
 - mm. *Onopordum acanthium* L. -- Scotch thistle
 - u-nn. *Orobanche ramosa* L. -- Branched broomrape
 - v-oo. *Panicum repens* L. -- Torpedo grass
 - w-pp. *Peganum harmala* L. -- African rue (Syrian rue)
 - x. ~~*Pennisetum clandestinum* Hochst. ex. Chiov. -- Kikuyu grass~~
 - qq. *Portulaca oleracea* L. -- Common purslane
 - y-rr. *Rorippa austriaca* (Crantz.) Bess. -- Austrian field-cress
 - z-ss. *Senecio jacobaea* L. -- Tansy ragwort
 - aa-tt. *Solanum carolinense* L. -- Carolina horsenettle
 - bb-uu. *Sonchus arvensis* L. -- Perennial sowthistle
 - vv. *Solanum viarum* Dunal -- Tropical Soda Apple
 - ee-ww. *Stipa brachychaeta* Godr. -- Puna grass
 - dd-xx. *Striga* spp. -- Witchweed
 - ee-yy. *Trapa natans* L. -- Water-chestnut
 - zz. *Tribulus terrestris* L. -- Puncturevine
- B. No change.
- C. No change.
- D. No change.
- E. No change.

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9. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable.
10. Incorporations by reference and their location in the rules:
R4-19-102(F) Table 1, will reference the following sections in the rules: R4-19-207, R4-19-208, R4-19-214, R4-19-301, R4-19-302, R4-19-303, R4-19-304, R4-19-308, R4-19-404, R4-19-503, R4-19-504, R4-19-507, R4-19-511, R4-19-804, R4-19-805, R4-19-807, R4-19-808, R4-19-809, and R4-19-815.
11. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 19. STATE BOARD OF NURSING

ARTICLE 1. DEFINITIONS

Section
R4-19-102. Time-Frames for Licensure, Certifications and Approvals

ARTICLE 1. DEFINITIONS

R4-19-102 Time-Frames for Licensure, Certifications, and Approvals

A. In this section:

1. "Applicant" means a person or entity seeking licensure, certification or approval of a nursing assistant program or a nursing program.
2. "Application Packet" means a Board approved application and the documentation necessary to establish an applicant's qualifications for licensure, certification or approval.

B. In computing the time-frames set forth in this section, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or official state holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday, or official state holiday.

C. For each type of licensure, certification, or approval granted by the Board, the overall time-frame described in A.R.S. § 41-1072(2) is set forth in Table 1. The applicant and the Executive Director of the Board may agree in writing to extend the overall time-frames set forth in Table 1. The overall time-frame and the substantive review time-frame described in A.R.S. § 41-1072(3) may not be extended by more than 25% of the overall timeframe.

D. For each type of licensure, certification, or approval granted by the Board, the administrative completeness review time-frame described in A.R.S. § 41-1072(1) is set forth in Table 1 and begins to run when the Board receives an application packet.

1. If the application packet is not complete, the Board shall send a deficiency notice to the applicant.
 - a. The deficiency notice shall list each deficiency.
 - b. The applicant shall submit to the Board the information or the documentation listed in the deficiency notice within the time period specified in Table 1 for responding to a deficiency notice. The time-frame for the Board to complete the administrative review is suspended until the Board receives the missing information or documentation.
 - c. If the applicant fails to provide the information or the documentation listed in the deficiency notice within the time period specified in Table 1, the application packet may be deemed withdrawn. If

the application is deemed withdrawn, the Board shall send a notice of withdrawal to the applicant informing the applicant that the application has been withdrawn.

2. If the application packet is complete, the Board shall send a written notice of administrative completeness to the applicant.
3. If a license, certificate, or approval is granted by the Board during the administrative completeness time-frame, the application is deemed complete. The Board shall not issue a separate written notice of administrative completeness.

E. For each type of licensure, certification, or approval granted by the Board, the substantive review time-frame described in A.R.S. § 41-1072(3) is set forth in Table 1 and begins to run on the postmark date of the notice of administrative completeness.

1. Applicants who disclose prior conduct that meets the definitions of unprofessional conduct set forth in A.R.S. § 32-1601 may be investigated and may be required to provide additional information or documentation to the Board.
2. During the substantive review time-frame, the Board may make 1 comprehensive written request for additional information or documentation. The applicant shall submit the additional information or documentation within the time period specified in Table 1. The time-frame for the Board to complete the substantive review of the application packet is suspended from the postmark date of the comprehensive written request for additional information or documentation until the day after the Board receives the additional information or documentation.
3. The Board shall issue a written order of denial of licensure, certification, or approval if it determines that the applicant does not meet the substantive criteria for licensure, certification, or approval required by statute or rule. The Board may deny licensure, certification, or approval if it determines that the applicant has engaged in unprofessional conduct as defined in A.R.S. § 32-1601 and licensure, certification, or approval is not in the best interest of the public. The written order of denial shall meet the requirements of A.R.S. § 41-1076.
4. The applicant may request a hearing by filing a written request with the Board within 10 days of service of the Board's order denying the application. Hearings shall be conducted in accordance with A.R.S. Title 41, Chapter 6, Article 6, and 4 A.A.C. 19, Article 6.
5. If the applicant fails to provide the information or documentation identified in the comprehensive written

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request specified in Table 1, the application shall be deemed withdrawn unless the applicant requests in writing that the application be denied or unless the Board determines that the applicant has committed an act of unprofessional conduct, as defined in A.R.S. § 32-1601, and deems that a formal denial is necessary. If the application is deemed withdrawn, the Board shall send a notice of withdrawal to the applicant and return the application packet.

6. If the applicant meets the substantive criteria for licensure, certification, or approval required by statute or rule and is qualified for licensure, certification, or approval as determined by the Board, the Board shall grant licensure, conditional licensure, certification, or approval to the applicant.

F. Time-frames - Table 1

<u>Type of License, Certificate or Pro- gram Approval</u>	<u>Applicable Rule</u>	<u>Overall Time- Frame (Days)</u>	<u>Administrative Completeness Time-Frame (Days)</u>	<u>Time To Respond to Deficiency Notice (Days)</u>	<u>Substantive Review Time-Frame (Days)</u>	<u>Time to Respond to Comprehensive Written Request (Days)</u>
<u>Initial Approval of Nursing Programs</u>	<u>R4-19-207</u>	<u>150</u>	<u>60</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>Full Approval of Nursing Programs</u>	<u>R4-19-208</u>	<u>150</u>	<u>60</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>Approval of Reen- try Update Pro- grams</u>	<u>R4-19-214</u>	<u>150</u>	<u>60</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>Licensure by Exam</u>	<u>R4-19-301</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Licensure by endorsement</u>	<u>R4-19-302</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Temporary License</u>	<u>R4-19-303</u>	<u>60</u>	<u>30</u>	<u>60</u>	<u>30</u>	<u>90</u>
<u>Biennial License Renewal</u>	<u>R4-19-304</u>	<u>120</u>	<u>30</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>School Nurse Certi- fication</u>	<u>R4-19-308</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Reinstatement of License</u>	<u>R4-19-404</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Nurse Practitioner Program Approval</u>	<u>R4-19-503</u>	<u>150</u>	<u>60</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>Nurse Practitioner Certification</u>	<u>R4-19-504</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Prescribing and Dis- pensing Authority</u>	<u>R4-19-507</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>

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<u>Type of License, Certificate or Program Approval</u>	<u>Applicable Rule (Days)</u>	<u>Overall Time Frame (Days)</u>	<u>Administrative Completeness Time Frame (Days)</u>	<u>Time To Respond to Deficiency Notice (Days)</u>	<u>Substantive Review Time Frame (Days)</u>	<u>Time to Respond to Comprehensive Written Request (Days)</u>
<u>Clinical Nurse Specialist Certification</u>	<u>R4-19-511</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Initial Approval of Nursing Assistant Training Programs</u>	<u>R4-19-804</u>	<u>120</u>	<u>30</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>Renewal of Approval of Nursing Assistant Training Programs</u>	<u>R4-19-805</u>	<u>120</u>	<u>30</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>Certified Nursing Assistant Certification by Exam</u>	<u>R4-19-807</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Certified Nursing Assistant Certification by Reciprocity</u>	<u>R4-19-808</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>
<u>Annual Certified Nursing Assistant Renewal</u>	<u>R4-19-809</u>	<u>120</u>	<u>30</u>	<u>180</u>	<u>90</u>	<u>120</u>
<u>Certified Nursing Assistant Reinstatement</u>	<u>R4-19-815</u>	<u>150</u>	<u>30</u>	<u>180</u>	<u>120</u>	<u>120</u>

NOTICE OF PROPOSED RULEMAKING

TITLE 12. Natural Resources

CHAPTER 4. Game and Fish Commission

PREAMBLE

1. Sections Affected

R12-4-106
R12-4-309

Rulemaking Action

New Section
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. § 17-231(A)(1)

Implementing statute: R12-4-106 implements A.R.S. § 41-1073 and elsewhere. The specific authorizing statutes for each license specified in R12-4-106 are as follows:

Aquatic Wildlife Stocking Permit

A.R.S. §§ 17-238, 17-306

Challenged Hunter Access/Mobility Permit

A.R.S. §§ 17-102, 17-30(B)

Crossbow Permit

A.R.S. § 17-102

Disabled Veteran's License

A.R.S. § 17-336(2)

Falconer License

A.R.S. § 17-238

Field Trial License

A.R.S. §§ 17-218(B)(8), 17-238, 17-306

Field Trial Training Permit

A.R.S. §§ 17-218(B)(8), 17-238, 17-306

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Fishing Permits	A.R.S. § 17-331
Guide License	A.R.S. § 17-362
License Dealer's License	A.R.S. §§ 17-333(A)(33), 17-334, 17-339
Minnow Dealer's License	A.R.S. § 17-231(B)(8)
Pioneer License	A.R.S. § 17-336(1)
Private Game Farm License	A.R.S. §§ 17-238, 17-306, 17-307
Questionnaire for Evaluation of Administrative Control Systems	A.R.S. §§ 17-296, 17-297, and 17-298
Scientific Collecting Permit	A.R.S. §§ 17-238, 17-231(B)(8), 17-306
Shooting Preserve License	A.R.S. §§ 17-218(B)(8), 17-238, 17-306
Tournament Fishing Permit	A.R.S. §§ 17-309(A)(23), 17-347
Watercraft Agents	A.R.S. §§ 5-311(A)(5) and 5-321(E)
White American Stocking License	A.R.S. §§ 17-317, 17-306
Wildlife Hobby License	A.R.S. §§ 17-218(B)(8), 17-238, 17-306, 17-333(A)(24)
Wildlife Holding Permit	A.R.S. §§ 17-231(B)(8), 17-238, 17-306
Wildlife Rehabilitation License	A.R.S. §§ 17-238, 17-306
Wildlife Service License	A.R.S. §§ 17-102, 17-238, 17-239, 17-306
Zoo License	A.R.S. §§ 17-238, 17-306

The implementing statute for R12-4-309 is A.R.S. § 17-102.

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

Name: Susan L. Alandar, Administrative Services Manager
Address: Arizona Game and Fish Department DOAS
2221 West Greenway Road
Phoenix, Arizona 85023-4399
Telephone: (602) 789-3289
Fax: (602) 789-3299

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

R12-4-106. Licensing Time-Frames

In 1996 the Legislature passed Senate Bill (S.B.) 1056, which requires state agencies to adopt by rule time-frames for reviewing and issuing licenses. In response to this, an inventory of all licenses, permits, registrations, etc. was created and then each was evaluated to determine if it constituted a "license" as contemplated by A.R.S. § 41-1073. (A memo to the Department Director from the Administrator for GRRC dated November 15, 1996, stated: "The determination of what does or does not constitute a license rests with your agency.") R12-4-106 contains the final listing of those licenses which fall under the requirements of the new law. They are arranged alphabetically, to make it easier for the reader to find the license of interest, with a cross-reference to the governing rule which contains application procedures, criteria, and other relevant requirements.

The majority of the Commission's rules for licensing already contain very specific application procedures and very specific overall time-frames. What is generally missing from the rules is the "administrative completeness review time-frame" required by the new law. It is therefore proposed to adopt a single new section (R12-4-106), a "matrix" providing the time-frames for all licenses affected by the new law. Another reason for this approach is that every rule which governs a license is scheduled for review pursuant to A.R.S. § 41-1056 during 1998. This agency's plan has been and is to review the substance and purpose of the licensing rules, not just to look at time-frames as a single and separate issue. This study could not be accomplished in time to comply with the new law and is in fact being conducted as the heart of the next 2 5-year reviews (1 report is due to GRRC in November of 1998, the other in February of 1999.)

What is not addressed in the rule. According to the legislation, time-frames are required only for licenses that require an application for processing. The new language in A.R.S. § 41-1073 prescribes that...

{n}o later than December 31, 1998, an agency that issues licenses shall have in place final rules establishing an *overall time-frame* during which the agency will either grant or deny each type of license that it issues. (Emphasis added.)

The definition of "overall time-frame" is "the number of days after receipt of an *application* for a license during which an agency determines whether to grant or deny a license." Critical to the analysis is whether a license requires an application, or whether a license is summarily issued upon request. The Department does issue some licenses based upon review of an application, and under this statute has developed time-frames. However, where the Department does not require an application for issuing a license, which includes most hunting and fishing licenses, the Department is not required to develop time-frames.

The term "application" is not defined in the administrative procedures statutes. However, an application is generally a written request in which the information provided is used in determining if the applicant meets the necessary qualifications for a license. This also has served as a guide when reviewing the licenses that require an application.

Reasoning for time-frames. The language of new A.R.S. § 41-1073(C) was carefully considered in reviewing and establishing the time-frames in new R12-4-106. In particular, potential impact of delay on the regulated community is weighed against the

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resources of the agency. The majority of these licenses are issued from regional offices, which allows a more responsive approach to local needs, but also means there are less personnel doing more varied types of work. Some reviews must be done by biologists who are also assigned field work. For this reason the time-frames given are "maximum", to allow for situations where the assigned person may not be available for licensing duties. It is extremely rare that the fully allotted time-frames must be used; particularly when the administrative completeness review is generally all that is necessary. In other words, if all required documentation and information is submitted, the license is issued, as there are no other criteria for denial. Such licenses are issued directly from the same "front counter" that sells hunting and fishing licenses, tags, and stamps, which are this agency's source of revenue. The Department does not share in the general fund, but is self-supporting. Licenses which fall into this category include:

Challenged Hunter Access/Mobility Permit

Crossbow Permit

Disabled Veteran's License

Pioneer License

All of these are licenses for personal activities, not business licenses. The administrative completeness review time-frame is only 1 day for these licenses. The substantive review time-frame remains necessary in the event there is question regarding the information or documentation. For instance, the "pioneer" license is authorized by A.R.S. § 17-336(1) and is a free hunting and fishing license for persons 70 years of age or older who have been a resident of this state for 25 or more consecutive years immediately preceding application for the license. The value of this license to a nonresident who might obtain it fraudulently is \$112. Attempts have been made by nonresident winter visitors to obtain a Pioneer license.

The following licenses require a more substantive review after the application has been reviewed for completeness, by biologists and other specialized personnel who may not always be immediately available. Again, these are "maximum" time-frames and the rule specifies that review and issuance may be conducted and completed sooner. All but 1 of these licenses can be subdivided into 4 basic categories: personal use only (nonprofit); scientific or research (generally no commercial connection); commercial (licenses necessary to conduct a business or part of a business); and those which may be for personal use or may be for a commercial use.

Personal Use	Scientific/Research	Commercial	Personal or Commercial
Falconer License	Scientific Collecting Permit	Guide License	Aquatic Wildlife Stocking Permit
Fishing Permit	Wildlife Holding Permit	License Dealer's License	Field Trial License
Wildlife Hobby License	Wildlife Rehabilitation License	Minnow Dealer's License	Field Trial Training Permit
		Private Game Farm License	Tournament Fishing Permit
		Shooting Preserve License	White American Stocking License
		Watercraft Agent	
		Wildlife Service License	
		Zoo License	

Thirty days is the standard maximum overall time-frame. Those which may take longer are the Aquatic Wildlife Stocking Permit, the Wildlife Rehabilitation License, and the Wildlife Service License. The reason for the extended time-frame lies in the unusual activities allowed under each license.

R12-4-410, which governs the Aquatic Wildlife Stocking Permit, specifies a general time-frame of 30 days unless the extended substantive review time-frame of 170 days is necessary because the request is for stocking aquatic wildlife which has never previously been introduced in the state or do not occur at the location where the stocking is to take place. The rule requires that the Department let the applicant know within 10 days (the administrative review time-frame) whether the extended period for approval or denial will be necessary.

The Wildlife Rehabilitation License (governed by R12-4-423) may take up to 60 days to issue or deny. It may allow possession and rehabilitation of delicate species or even threatened or endangered species protected by federal law and so requires special

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attention. And finally, the Wildlife Service License (R12-4-421) is extremely unique in that it allows live capture and release of live wildlife, something normally prohibited by A.R.S. § 17-306. Applicants must be screened carefully.

The exception not listed in the above is the "Questionnaire for Evaluation of Administrative Control Systems." The governing rule for this, R12-4-713, is currently undergoing the rulemaking process. If adopted, the rule would relate to eligibility of non-profit and not-for-profit organizations for Heritage grants. A special evaluation is necessary for nonprofit and not for profit corporations to ensure they have administrative controls in place to protect public funds. The type of requirements which must be met are already inherent within administrative control systems of public agencies, which have been the only organizations eligible for Heritage grants, but they may not be present in nonprofit and not for profit corporations. To ensure these corporations know what controls are necessary, and to aid in the review of established administrative control systems of potential grant recipients, a questionnaire has been developed and will be available from the Department. The questionnaire provides the framework from which the Department will evaluate and determine if there are major weaknesses in the management practices, accounting systems, or internal controls of any nonprofit or not for profit organization that would like to become eligible to apply for a Heritage grant. Legal counsel advises that this would appear to fall within the category of "licenses" for which licensing time-frames must be established. Therefore the time-frames are listed in R12-4-106. If R12-4-713 is not adopted and approved prior to adoption of R12-4-106, the reference to it will be removed from R12-4-106.

R12-4-309. Restricted Hunts

The rule was originally promulgated to further deter hunters from participating in the unlawful practice of "buddy hunting." Buddy hunting is where 1 hunter shoots an animal for another hunter and the shooter is usually not permitted to hunt for the animal killed. Such actions increase the total harvest of the resource. The number of permits made available is based upon total desired harvest and the expected factor for the percentage of successful hunters. When the success ratio goes up, the number of available permits must go down. That reduction in permit numbers has 3 affects: it takes away hunting opportunity for legal hunters, reduces Department revenue, and reduces indirect revenue from hunting to the Arizona economy.

The tendency to "buddy hunt" seems to increase among otherwise law abiding hunters in situations where the animal being hunted occurs in large concentrations and high permit numbers are offered for any animal or antlerless animals (javelina and elk). Elk hunters are further motivated to take extra steps to go home with a filled elk tag because elk is a difficult hunting permit to acquire through the big game permit-tag draw system and once drawn the opportunity to shoot an elk is high, with firearms hunter success for elk exceeding 55%. The rule also offers a higher quality hunting experience for those obtaining elk and javelina hunting permits by disallowing other rifle, muzzle loader or archery hunters from being in the field at the time of these hunts. Archery hunters in particular, but also early season bull elk hunters, value having the hunting field restricted by the rule.

The 1996 review of this rule resulted in the decision to explore exempting some management units from the rule during elk hunts to increase hunting opportunity for other hunters when this can be done without decreasing value for elk hunters. The proposed changes acknowledge that the rule is needed most in management units where elk herds are large and/or dispersed through most of the management unit.

Conversely, where elk have expanded at low densities into game management units in Arizona and elk populations are very small and/or occur in small geographic areas the rule is not needed. The lack of need is because the combination of high numbers of elk and elk hunters in the same place does not occur. Also, for units like 16A and 21, the allocation of elk permits is very small and the size of area where elk occur is also very small, making it easy for enforcement officers to monitor hunter compliance with existing regulations against "buddy hunting".

Elk hunts have been established in some of the units excluded from the rule with the intent to severely reduce or eliminate the elk population (12A, 12B, 16A south, and 44A). In other cases very few elk permits are offered to hunt small elk populations which occur in small geographic areas within the units (16A north and 21), and lastly there are units with high elk populations in part of the units but low density to no elk or elk hunters in other parts. These are recommended for exclusion from the rule (22 south, 23 south, and 27 south). Restructuring the rule to list the units affected will also exclude any units which may be opened for the 1st time to elk hunting in the future. The list of units included in the draft rule for elk hunts are all located in north central Arizona in Yavapai, northern Gila, southeastern Mohave, Coconino, Apache, Navajo and northern Greenlee counties. Elk are numerous in these units or the elk herds are widely dispersed through much of the unit.

The reason for the exclusion of units or portions of units not listed in the rule is to reduce the impact of restricting other hunting in these units during scheduled elk hunts when the number of hunters afield in pursuit of other wildlife far exceeds the number of permitted elk hunters and the likelihood of hunters encountering elk in large herds is low. For instance, the North Kaibab (12A) located on the north rim of the Grand Canyon is a very popular archery deer unit. More than 2,500 hunters archery hunt deer in this unit every year. Were R12-4-309 in effect, the scheduling of an elk hunt with 25-50 permits during the archery deer hunt would disallow hundreds of archery deer hunters from hunting in that unit.

Notice of Rulemaking Docket Opening for R12-4-106: 3 A.A.R. 3262, November 4, 1997.

Notice of Rulemaking Docket Opening for R12-4-309: 3 A.A.R. 869, March 28, 1997.

5. 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

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

R12-4-106. No economic impact is expected from this proposed new section.

R12-4-309. The proposal would extend hunting opportunity in some areas to persons other than elk hunters. The impact is not expected to be great but potential benefits outweigh potential negative impact.

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

Name: Susan L. Alandar, Administrative Services Manager

Address: Arizona Game and Fish Department DOAS
2221 West Greenway Road
Phoenix, Arizona 85023-4399

Telephone: (602) 789-3289

Fax: (602) 789-3299

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

Written comments will be accepted at the above address until February 17, 1998. Public hearings to discuss this proposal will be held as follows:

Date: February 17, 1998

Time: 6 p.m.

Location: Arizona Game and Fish Department
2878 East White Mountain Boulevard
Pinetop, Arizona

Date: February 17, 1998

Time: 5 p.m.

Location: Arizona Game and Fish Department
3500 Lake Mary Road
Flagstaff, Arizona

Date: February 17, 1998

Time: 6 p.m.

Location: Arizona Game and Fish Department
2222 West Greenway Road
Roadrunner Room
Phoenix, Arizona

Date: February 18, 1998

Time: 7 p.m.

Location: Arizona Game and Fish Department
5325 North Stockton Hill Road
Kingman, Arizona

Date: February 18, 1998

Time: 7 p.m.

Location: Arizona Game and Fish Department
9140 East County 10½ Street
Yuma, Arizona

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Date: February 18, 1998
Time: 7 p.m.
Location: Arizona State Office Complex
400 West Congress, Room 158
Tucson, Arizona

Date: February 19, 1998
Time: 7 p.m.
Location: Ramada Inn
420 East Highway 70
Safford, Arizona

The Game and Fish Commission will hold an additional public hearing and may take final action to amend the rule on:

Date: March 28, 1998
Time: 1:30 p.m.
Location: Best Western Inn Suites
6201 North Oracle Road
Tucson, Arizona

The Arizona Game and Fish Commission follows Title II of the Americans with Disabilities Act. The Commission does not discriminate against persons with disabilities who wish to make oral or written comments on proposed rulemaking or otherwise participate in the public comment process. Individuals with disabilities who need a reasonable accommodation (including auxiliary aids or services) to participate in the public comment process, or who require this information in an alternate form, may contact Susan L. Alandar at (602) 789-3289 (Voice); 800-367-8939 (TDD); 2221 West Greenway Road, Phoenix, Arizona 85023-4399. Requests should be made as soon as possible so that the Arizona Game and Fish Department will have sufficient time to respond.

9. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable.
10. Incorporations by reference and their location in the rules:
Not applicable.
11. The full text of the rules follows:

TITLE 12. NATURAL RESOURCES

CHAPTER 4. GAME AND FISH COMMISSION

ARTICLE 1. DEFINITIONS AND GENERAL PROVISIONS

Section

R12-4-106. Licensing Time-Frames

ARTICLE 3. TAKING AND HANDLING OF WILDLIFE

R12-4-309. Restricted Hunts

ARTICLE 1. DEFINITIONS AND GENERAL PROVISIONS

R12-4-106. Licensing Time-Frames

A. As required by A.R.S. § 41-1072 et. seq., the Department will either grant or deny the following licenses within the listed time-frames. All periods listed are calendar days, and all are maximum time periods. Licenses may be reviewed and issued or denied in less time.

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<u>Name of License</u>	<u>Governing Rule</u>	<u>Administrative Completeness Review Time-Frame</u>	<u>Substantive Review Time-Frame</u>	<u>Overall Time-Frame</u>
<u>Aquatic Wildlife Stocking Permit</u>	<u>R12-4-410</u>	<u>10 days</u>	<u>170 days</u>	<u>180 days</u>
<u>Challenged Hunter Access/Mobility Permit</u>	<u>R12-4-217</u>	<u>1 day</u>	<u>29 days</u>	<u>30 days</u>
<u>Crossbow Permit</u>	<u>R12-4-216</u>	<u>1 day</u>	<u>29 days</u>	<u>30 days</u>
<u>Disabled Veteran's License</u>	<u>R12-4-202</u>	<u>1 day</u>	<u>29 days</u>	<u>30 days</u>
<u>Falconer License</u>	<u>R12-4-422</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Field Trial License</u>	<u>R12-4-415</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Field Trial Training Permit</u>	<u>R12-4-416</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Fishing Permits</u>	<u>R12-4-310</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Guide License</u>	<u>R12-4-208</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>License Dealer's License</u>	<u>R12-4-105</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Minnow Dealer's License</u>	<u>R12-4-411</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Pioneer License</u>	<u>R12-4-201</u>	<u>1 day</u>	<u>29 days</u>	<u>30 days</u>
<u>Private Game Farm License</u>	<u>R12-4-413</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Questionnaire for the Evaluation of Administrative Control Systems</u>	<u>R12-4-713</u>	<u>45 days</u>	<u>45 days</u>	<u>90 days</u>
<u>Scientific Collecting Permit</u>	<u>R12-4-418</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Shooting Preserve License</u>	<u>R12-4-414</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Tournament Fishing Permit</u>	<u>R12-4-215</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Watercraft Agents</u>	<u>R12-4-509</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>White American Stocking License</u>	<u>R12-4-424</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Wildlife Hobby License</u>	<u>R12-4-419</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Wildlife Holding Permit</u>	<u>R12-4-417</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>
<u>Wildlife Rehabilitation License</u>	<u>R12-4-423</u>	<u>10 days</u>	<u>50 days</u>	<u>60 days</u>
<u>Wildlife Service License</u>	<u>R12-4-421</u>	<u>10 days</u>	<u>50 days</u>	<u>60 days</u>
<u>Zoo License</u>	<u>R12-4-420</u>	<u>10 days</u>	<u>20 days</u>	<u>30 days</u>

B. Issuance of Special License Tags is governed by R12-4-120. Proposals are accepted between July 1 and September 30 of each year. Administrative review is completed by the Department within 5 days. The Game and Fish Commission makes its decision on issuance or denial in an open meeting within 30 days after the closing date for proposals. The substantive review time-frame is 115 days and the overall time-frame is 120 days.

ARTICLE 3. TAKING AND HANDLING OF WILDLIFE

R12-4-309. Restricted Hunts

A. With the exceptions listed in subsection (C) of this rule, hunt areas established by Commission order for the following seasons are closed to hunting by all persons not possessing the valid big game tag required for that season:

1. All elk seasons within the following units as described in R12-4-108:
Unit 1.
Unit 2B.
Unit 2C.

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- Unit 3A.
 - Unit 3B.
 - Unit 3C.
 - Unit 4A.
 - Unit 4B.
 - Unit 5A.
 - Unit 5B.
 - Unit 6A.
 - Unit 6B.
 - Unit 7.
 - Unit 8.
 - Unit 9.
 - Unit 10.
 - Unit 17A.
 - Unit 17B.
 - Unit 18A.
 - Unit 18B.
 - Unit 19A.
 - Unit 19B.
 - Unit 22, except the portion in the Mazatzal Mountains.
 - Unit 23, except the portion in the Sierra Ancha Mountains.
 - Unit 27, except the portion lying south of the line beginning at the New Mexico state line and Blue River, southwesterly along Blue River to its juncture with Strayhorse and Bear Canyon Trails, southwesterly on Strayhorse and Bear Canyon Trails to Forest Road 217, north on Forest Road 217 to the San Carlos Indian Reservation.
2. All general javelina seasons in all units.
- 1. ~~General elk season, except in those portions of Unit 22 in the Mazatzal Mountains; Unit 23 in the Sierra Ancha Mountains; and that portion of Unit 27 lying south of the line beginning at the New Mexico state line and Blue River, southwesterly along Blue River to its juncture with Strayhorse and Bear Canyon Trails, southwesterly on Strayhorse and Bear Canyon Trails to Forest Road 217, north on Forest Road 217 to the San Carlos Indian Reservation;~~
 - 2. ~~Muzzle loader elk season;~~
 - 3. ~~Archery only elk season;~~
 - 4. ~~General javelina season.~~
 - B. ~~No change.~~
 - C. ~~No change.~~
 - 1. ~~No change.~~
 - 2. ~~No change.~~
 - 3. ~~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.~~
 - 4. ~~No change.~~
 - D. ~~This rule is effective January 1, 1997.~~

NOTICE OF PROPOSED RULEMAKING

**TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS;
SECURITIES REGULATION**

CHAPTER 4. CORPORATION COMMISSION - SECURITIES

PREAMBLE

1. **Sections Affected** **Rulemaking Action**
R14-4-141 New Section
2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Constitutional authority: Arizona Constitution Article XV §§ 4, 6 and 13
Authorizing statute: A.R.S. §§ 44-1821(A) and 44-1845(B)(2)
Implementing statute: A.R.S. § 44-1845(B)(2)
3. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Leslie Block, General Counsel
Address: Arizona Corporation Commission, Securities Division
1300 West Washington, Third Floor
Phoenix, Arizona 85007
Telephone: (602) 542-4242
Fax: (602) 542-7470
4. **An explanation of the rule, including the agency's reasons for initiating the rule:**
R14-4-141 provides a limited exemption from the securities and dealer registration requirements of A.R.S. §§ 44-1841 and 44-1842 for issuers engaging in solicitations of interest in compliance with the Rule. The Rule permits an issuer (or a dealer acting on behalf of an issuer) to use solicitations of interest to assess investor interest in a potential securities offering. A solicitation of

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interest made in compliance with the Rule would be an exempt offer. The Rule provides no exemption for sales of securities. The Rule sets forth in detail the technical requirements and procedures an issuer must comply with in order to solicit investor interest without engaging in an unregistered offering of securities.

An issuer must comply with the Rule's detailed requirements to avail itself of the exemption. An issuer must be a United States, Canadian, or Mexican entity contemplating a securities offering other than a "blind pool" offering. The issuer must intend to either register the security in Arizona prior to sale or to sell the securities pursuant to a valid exemption in Arizona.

An issuer relying on the proposed Rule must file a Solicitation of Interest Form (the "Form") with the Securities Division 10 business days prior to the initial solicitation of interest. This enables the Securities Division to review the solicitation materials prior to their use. Further, an issuer must provide an offeree with a copy of the Form within 5 days of any oral communication with the offeree regarding the contemplated offering.

During the solicitation of interest period, the issuer may not solicit or accept money. In addition, the issuer may not solicit a commitment to purchase securities. Issuers are limited to accepting indications of interest from an investor to receive a prospectus for the security once available.

The exemption is not available if an issuer or its agents have been subject to certain administrative or judicial actions. Additionally, the Director of Securities may revoke the availability of this Rule prior to any particular solicitation of interest with respect to a particular issuer or transaction if the Director determines that there is a reasonable likelihood that the solicitation of interest would work or tend to work a fraud or deceit upon the offerees.

If an issuer fails to comply with the conditions of the Rule, it may be subject to liability for having conducted an unregistered, unlawful offer. Civil and administrative liabilities may attach under the Arizona Securities Act. However, the Rule has a provision allowing an issuer to make limited insignificant deviations from the technical provisions of the Rule without losing the exemption.

Because offers made pursuant to the Rule will constitute a public solicitation, issuers seeking to rely on a private placement exemption must wait until 6 months after the last communication under the Rule to proceed with the private offering.

The purpose of the Rule is to: (1) allow issuers to assess the probability of success of a securities offering prior to incurring the often considerable expense of registering the offering; and (2) enable issuers to significantly increase the probability of an offering's success by soliciting investor input on features that would make the investment more attractive. The Rule, which is based on a model developed by the North American Securities Administrators Association and on the rules adopted by other states, has adequate safeguards to protect investors, while at the same time stimulating economic growth by benefitting small businesses and investors without unnecessary expense.

5. 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:

The Rule will diminish the grant of authority to require the registration of the offer of securities made pursuant to a solicitation of interest. Issuers complying with the Rule will be able to offer securities to investors without registration of the securities. However, the Rule does not permit any sales to be made without registration. Despite the reduction in authority, the Rule is desirable to promote the significant statewide interest of assisting businesses in capital formation in a manner which does not impose unnecessary expenses.

The Rule significantly benefits issuers by allowing them to assess the probability of an offering's success before incurring the expense of registering the securities under the Arizona Securities Act. An issuer utilizing the proposed Rule will incur some legal expense in preparing and filing the Solicitation of Interest Form. However, if the offering conducted under the Rule indicates insufficient investor interest in the investment, the issuer will have avoided the considerable legal and accounting expenses associated with a securities registration. In addition, the Rule benefits issuers by allowing them to increase the probability of success of a proposed offering by publicly soliciting investor input on the structure of the offering in order to maximize its attractiveness to investors.

The risk of harm to the general investing public is limited, as the Rule exempts only offers, not the ultimate sale of the securities. An issuer may not solicit a commitment to purchase securities, nor may it solicit or accept money during the solicitation of interest period. The Commission also retains anti-fraud jurisdiction over any offering under the Rule. In addition, the Director may revoke the availability of the Rule prior to any particular Solicitation of Interest if the Director determines that there is a reasonable likelihood that the Solicitation of Interest would work or tend to work a fraud or deceit upon the offerees thereof. Thus, the significant statewide interest in promoting capital formation for small businesses should be advanced without any significant loss of authority to the Commission.

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

Pursuant to A.R.S. § 41-1055(D)(3), the Commission is exempt from providing an economic, small business, and consumer impact statement.

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

Not applicable.

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

Date: March 3, 1998

Time: 10 a.m.

Location: Arizona Corporation Commission
1200 West Washington Avenue
Phoenix, Arizona 85007

Nature: Oral Proceeding

Close of Record: Open Meeting of the Arizona Corporation Commission at which the Commission takes final action with respect to the adoption of the Rule.

Any person may submit written comments prior to the oral proceeding to the person listed in question #3.

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

None.

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

None.

11. The full text of the rule follows:

**TITLE 14. PUBLIC SERVICE CORPORATIONS; CORPORATIONS AND ASSOCIATIONS;
SECURITIES REGULATION**

CHAPTER 4. CORPORATION COMMISSION - SECURITIES

**ARTICLE 1. IN GENERAL RELATING TO THE
ARIZONA SECURITIES ACT**

Section

R14-4-141. Solicitation of Interest Prior to the Filing of the Registration Statement

**ARTICLE 1. IN GENERAL RELATING TO THE
ARIZONA SECURITIES ACT**

R14-4-141. Solicitation of interest prior to the filing of the registration statement

A. The following definitions shall apply to this section:

1. "Securities Act" means the Securities Act of Arizona, A.R.S. § 44-1801 et seq.
2. "SEC" means the United States Securities and Exchange Commission.
3. "Solicitation of Interest Form" means the document used to solicit indications of interest in a security, which must contain, in all material respects, the information set forth in subsection (J).

B. An offer, but not a sale, of a security made by an issuer, or on behalf of an issuer by a dealer registered under Article 9 of the Securities Act, for the sole purpose of soliciting an indication of interest in receiving a prospectus, or its equivalent, for such security is exempt from A.R.S. § 44-1841, and the issuer and its employees are exempt from A.R.S. § 44-1842, if all of the following conditions are satisfied:

1. The issuer is, or will be, a business entity organized under the laws of 1 of the states or possessions of the United States or 1 of the provinces or territories of Canada or 1 of the states of Mexico, and is not conducting or intending to conduct a blind pool offering as defined in A.R.S. § 44-1801(1).
2. The issuer intends to register the security in Arizona prior to sale or the securities will be sold pursuant to a valid exemption in Arizona.
3. Ten business days prior to the initial solicitation of interest under this section, the issuer files with the Commis-

sion a Solicitation of Interest Form along with any other items to be used, directly or indirectly, to conduct solicitations of interest, including, but not limited to, the script of any broadcast to be made and a copy of any notice or advertisement to be published.

4. Five business days prior to usage, the issuer files with the Commission any material amendments to the foregoing items or additional items to be used to conduct solicitations of interest, except for items provided to a particular offeree pursuant to a request by that offeree.
5. The issuer does not use any Solicitation of Interest Form, script, advertisement or other item to solicit indications of interest, which the Division has notified the issuer not to distribute.
6. During the solicitation of interest period, the issuer, or the dealer on behalf of the issuer, does not solicit or accept money or a commitment to purchase securities.
7. Any published notice, published advertisement or script for broadcast must contain at least the identity of the chief executive officer of the issuer, a brief general description of the issuer's business and products, and the 1st paragraph of the legend required in the Solicitation of Interest Form pursuant to subsection (J)(2)(g).
8. All communications with prospective investors made in reliance on this section must cease after a registration statement is filed in Arizona.

C. The issuer, or the dealer on behalf of the issuer, may communicate with any offeree about the contemplated offering provided the offeree is supplied the most current Solicitation of Interest Form no later than 5 business days from the communication. The requirements of this subsection do not apply to issuer communications made solely in the form of scripted broadcasts, published notices or published advertisements.

D. Unless the disqualification is waived or ceases to exist under subsection (E), the exemption of subsection (B) is not available if the issuer or any of its predecessors, affiliates, directors, officers, general partners, or beneficial owners of 10% or more of any class of its equity securities:

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1. Has been convicted of a felony of which fraud is an essential element, or which involves racketeering, or a transaction in securities, or an offense listed in A.R.S. § 13-2301(D)(4).
 2. Has been convicted within 10 years of the date of the filing of the Solicitation of Interest Form of a misdemeanor of which fraud or dishonesty is an essential element, or involving racketeering, or a transaction in securities.
 3. Is subject to an order, judgment, or decree of any court of competent jurisdiction entered within 10 years of the date of the filing of the Solicitation of Interest Form, which temporarily, preliminarily or permanently enjoins or restrains such person from engaging in, or continuing, any conduct or practice in connection with the sale or purchase of securities, or involving fraud, deceit, racketeering or consumer protection laws.
 4. Has been subject to any state or federal administrative order or judgment in connection with the purchase or sale of securities entered within 5 years of the date of the filing of the Solicitation of Interest Form.
 5. Is subject to the reporting requirements of the Securities Exchange Act of 1934 and has not filed all required reports during the 12 calendar months before the filing of the Solicitation of Interest Form.
 6. Is subject to an SEC order denying or revoking registration as a broker or dealer in securities under the Securities Exchange Act of 1934, or is subject to an order denying or revoking membership in a national securities association registered under the Securities Exchange Act of 1934, or has been suspended for a period exceeding 6 months, or expelled from membership in a national securities exchange registered under the Securities Exchange Act of 1934.
- E. The Commission or Director of Securities may, at their discretion, waive any disqualification caused by subsection (D). In addition, a disqualification under subsection (D) ceases to exist if:
1. The basis for the disqualification is removed by the jurisdiction creating it;
 2. The jurisdiction in which the disqualifying event occurred issues a written waiver of the disqualification; or
 3. The jurisdiction in which the disqualifying event occurred declines in writing to enforce the disqualification.
- F. A failure to comply with all of the requirements of subsections (B) and (C) will not result in the loss of the exemption from A.R.S. §§ 44-1841 and 44-1842 for any offer to a particular individual or entity if the issuer shows all of the following:
1. The failure to comply did not pertain to a condition directly intended to protect that particular individual or entity.
 2. The failure to comply was insignificant with respect to the offering as a whole, and
 3. A good faith and reasonable attempt was made to comply with all applicable conditions of subsections (B) and (C).
- G. Any issuer, or other person on behalf of an issuer, who solicits indications of interest under this section, may not make offers or sales in reliance on A.R.S. § 44-1844(A)(1) or A.A.C. R14-4-126 until 6 months after the last communication with a prospective investor made pursuant to this section.
- H. All offers and communications, including but not limited to, the Solicitation of Interest Form, made in reliance on this section are subject to the anti-fraud provisions of the Securities Act.
- I. The Director of Securities may revoke the availability of this exemption prior to any particular solicitation of interest with respect to a particular issuer or transaction if the Director of Securities determines that there is a reasonable likelihood that the solicitation of interest would tend to work a fraud or deceit upon the offerees. In the event the Director of Securities makes such a determination, the issuer of the solicitation of interest may request a hearing in accordance with the provisions of Article 11 of the Securities Act by notifying the Commission within 10 days after written notice of the Director's determination.
- J. The following sets forth the minimum information that must be included in a Solicitation of Interest Form. Additional information may be included. Except for the title, the required information may be presented graphically in any manner.
1. The title of the Solicitation of Interest Form must include the phrase: "SOLICITATION OF INTEREST."
 2. The Solicitation of Interest Form must include each of the following items:
 - a. Name of the issuer;
 - b. Street address of the issuer's principal office;
 - c. Issuer's telephone number;
 - d. Date and place of organization of the issuer;
 - e. Dollar amount of the proposed offering;
 - f. Name of the issuer's chief executive officer or equivalent;
 - g. The following legend, or a legend which is substantially equivalent in plain and concise language: "THIS IS A SOLICITATION OF INTEREST ONLY. NO MONEY OR OTHER CONSIDERATION IS BEING SOLICITED AND NONE WILL BE ACCEPTED. NO SALES OF THE SECURITIES WILL BE MADE, OR COMMITMENT TO PURCHASE ACCEPTED, UNTIL THE DELIVERY OF A FINAL OFFERING CIRCULAR [PROSPECTUS] THAT INCLUDES COMPLETE INFORMATION ABOUT THE ISSUER AND THE OFFERING. AN INDICATION OF INTEREST MADE BY A PROSPECTIVE INVESTOR INVOLVES NO OBLIGATION OR COMMITMENT OF ANY KIND. THIS OFFER IS BEING MADE PURSUANT TO AN EXEMPTION FROM REGISTRATION UNDER FEDERAL AND STATE SECURITIES LAWS. NEITHER THE FEDERAL NOR THE STATE AUTHORITIES HAVE CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS DOCUMENT OR ANY OTHER DOCUMENT PRESENTED TO YOU IN CONNECTION WITH THIS OFFER. NO SALE MAY BE MADE UNTIL THE OFFERING CIRCULAR [PROSPECTUS] IS REGISTERED IN THIS STATE AND IS QUALIFIED OR REGISTERED BY THE SECURITIES AND EXCHANGE COMMISSION."
 - h. A statement indicating whether the issuer is in the development stage, is conducting operations, has never conducted operations, or other applicable description.

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- i. A general description of the issuer's business or proposed business including the products or goods that are, or will be, produced or services that are, or will be, rendered, how these products or services are, or will be, produced or rendered, and how and when the issuer intends to carry out its activities.
- j. A general description of the purposes for which the issuer intends to use the proceeds of the proposed offering.
- k. The following information for all executive officers and directors: name, title, office, street address, telephone number, employment history (employers, titles and dates of positions held during the past 5 years), and education if less than 5 years of business experience (degrees, schools and dates).

NOTICE OF PROPOSED RULEMAKING

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

PREAMBLE

- | <u>1. Sections Affected</u> | <u>Rulemaking Action</u> |
|------------------------------------|---------------------------------|
| R20-6-1105 | Amend |
| R20-6-1106 | Amend |
| R20-6-1110 | Amend |
| R20-6-1113 | Amend |
| R20-6-1114 | Amend |
| Appendix B | Amend |
| Appendix F | Amend |
2. **The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statutes: A.R.S. §§ 20-143, 20-1133; 42 U.S.C. § 1395ss
Implementing statutes: A.R.S. § 20-1133; 42 U.S.C. § 1395ss
3. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Gregory Y. Harris
Address: Arizona Department of Insurance
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018
Telephone: (602) 912-8451
Fax: (602) 912-8452
4. **An explanation of the rule, including the agency's reasons for initiating the rule:**
Medicare Supplement insurance is regulated by the state based on minimum standards prescribed by federal law. These changes reflect changes to federal law prescribed pursuant to the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), Subtitle G, Section 271 and technical corrections previously requested by the Governor's Regulatory Review Committee. Without the changes mandated by federal law, Medicare Supplement insurance policies may not be sold in Arizona, except as directly regulated by the Federal Department of Health and Human Services/Health Care Financing Administrations (DHHS/HCFA).
5. **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.
6. **The summary of the economic, small business, and consumer impact:**
These amendments are required by federal law of all issuers of Medicare Supplement insurance. Any cost associated with these amendments is the result of federal law and not the result of adoption of these amendments. The technical corrections requested by the Governor's Regulatory Review Committee merely involve reformatting of the rules and do not add new requirements for insurers.
7. **The name and address of agency personnel with whom persons may communicate regarding the accuracy of the economic, small business, and consumer impact statement:**
Name: Gregory Y. Harris
Address: Arizona Department of Insurance
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018

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Telephone: (602) 912-8451

Fax: (602) 912-8452

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

Date: February 12, 1998

Time: 2:00 p.m.

Address: Arizona Department of Insurance
3rd Floor Hearing Room
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018

Nature: Oral proceeding. The Department will accept written comments received by 5 p.m. February 12, 1997, or postmarked no later than that date.

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

Not applicable.

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

Not applicable.

11. The full text of the rule follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

Section

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

R20-6-1106. Standard Medicare Supplement Benefit Plans

R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium

R20-6-1113. Required Disclosure Provisions

R20-6-1114. Requirements for Application forms and Replacement Coverage

Appendix B. MEDICARE SUPPLEMENT COVERAGE PLANS

Appendix F. MEDICARE DUPLICATION DISCLOSURE STATEMENTS

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

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after April 1, 1992. 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.

B. General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Article.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the losses arise from a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these changes.
4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
5. Each Medicare supplement policy shall be guaranteed renewable and the issuer:
 - a. Shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
 - b. Shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
6. If a Medicare supplement policy is terminated by a group policyholder and is not replaced as provided under subsection (B)(8), the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder:
 - a. Provides for continuation of the benefits contained in the group policy, or
 - b. Provides for benefits that otherwise meet the requirements of subsection (B).
7. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - a. Offer the certificate holder the conversion opportunity described in subsection (B)(6); or

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- b. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
8. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the replacement group policy shall not exclude preexisting conditions that would have been covered under the group policy being replaced.
9. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.
10. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the medical assistance.
- a. If benefits and premiums are suspended under subsection (B)(10), and if the policyholder or certificate holder loses entitlement to medical assistance under Title XIX of the Social Security Act, the policy or certificate shall be automatically reinstated, effective as of the date of termination of the entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss of the entitlement and pays the premium attributable to the period beginning when the entitlement to the medical assistance ended.
- b. Reinstitution of coverage under subsection (B)(10)(a):
- i. Shall not provide for any waiting period with respect to treatment of preexisting conditions;
 - ii. Shall provide for coverage that is substantially equivalent to coverage in effect before the date of the suspension; and
 - iii. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.
- C. Standards for basic "core" benefits common to all benefit plans. † Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not instead of the basic "core" package.
- 1.a. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- 2.b. Coverage of Part A Medicare-eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
- 3.e. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A-eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;
- 4.d. Coverage under Medicare Parts A and B for the reasonable cost of the 1st 3 pints of blood or equivalent quantities of packed red blood cells, unless replaced; and
- 5.e. Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
- D. Standards for additional benefits. † The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by R20-6-1106.
- 1.a. Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;
- 2.b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;
- 3.e. Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;
- 4.d. Eighty percent of the Medicare Part B excess charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
- 5.e. One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
- 6.f. Basic outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar-year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
- 7.g. Extended outpatient prescription drug benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar-year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare;
- 8.h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by Medicare if provided in the United States and that began during the 1st 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" means care needed

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- immediately because of an injury or an illness of sudden and unexpected onset;
- 9.i. Preventive medical care benefit: Coverage for the following preventive health services:
- a.i. An annual clinical preventive medical history and physical examination that may include tests and services described in subsection (D)(9)(b) of this Rule ~~subdivision (ii) of this subparagraph~~ and patient education to address preventive health care measures;
- b.ii. Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:
- i.(1) Fecal occult blood test or digital rectal examination, or both;
- ii.(2) Mammogram;
- iii.(3) Dipstick urinalysis for hematuria, bacteriuria and proteinuria;
- iv.(4) Pure tone, air only, hearing screening test, administered or ordered by a physician;
- v.(5) Serum cholesterol screening every 5 years;
- vi.(6) Thyroid function test; and
- vii.(7) Diabetes screening;
- c.iii. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every 10 years;
- d.iv. Any other tests or preventive measures determined appropriate by the attending physician; and
- e.v. Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare;
- 10.j. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery,
- a.i. Coverage requirements; and limitations
- i.(1) At-home recovery services provided must be primarily services that assist in activities of daily living;
- ii.(2) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare;
- b.(3) Coverage is limited to:
- i.(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;
- ii.(b) The actual charges for each visit to a maximum reimbursement of \$40 per visit;
- iii.(c) \$1,600 per calendar year;
- iv.(d) Seven visits in any 1 week;
- v.(e) Care furnished on a visiting basis in the insured's home;
- vi.(f) Services provided by a care provider as defined in R20-6-1102(4);
- vii.(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and
- viii.(h) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than 8 weeks after the service date of the last Medicare-approved home health care visit.
- c.(4) Coverage is excluded for:
- i.(a) Home care visits paid for by Medicare or other government programs; and
- ii.(b) Care provided by family members, unpaid volunteers, or providers who are not care providers; and
- 11.k. New or innovative benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits that do not violate any provision of A.R.S. Title 20, or otherwise conflict with this Article and are in addition to the benefits provided in a policy or certificate that otherwise comply with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies.

R20-6-1106. Standard Medicare Supplement Benefit Plans

- A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as described in A.A.C. R20-6-1105(C).
- B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in R20-6-1105(D)(11) ~~A.A.C. R20-6-1105(D)(2)(e)~~ and in A.A.C. R20-6-1107.
- C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this rule and conform to the definitions in R20-6-1103. Each benefit shall be structured in accordance with the format and order provided in R20-6-1105(C) and (D) ~~and list the benefits in the order shown in this subsection.~~ For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.
- D. An issuer may use other designations, in addition to the benefit plan designations required in subsection (C) of this rule.
- E. Make-up of benefit plans:
1. Standardized ~~Standardization~~ Medicare supplement benefit plan "A" shall be limited to the basic "core" benefits common to all benefit plans, as described in R20-6-1105(C).
 2. Standardized ~~Standardization~~ Medicare supplement benefit plan "B" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible as described in R20-6-1105(D)(1)(a).
 3. Standardized ~~Standardization~~ Medicare supplement benefit plan "C" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as

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- described in R20-6-1105(D)(1), (2), (3), and (8) R20-6-1105(D)(1)(a), (b), (e) and (h) respectively.
4. Standardized Standardization Medicare supplement benefit plan "D" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as described in R20-6-1105(D)(1), (2), (8), and (10) R20-6-1105(D)(1)(a), (b), (h) and (j) respectively.
 5. Standardized Standardization Medicare supplement benefit plan "E" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the preventive medical care as defined in R20-6-1105(D)(1), (2), (8), and (9) R20-6-1105(D)(1)(a), (b), (h) and (i) respectively.
 6. Standardized Standardization Medicare supplement benefit plan "F" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1), (2), (3), (5), and (8) R20-6-1105(D)(1)(a), (b), (e), (e) and (h) respectively.
 7. Standardized Standardization Medicare supplement benefit plan "G" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, 80% percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as described in R20-6-1105(D)(1), (2), (4), (8), and (10) R20-6-1105(D)(1)(a), (b), (d), (h) and (j) respectively.
 8. Standardized Standardization Medicare supplement benefit plan "H" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1), (2), (6), and (8) R20-6-1105(D)(1)(a), (b), (f) and (h) respectively.
 9. Standardized Standardization Medicare supplement benefit plan "I" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, 100% percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefits as defined in R20-6-1105(D)(1), (2), (5), (6), (8), and (10) R20-6-1105(D)(1)(a), (b), (e), (f), (h) and (j) respectively.
 10. Standardized Standardization Medicare supplement benefit plan "J" shall include only the following: The core benefit as described in R20-6-1105(C) of this Article, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% percent of the Medicare Part B excess charges, extended basic prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as described in R20-6-1105(D)(1), (2), (3), (5), (7), (8), (9), and (10) R20-6-1105(D)(1)(a), (b), (e), (e), (g), (h), (i) and (j) respectively.
- R20-6-1110. Loss Ratio Standards and Refund or Credit of Premium**
- A. Loss ratio standards.**
1. A Medicare supplement policy or certificate form shall not be delivered or issued for delivery unless the policy or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy or certificate:
 - a. At least 75% of the aggregate amount of premiums earned in the case of group policies, or
 - b. At least 65% of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses if coverage is provided by a health care services organization on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices.
 2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.
 3. For policies issued before December 18, 1991, expected claims in relation to premiums shall meet:
 - a. The originally filed anticipated loss ratio when combined with the actual experience since inception;
 - b. The appropriate loss ratio requirement from subsection (A)(1) when combined with the actual experience beginning with April 28, 1996, to date; and
 - c. The appropriate loss ratio requirement from subsection (A)(1) over the entire future period for which the rates are computed to provide coverage.
- B. Refund or credit calculation.**
1. An issuer shall collect and file with the Director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.
 2. If on the basis of the experience as reported, the benchmark ratio since inception exceeds the adjusted experience ratio since inception, a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies or certificates issued within the reporting year shall be excluded.
 3. For policies or certificates issued before December 18, 1991, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after April 28, 1996. The issuer shall submit the 1st report under this subsection by May 31, 1998.
 4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds

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.5% of the annualized premium in force as of December 31 of the reporting year. The refund or credit shall include interest from the end of the calendar year to the date of the refund or credit at a rate not less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of premium rates.

1. An issuer of Medicare supplement policies or certificates issued in this state before or after the effective date of this rule shall file annually by no later than January 1 its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums, by policy duration for approval by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected 3rd-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.
2. Before the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Director:
 - a. Premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting documents necessary to justify the adjustment shall accompany the filing.
 - i. An issuer shall make premium adjustments to produce an expected loss ratio under a policy or certificate that conforms with minimum loss ratio standards for Medicare supplement policies or certificates and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment that would modify the loss ratio experience under the policy or certificate other than the adjustments described in this subsection shall be made with respect to a policy or certificate at any time other than upon its renewal date or anniversary date.
 - ii. If an issuer fails to make premium adjustments in accordance with this rule, the Director may order premium adjustments, refunds, or credits deemed necessary to achieve the loss ratio required by this rule.
 - b. Any riders, endorsements, or policy forms needed to modify the Medicare supplement policy or certificate to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

- D. Public hearings.** The Director may conduct a public hearing or hearings to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is

not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. The Director shall give notice of the hearing in accordance with A.R.S. § 20-163.

- E.** As used in this rule, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

R20-6-1113. Required Disclosure Provisions

A. General rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the renewal or continuation provision shall be consistent with the type of contract issued. The provision shall be captioned as a renewal or continuation provision, shall appear on the 1st page of the policy or certificate, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's or certificate holder's age.
2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits or coverage are required by the minimum standards for Medicare supplement policies, or the increased benefits or coverage is required by law. If a separate additional premium is charged for benefits or coverage provided in connection with riders or endorsements, the additional premium charge shall be set forth in the policy.
3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.
4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."
5. Medicare supplement policies and certificates shall have a notice prominently printed on or attached to the 1st page of the policy or certificate stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
6. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense-incurred or indemnity basis, to a person eligible for Medicare shall provide to the applicant a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-

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point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this Article. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request or, if not requested, no later than at the time the policy is delivered.

7. For the purposes of subsection (A)(6), "form" means language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice requirements.

1. As soon as practicable, but no later than 30 days before the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates. The notice shall:

- a. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and
b. Inform each policyholder and certificate holder when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

C. Outline of coverage requirements for Medicare supplement policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

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

4. The outline of coverage shall include the items in the order prescribed in Appendix B. The information contained in the outline of coverage shall be correct as of the date of its issuance and shall include amounts payable by Medicare, the insured's deductible and what the policy or certificate pays.

D. Notice regarding policies or certificates that are not Medicare supplement policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in R20-6-1101(B), issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy or certificate that the policy or certificate is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the 1st page of the outline of coverage delivered to insureds under the policy or, if no outline of coverage is delivered, to the 1st page of the policy or certificate delivered to insureds. The notice shall be in not less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the company.

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (D)(1) shall provide the applicable statement in Appendix F, ~~the extent to which the policy duplicates Medicare.~~ The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

APPENDIX B

[12 point]

[COMPANY NAME]

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE - COVER PAGE:

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

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

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

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A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care

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

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APPENDIX B (CONT'D)

PREMIUM INFORMATION [boldface type]

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

DISCLOSURES [boldface type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [boldface type]

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

RIGHT TO RETURN POLICY [boldface type]

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

POLICY REPLACEMENT [boldface type]

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

NOTICE [boldface type]

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

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT [boldface type]

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

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

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

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

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APPENDIX B (CONT'D)

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$0	\$[764]628 (Part A Deductible)
61st thru 90th day	All but \$[191] 157 a day	\$[191] 157a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382] 344a day	\$[382] 344a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50] 78.50	\$0	Up to \$[95.50] 78.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN A

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

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

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

PARTS A & B

HOME HEALTH CARE

MEDICARE-APPROVED SERVICES

- Medically necessary skilled care services and medical supplies
- Durable medical equipment

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

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APPENDIX B (CONT'T)

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$ 764 628	\$ 764 628 (Part A Deductible)	\$0
61st thru 90th day	All but \$ 191 157 a day	\$ 191 157 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$ 382 314 a day	\$ 382 314 a day	\$0
- Once lifetime reserve days are used			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$ 95.50 78.50	\$0	Up to \$ 95.50 78.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]457 a day	\$[191]457 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]314 a day	\$[382]314 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$[100] of Medicare-Approved Amounts *	\$0	\$[100] (the Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare-Approved Amounts *	\$0	\$[100] (Part B Deductible)	\$0 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0
PARTS A & B			
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare-Approved Amounts *	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over \$50,000 lifetime maximum

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PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]457 a day	\$[191]457 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]344 a day	\$[382]344 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN D

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

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

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE

Medically necessary emergency care services during the 1st 60 days of each trip outside the USA

First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over \$50,000 lifetime maximum

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APPENDIX B (CONT'D)

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]457 a day	\$[191]457 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]344 a day	\$[382]344 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN E

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

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

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

PARTS A & B

HOME HEALTH CARE

MEDICARE-APPROVED SERVICES

- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare-Approved Amounts *	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

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APPENDIX B (CONT'D)

PLAN E

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

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

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APPENDIX B (CONT'D)

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]157 a day	\$[191]157 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]314 a day	\$[382]314 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN F

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

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

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

PARTS A & B

HOME HEALTH CARE

MEDICARE-APPROVED SERVICES

- Medically necessary skilled care services and medical supplies

100%

\$0

\$0

- Durable medical equipment

First \$[100] of Medicare-Approved Amount *

\$0

\$[100] (Part B Deductible)

\$0

Remainder of Medicare-Approved Amounts 80%

20%

\$0

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SERVICES

MEDICARE PAYS

PLAN PAYS

YOU PAY

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE

Medically necessary emergency care services
during the 1st 60 days of each trip outside
the USA

First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over \$50,000 lifetime maximum

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APPENDIX B (CONT'D)

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]457 a day	\$[191]457 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]344 a day	\$[382]344 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs

SKILLED NURSING FACILITY CARE *

You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.

First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs

BLOOD

First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

HOSPICE CARE

Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
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APPENDIX B (CONT'D)

PLAN G

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

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

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

PARTS A & B

HOME HEALTH CARE

MEDICARE-APPROVED SERVICES

- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare-Approved Amounts *	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

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APPENDIX B (CONT'D)

PLAN G

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

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

OTHER BENEFITS

FOREIGN TRAVEL - NOT COVERED BY MEDICARE

Medically necessary emergency care services during the 1st 60 days of each trip outside the USA

First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over \$50,000 lifetime maximum

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APPENDIX B (CONT'D)

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]457 a day	\$[191]457 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]314 a day	\$[382]314 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN H

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

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

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

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APPENDIX B (CONT'D)

PLAN H

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS -			
NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50% - \$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over \$50,000 lifetime maximum

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APPENDIX B (CONT'D)

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]157 a day	\$[191]157 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]344 a day	\$[382]344 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN I

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

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

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

PARTS A & B

HOME HEALTH CARE

MEDICARE-APPROVED SERVICES

- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare-Approved Amounts *	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

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APPENDIX B (CONT'D)

PLAN I

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	\$0	Up to the number Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	
OTHER BENEFITS			
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50% - \$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All costs
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services during the 1st 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over \$50,000 lifetime maximum

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APPENDIX B (CONT'D)

PLAN J

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[764]628	\$[764]628 (Part A Deductible)	\$0
61st thru 90th day	All but \$[191]457 a day	\$[191]457 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382]344 a day	\$[382]344 a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
- Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE *			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95.50]78.50 a day	Up to \$[95.50]78.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out patient drugs and inpatient respite care	\$0	Balance

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APPENDIX B (CONT'D)

PLAN J

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

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

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

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APPENDIX B (CONT'D)

PLAN J

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit)	\$0	Up to the number of Medicare-Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	
OTHER BENEFITS			
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50% - \$3,000 calendar year maximum benefit	50%
Over \$6,000 each calendar year	\$0	\$0	All costs
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All costs

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

Appendix F

MEDICARE DUPLICATION DISCLOSURE STATEMENTS

**Instructions for use of the Disclosure Statements for
 Health Insurance Policies Sold to Medicare Beneficiaries
 that Duplicate Medicare**

- ~~1. Federal law, P.L. 103-432, prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.~~
- ~~1.2. All types of health insurance policies that duplicate Medicare shall include 1 of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).~~
- ~~2.3. State and Federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.~~
- ~~3.4. Property/Casualty and Life insurance policies are not considered health insurance.~~
- ~~4.5. Disability income policies are not considered to provide benefits that duplicate Medicare.~~
- ~~5.6. The federal law does not pre-empt state laws that are more stringent than the federal requirements.~~
- ~~6.7. The federal law does not pre-empt existing state form filing requirements.~~

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[For policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS <u>THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</u>

~~**This is not Medicare Supplement Insurance**~~

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

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

~~This insurance duplicates Medicare benefits when it pays:~~

- ~~• hospital or medical expenses up to the maximum stated in the policy~~

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

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

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[For policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~**This is not Medicare Supplement Insurance**~~

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

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

~~This insurance duplicates Medicare benefits when:~~

- ~~any of the services covered by the policy are also covered by Medicare~~

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~This is not Medicare Supplement Insurance~~

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

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

~~This insurance duplicates Medicare benefits when it pays:~~

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

~~**This is not Medicare Supplement Insurance**~~

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

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

~~This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.~~

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

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

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

Before You Buy This Insurance

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

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

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

~~This is not Medicare Supplement Insurance~~

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

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

~~This insurance duplicates Medicare benefits when:~~

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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[For policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~**THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~**This is not Medicare Supplement Insurance**~~

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

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

~~**This insurance duplicates Medicare benefits when:**~~

- ~~• any expenses or services covered by the policy are also covered by Medicare; or~~
- ~~• it pays the fixed dollar amount stated in the policy and Medicare covers the same event~~

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~This is not Medicare Supplement Insurance~~

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

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

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

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

Before You Buy This Insurance

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

[For long-term care policies providing nursing home benefits only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

This is not Medicare Supplement Insurance

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

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

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

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

Before You Buy This Insurance

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

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[For policies providing home care benefits only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~**This is not Medicare Supplement Insurance**~~

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

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

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

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

Before You Buy This Insurance

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

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[For other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
~~**THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**~~
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

~~**This is not Medicare Supplement Insurance**~~

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

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

~~**This insurance duplicates Medicare benefits when it pays:**~~

- ~~the benefits stated in the policy and coverage for the same event is provided by Medicare~~

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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