

NOTICES OF PROPOSED RULEMAKING

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

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

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TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 46. BOARD OF APPRAISAL

PREAMBLE

<u>I. Sections Affected</u>	<u>Rulemaking Action</u>
R4-46-101	Amend
R4-46-103	Amend
R4-46-104	Amend
R4-46-106	Amend
R4-46-201	Amend
R4-46-202	Amend
R4-46-203	New Section
R4-46-204	Renumber
R4-46-204	Amend
R4-46-205	Renumber
R4-46-205	Amend
R4-46-206	Renumber
R4-46-206	Amend
R4-46-207	Renumber
R4-46-207	Amend
R4-46-208	New Section
R4-46-209	Renumber
R4-46-209	Amend
R4-46-210	Renumber
R4-46-210	Amend
R4-46-301	Amend
R4-46-302	Repeal
R4-46-302	Renumber
R4-46-302	Amend
R4-46-303	Renumber
R4-46-303	Amend
R4-46-304	Renumber
R4-46-304	Amend
R4-46-305	Renumber
R4-46-305	Amend
R4-46-401	Amend
R4-46-501	Amend
R4-46-502	Amend
R4- 46-503	Amend
Article 6	Repeal
Article 6	New Article
R4-46-601	Repeal
R4-46-601	New Section
R4-46-602	New Section

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

Authorizing statute: A.R.S. § 32-3605

Implementing statutes: A.R.S. §§ 32-3601, 32-3606(4), 32-3605(C), 32-3607, 32-3605(B)(2)(3), 32-3605(B)(7), 32-3605(B)(5)(6), 32-3620(C), 32-36-05(B)(8), 32-3625(D), 32-3605(B)(8), 32-3606(2), 32-3605(B)(8)(5), 32-3606(3), 32-3621, 32-3605(B)(10)(11), 32-3625(G), 32-3605 (A)(1), 32-3605(B)(4)(8), 32-3655

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

Names: Shirley L. Berry
Address: Arizona Board of Appraisal
1400 West Washington, Suite 360
Phoenix, Arizona 85007
Telephone: (602) 542-1539
Fax: (602) 542-1598

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

All rules are written to comply with the provisions of Title XI of the Financial Institutions Reform, Recovery and Enforcement Act of 1989, and State statutes applicable to Real Estate Appraisers and Property Tax Agents. Changes in existing rules are planned to help clarify and give meaning to the rules.

R4-46-101 - Definitions - to provide definitions of terms used in the subsequent sections.

R4-46-103 - Board Records: Public Access: Copying Fees - determines the manner in which the Board shall maintain, make available, provide copies, and remove from office records of the Board.

R4-46-104 - Confidential Records - determines the confidentiality of records necessary to protect the rights of persons, also to adhere to the public's right to access.

R4-46-105 - Meetings - sets minimum meetings and gives Board authority to set additional meetings.

R4-46-106 - Fees - gives Board authority to set and collect fees and specifies the amount.

R4-46-201 - Appraiser Qualification Criteria - adopts requirements for qualification as Arizona licensed/certified appraisers.

R4-46-202 - Application for Original License or Certificate - determines necessity for application, test, and fees.

R4-46-203 - Procedures for Processing Applications - to set procedures giving time frames for the application process.

R4-46-204 - Appraiser Examinations - provides requirements, scheduling, excused absences, forfeiture, subject matter, and reexamination criteria.

R4-46-205 - Issuance of License or Certificate - provides criteria for issuance of license/certificate.

R4-46-206 - Hearing on Denial of License or Certification - provides redress to licensee/certificate holder after denial of license or certificate.

R4-46-207 - Renewal of License or Certificate - sets forth requirements for renewal of license/certificate.

R4-46-208 - Renewal of an Expired License or Certificate - provides for renewal within a given time period.

R4-46-209 - Replacement License or Certificate - provides a uniform means to replace license/certificate.

R4-46-210 - Change of Address - sets time period to notify Board of change of address.

R4-46-301 - Investigations, Informal Proceedings and Summary Suspensions - gives the Board authority to investigate violations and take action of investigations.

Re-46-302 - Formal Hearing Procedures - sets notice time, possible use of hearing officer, conduct of hearing, provides for failure to appear, sets means to make and keep record of hearing.

R4-46-303 - Rehearing of Board's Decision - provides for rehearing of Board's decision, gives time lines and procedures to be followed.

R4-46-304 - Duty to Obtain Conviction of Reinstatement after Revocation - provides for application for reinstatement and sets criteria for determination and limitation of right of reinstatement.

R4-46-301 - Standard of Appraisal Practice - sets the standards to which the appraisers must comply. This rule was changed from the proposed text to include the latest publication of the Uniform Standards of Professional Appraisal Practice.

R4-46-501 - Board Approval Requirement (Education) - provides for Board approval of education courses and exempts those not required to get Board approval. Sets forth requirements and criteria for education provider approval.

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R4-46-502 - Appraiser Applicant Prerequisite Education Equivalency Approval - requirements for applicant use of courses not Board approved.

R4-46-503 - Hearing on Denial of Prerequisite Education Provider or Course Approval - allows for a hearing on course approval.

R4-46-601 - Standards of Practice for Property Tax Agents - sets provisions for disciplining Property Tax Agents.

R4-42-602 - Disciplinary Proceedings: Board Action: Notice of Requirements - Sets manner in which Board shall process hearings and disciplinary matters involving Property Tax Agents.

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:
Groups that would be affected primarily would be the Board of Appraisal, the licensed/certified appraisers, the public, and other agencies. Considerations given were cost to the Board to see that there is compliance, including possible court cost. Cost of fees to the appraisers and property tax agents, possible litigation fees, education fees were considered, and loss of income. Cost or revenue to the course providers was considered. Public's right to access records and cost associated were considered. Impact of possible losses to the public were considered. The majority of the rules have been in effect since the Board, was established and there should be no appreciable change in the economic 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: Shirley L. Berry
Address: Arizona Board of Appraisal
1400 West Washington, Suite 360
Phoenix, Arizona 85007
Telephone: (602) 542-1539
Fax: (602) 542-1598

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: March 10, 1998
Time: 9 a.m.
Location: Arizona Board of Appraisal
1400 West Washington, 3rd Floor Conference Room
Phoenix, Arizona
Nature: Open meeting to hear opinions and suggestions, and to adopt, amend or repeal the rule.

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:
Appraiser Qualification Criteria, established by the Appraisal Foundation, dated February 16, 1994. The location in the rules is R4-46-201 (A).
National Uniform Examination Content Outline, dated November 4, 1993 published by the Appraisal Foundation. The location in the rules is R4-46-204 (D).
Uniform Standards of Professional Appraisal Practice, 1998 Edition published by the Appraisal Foundation. The location in the rules is R4-46-401.

11. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 46. BOARD OF APPRAISAL

ARTICLE 1. DEFINITIONS

Section
R4-46-101. Definitions
R4-46-103. Board Records; Public Access; Copy fees
R4-46-104. Confidential Records

R4-46-106. Fees

ARTICLE 2. LICENSING AND CERTIFICATION

Section
R4-46-210. Appraiser Qualification Criteria
R4-46-202. Application for License or Certificate

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- R4-46-203. Procedures for Processing Applications
- R4-46-204. Appraiser Examinations
- R4-46-205. Issuance of License or Certificate
- R4-46-206. Hearing on Denial of a License or Certificate
- R4-46-207. Renewal of License or Certificate
- R4-46-208. Renewal of an Expired License or Certificate
- R4-46-209. Replacement License or Certificate
- R4-46-210. Change of Address

**ARTICLE 3. HEARINGS AND DISCIPLINARY
PROCEEDINGS**

- Section
- R4-46-301. Investigations, Informal Proceedings and Summary
 - R4-46-302. Formal Hearing Procedures
 - R4-46-303. Rehearing of Board's Decisions
 - R4-46-304. Conviction and Judgement Disclosure
 - R4-46-305. Terms and Conditions of Reapplication After Revocation

ARTICLE 4. STANDARDS OF PRACTICE

- Section
- R4-46-401. Standards of Appraisal Practice

ARTICLE 5. COURSE APPROVAL

- Section
- R4-46-501. Course Approval
 - R4-46-502. Course Equivalency Approval
 - R4-46-503. Hearing on Denial of Course Approval

ARTICLE 6. PROPERTY TAX AGENTS

- Section
- R4-46-601. Standards of Practice
 - R4-46-602. Disciplinary Proceedings; Board Action; Notice Requirements

ARTICLE 1. GENERAL PROVISIONS

R4-46-101. Definitions

In these rules, unless the context otherwise requires:

- A. "Arizona or State Certified General Appraiser" means the State Certified General Real Estate Appraiser Classification set forth in A.R.S. § 32-3612(A)(1) and corresponds to the Certified General Real Property Appraiser Classification of the Appraisal Foundation.
- B. "Arizona or State Certified Residential Appraiser" means the State Certified Residential Real Estate Appraiser Classification set forth in A.R.S. § 32-3612(A)(2) and corresponds to the Certified Residential Real Property Appraiser Classification of the Appraisal Foundation.
- C. "Arizona or State Licensed Appraiser" means the Licensed Real Estate Appraiser Classification set forth in A.R.S. § 32-3612(A)(3) and corresponds to the Licensed Real Property Appraiser Classification of the Appraisal Foundation.
- D. "Appraisal Foundation" means the educational organization as defined by A.R.S. § 32-3601(3) which is the parent organization of the Appraiser Qualifications Board and the Appraisal Standards Board. The Appraisal Foundation is located at 1029 Vermont Ave., N.W. Suite 900, Washington, D.C. 20005.
- E. ~~"Appraisal Standards Board" means the Board of the Appraisal Foundation organized to promote the implementation of the Uniform Standards of Professional Appraisal Practice ("USPAP").~~
- F. "Appraiser" means an Arizona Licensed Appraiser, an Arizona Certified Residential Appraiser, or an Arizona Certified General Appraiser.

G. ~~"Appraiser Qualifications Board" means the board of the Appraisal Foundation organized to establish qualification criteria for state-licensed and certified appraisers.~~

H. "Board" means the Arizona Board of Appraisal established by A.R.S. § 32-3604. The Board for purposes of Article 3, may include an administrative law judge.

I. ~~"Continuing education" means the continuing course work set forth in the Appraiser Qualifications Board, Appraiser Qualification Criteria for Residential and General Classifications of Real Property Appraisers, Section I(A)(4)(a)(1), (2), and (4) of the Licensed Real Property Appraiser Classification, Appraiser Qualification Criteria; Section II(A)(4)(a)(1), (2), and (4) of the Certified Residential Real Property Appraiser Classification, Appraiser Qualification Criteria and Section III(a)(4)(a)(1), (2), and (4) of the Certified General Real Property Appraiser Classification, Appraiser Qualification Criteria dated February 9, 1993, not including any subsequent amendments, restatements, revisions, and/or replacement criteria, published by the Appraisal Foundation which the Board incorporates by reference. Copies are on file with the Secretary of State. Copies may be obtained from the Board or the Appraisal Foundation.~~

J. "Party" means each person or agency named or admitted as party or properly seeking and entitled to participate in any proceeding before the Board.

K. ~~"Prerequisite education" means the qualifying course work set forth in the Appraiser Qualifications Board, Appraiser Qualification Criteria for Residential and General Classifications of Real Property Appraisers, Section I(A)(2)(a)(1), (2), and (4) (7) of Licensed Real Property Appraiser Classification, Appraiser Qualification Criteria; Section II(A)(2)(a)(1), (2), and (4) (7) of Certified Residential Real Property Appraiser Classification, Appraiser Qualification Criteria; and Section III(A)(2)(a)(1), (2), (4) (7) of Certified General Real Property Appraiser Classification Appraiser Qualification Criteria, published by the Appraisal Foundation dated February 9, 1993, not including any subsequent amendments, restatements, revisions, and/or replacement criteria. Copies are on file with the Secretary of State. Copies may be obtained from the Board or the Appraisal Foundation.~~

"Respondent" means Appraiser, Course Provider, Property Tax Agent or any other party responding to a motion in a proceeding before the Board.

L. "Provider" means any organization or individual offering prerequisite or continuing education courses.

M. "Rules" means the Arizona Board of Appraisal Rules requirement set forth in the Arizona Administrative Code, Title 4, Chapter 46 Arizona Board of Appraisal rules.

"USPAP" means the Uniform Standards of Professional Appraisal Practice.

R4-46-103. Board Records; Public Access; Copying Fees

A. The Board shall ~~keep~~ maintain all records reasonably necessary or appropriate to maintain an accurate knowledge of its official activities including, but not limited to: Applications applications for an a initial license or certificate, renewal, applications, or examination results; documents, transcripts, and pleadings relating to disciplinary proceedings and to hearings on the denial of a license or certificate; investigative reports; staff memoranda; and general correspondence between any person and the Board, members of the Board, or staff members.

B. A person shall not remove No Board records shall be removed from the office of the Board unless the records they are in the custody and control of a Board member, a member of the Board's staff, or the Board's attorney. The Executive

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Director may designate a staff member to observe and monitor any examination of Board records.

- C. The Board shall provide copies Copies of all records available for public inspection and copying shall be provided according to the procedures described in A.R.S. Title 39, Chapter 1, Article 2.

R4-46-104. Confidential Records

The Board shall not disclose:

1. ~~Except as provided in subsection (C), the Questions~~ questions contained in any examination administered by or for the Board or in any examination submitted to the Board for course approval ~~shall not be made available for public inspection at any time.~~
 2. ~~Questions and~~ The answers of individual examinees ~~shall not be made available for public inspection or copying.~~ However, the Board shall provide the grades of each examinee ~~shall be made available for public inspection and copying on and after the date set by the Board for the release of examination results.~~
- G. ~~Notwithstanding the foregoing, upon receipt of a written request within 30 days of a notice of a test result by an individual who failed the examination, the Board will make arrangements to allow the individual to review the questions and answers of the examination, provided however, that the applicant will not be allowed to copy the questions or answers.~~
3. ~~Minutes of the Board's executive sessions; and of the board shall not be made available for public inspection or copying appraisal reports.~~

R4-46-106. Fees

- A. ~~Except as provided in paragraphs D and E, the~~ The Board shall charge and collect the following fees:

1. Initial Application and 1st Biennial License

	\$400
a. Arizona Licensed Appraiser	\$400
b. Arizona Certified Residential Appraiser	\$400
c. Arizona Certified General Appraiser	\$400
2. Examination Fee \$100
3. Reexamination Fee \$100
4. Biennial Renewal of a License or Certificate \$425
5. Delinquent Renewal Fee (in addition to the Renewal fee) \$25
6. Biennial Federal Registry Fee \$50
7. Nonresident Temporary License or Certified \$150
8. Duplicate License or Certificate \$5
9. ~~Fee for Prerequisite Education Courses; Course Review:~~
 - a. Fee for qualifying education
 - i. Initial Review and Approval \$300
 - ii. Fee for Review of Course Previously Approved \$50
 - b. Fee for continuing education
10. ~~Administrative Fee for Continuing Education Course Review~~
 - i. Initial Review and Approval of 2-hours courses \$50
 - ii. Initial Review and Approval of 3-and 4-hour courses \$100
 - iii. Initial Review and Approval of any course 5 hours or longer \$150
 - iv. Fee for Review of any course previously ~~Course Previously approved~~ Approved \$50

- B. A person Payment of fees shall ~~pay~~ be made by certified check, cashier's check, or money order payable to the Arizona Board of Appraisal.

- C. A person making a public record request shall pay the Board reasonable cost of reproduction consistent with A.R.S. Title 39, Chapter 1, Article 2. A person shall pay for the cost of reproduction to the Board by cash, money order, certified check, personal check or cashier's check.

- D. The fee for an initial application filed after June 30, 1998, and before July 1, 2000, shall be \$300.00

- E. The renewal application fee for a license or certificate expiring after June 30, 1998, and before July 1, 2000, shall be \$225.00.

ARTICLE 2. LICENSING AND CERTIFICATION

R4-46-201. Appraiser Qualification Criteria

- A. Except as provided in subsection (B) through (C) an applicant for the applicable classification of license or certificate should meet that classification's Appraiser Qualification Criteria, established by the Appraisal Foundation and dated February 16, 1994, which are incorporated by reference and on file with the Board and the Office of the Secretary of State. This incorporation by reference includes no future additions or amendments. A copy of the Appraiser Qualification Criteria may be obtained from the Board or the Appraisal Foundation. Persons desiring to obtain licensure or certification as a state certified or licensed appraiser shall, in addition to satisfying the criteria set forth in subsections (B), (C), or (D), complete 2 hours of study of A.R.S. Title 32, Chapter 36 and these rules:
- B. The incorporation by reference in subsection (A) does not govern an Appraiser's scope of practice. The scope of practice for each classification of license or certificate is set forth in A.R.S. § 32-3612(A). The incorporation by reference in subsection (A) does not govern the minimal amount of experience, measured in hours or years, necessary for certification. The minimum experience required for certification is set forth in A.R.S. § 32-3615(A). Arizona Licensed Real Estate Appraiser: The scope of practice for an Arizona Licensed Real Estate Appraiser is set forth in A.R.S. § 32-3612(A)(3). The Board adopts as its requirements for qualification as an Arizona Licensed Real Estate Appraiser and incorporates by reference the minimum criteria as set forth in Appraiser Qualifications Board Appraiser Qualification Criteria for Residential and General Classifications of Real Property Appraisers Licensed Real Property Appraiser Classification, Appraiser Qualification Criteria, dated February 9, 1993, published by the Appraisal Foundation and which are on file with the Secretary of State. The Board does not incorporate the scope of practice set forth in section I or the provisions of sections A(2)(a)(3) and A(4)(a)(3) or any subsequent amendments, restatements, revisions, and/or replacement criteria. Copies may be obtained from the Board or Appraisal Foundation.
- C. An applicant for any classification of a license or certificate shall complete at least 2 hours of course work covering A.R.S. Title 32, Chapter 36 and these rules. Arizona Certified Residential Real Estate Appraiser: The scope of practice for an Arizona Certified Residential Real Estate Appraiser is set forth in A.R.S. § 32-3612(A)(2). The experience qualifications for an Arizona Certified Residential Real Estate Appraiser are set forth in A.R.S. § 32-3615(A)(1) and (2). In addition, the Board incorporates by reference the minimum criteria for a Certified Residential Real Property Appraiser Classification, as set forth in the Appraiser Qualifications Board Appraiser Qualification Criteria for Residential and General Classifications of Real Property Appraiser Certified Residential Real Property Appraiser Qualification,

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~~Appraiser Qualification Criteria, adopted February 9, 1993, published by the Appraisal Foundation and which are on file with the Secretary of State. The Board does not incorporate the scope of practice set forth in section II or sections A(2)(a)(3) and A(4)(a)(3) or any subsequent amendments, restatements, revisions, and/or replacement criteria of the minimum criteria described above. Although the Board does not incorporate the 2-year experience criterion set forth in section 3 of minimum criteria, the Board does not incorporate the methods of computing the criteria set forth in section 3(a), (b), and (c).~~

D. Regardless of whether a transaction is federally related:

1. A State Licensed Residential Appraiser is limited to transactions involving 1 to 4 family residential real property have a value of less than 1,000,000 and not involving complex 1 to 4 family residential real property.
2. A State Certified Residential Appraiser is limited to the scope of practice set forth in A.R.S. § 32-3612(A)(2). Arizona Certified General Real Estate Appraiser: The scope of practice for an Arizona Certified General Real Estate Appraiser is set forth in A.R.S. § 32-3612(A)(1). The experience qualifications for an Arizona Certified General Real Estate Appraiser are set forth in A.R.S. § 32-3615(A)(1) and (2). In addition, the Board incorporates by reference the minimum criteria for a Certified General Real Estate Appraiser Classification, as set forth in the Appraiser Qualifications Board Appraiser Qualification Criteria for Residential and General Classification of Real Property Appraiser, Certified General Real Property Appraiser Classification — Appraiser Qualification Criteria, dated February 9, 1993, published by the Appraisal Foundation and which are on file with the Secretary of State. The Board does not incorporate the scope of practice set forth in section III or sections A(2)(a)(3) and A(4)(a)(3) or any subsequent amendments, restatements, revisions, and/or replacement criteria of the minimum criteria described above. Although the Board does not incorporate the 2-year experience criterion set forth in section 3 of the minimum criteria, the Board does incorporate the methods of computing the criteria set forth in Section 3(a), (b), and (c).

R4-46-202. Application for Original License or Certificate

- A.** An applicant for a state certificate or license shall submit a completed application accompanied by the appropriate initial application fee. Once the application has been filed, no fees are non-refundable, will be refunded to the applicant.
- B.** To be eligible for a license or certificate, an applicant shall: If the test provider does not allow for test on demand, the Board will require applications to be filed at least 45 days prior to examination date.
 1. Meet the Appraiser Qualification Criteria contained in A.R.S. Title 32, Chapter 36, Article 2 and these rules;
 2. Achieve a passing score on the applicable examination required by R4-46-204(D), unless exempted under A.R.S. § 32-3626;
 3. Pay all required application and examination fees;
 4. Pay the biennial registry fee; and
 5. Comply with the requirements of A.R.S. § 32-3611.
- C.** An applicant shall meet all requirements for a license or certified within 1 year of filing the application or the applicant's file will be closed and the applicant shall reapply, meeting the requirements of R4-46-202(B). The Board shall notify an applicant whose application has been closed by certified mail

or personal service at the applicant's last known address of record. Notice is complete upon deposit in the U.S. mail or by service as permitted under Arizona Rules of Civil Procedure.

R4-46-203. Procedures for Processing Applications

- A.** To comply with A.R.S. Title 41, Chapter 6, Article 7.1, and the Board established the following time frames for all licenses and certificates.
 1. The Board shall notify the applicant within 45 days of receipt of the application that it either complete or incomplete. If the application is incomplete, the notice shall specify what information is missing.
 2. The Board shall not substantively review an application until the applicant has fully complied with the requirements of R4-46-202. The Board shall render a final decision not later than 45 days after the applicant successfully completes all requirements of R4-46-202.
 3. Although the applicant may have up to 1 year to comply with requirements of R4-46-202, the overall time frame for board action is 90 days, 45 days for administrative completeness review and 45 days for substantive review.
- B.** If the Board denies a license, the Board shall send the applicant written notice explaining:
 1. The reason for denial, with citations to supporting statutes or rules;
 2. The applicant's right to seek a hearing to challenge the denial; and
 3. The time periods for appealing the denial.

R4-46-204. ~~R4-46-203.~~ Appraiser Examinations

- A.** The Board shall not schedule an applicant for Time and Place: Applicants will not be scheduled for an examination until the applicant has they have completed all of the prerequisite education requirements requirement.
- B.** If the test provider does not allow for a test on demand, an applicant shall file an application to take the examination at least 45 days prior to the examination date.
- C. B.** Rescheduling; excused absences; forfeiture;
 1. Except as provided in subsections 2 and 3, subsection (B)(2), the Board shall not provide an applicant who has been scheduled for an a particular examination date with will not be rescheduled for a later examination date unless the applicant files a new application and pays a 2nd examination fee, without filing another application and fees, unless a request to be prescheduled is made at least 15 days in advance of the applicant's originally scheduled examination date.
 2. The Board An applicant may grant be granted an excused absence from a scheduled examination if the applicant provides evidence satisfactory to the Board the absence was the direct result of an emergency situation or condition which was beyond the applicant's control and which could not have been reasonably foreseen by the applicant. An applicant shall promptly make a A request for an excused absence must be made promptly in writing and support the request with must be supported by appropriate documentation verifying the reason for the absence. A request for an excused absence received more than 15 days after the examination date will be denied unless the applicant was unable to file a timely request due to the same circumstances that prevented the applicant from taking the examination.
- D. C.** Subject Matter: Each applicant shall take an examination for the applicable classification of license or certificate that covers the subject matter set

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forth in the National Uniform Examination content outline, dated November 4, 1993, which is incorporated by reference and on file with the Board and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments. A copy of the outline may be obtained from the Board or the Appraisal Foundation.

1. ~~The examination for licensure as an Arizona Licensed Appraiser shall test applicants on the general subject areas set forth in the Appraiser Qualifications Board National Uniform Examination Content Outline for Licensed, Certified Residential, and Certified General Real Property Appraiser Classifications, National Uniform Examination Content Outline Licensed Real Property Appraiser Classification dated November 4, 1993, published by the Appraisal Foundation which is incorporated by reference, not including later amendments, and is on file with the Secretary of State. Copies of the content outline may be obtained from the Board or the Appraisal Foundation.~~
2. ~~The examination for licensure as an Arizona Certified Residential Appraiser shall test applicants on the general subject areas set forth in the Appraiser Qualifications Board National Uniform Examination Content Outlines for Licensed, Certified Residential, and Certified General Real Property Appraiser Classifications, National Uniform Examination Content Outline Certified Residential Real Property Appraiser Classification, dated November 4, 1993, published by the Appraisal Foundation, which is incorporated by reference, not including late amendments, and is on file with the Secretary of State. Copies of the content outline may be obtained from the Board or the Appraisal Foundation.~~
3. ~~The examination for certification as an Arizona Certified General Appraiser shall test applicants on the general subject areas set forth in the Appraiser Qualifications Board National Uniform Examination Content Outlines for Licensed, Certified Residential, and Certified General Real Property Appraiser Classifications, National Uniform Examination Content Outline Certified General Real Property Appraiser Classification, dated November 4, 1993, published by the Appraisal Foundation, which is incorporated by reference, not including any subsequent amendments, restatements, revisions, and/or replacement content outlines, and which is on file with the Secretary of State. Copies of the content outline may be obtained from the Board or the Appraisal Foundation.~~

E. D. Reexamination:

1. An applicant for a license licensure or certificate certification who fails to pass an examination or fails to appear for a scheduled examination for which the applicant has been scheduled may schedule another examination by filing a new upon-written application and paying to the Board on a prescribed form accompanied by the reexamination fee.
2. Any individual who fails the examination 5 times and wishes to retake the examination must reapply to the Board after receiving the test results from the test provider and retake qualifying education in the areas failed and present evidence of successfully completing the classes.

R-4-46-205 R4-46-204. Issuance of License or Certificate

The applicant who has met the Appraiser Qualification Criteria prescribed in R4-46-202(B), and achieved a passing score on the applicable examination, paid the application and biennial registry fee shall be issued a license or certificate which entitles the appli-

cant to practice as an Appraiser for the term of the license or certificate.

If, within 12 months of filing an application, an applicant meets the minimum qualification criteria for licensure or certification and achieves a passing score on the examination, the applicant shall pay the biennial federal registry fee and will be issued a license or certificate. The license or certificate shall entitle the applicant to practice as an Arizona Licensed Appraiser, Arizona Certified Residential Appraiser, or Arizona Certified General Appraiser for the duration of the license or certificate. A Certified Residential Appraiser may not use the designation "Certified Appraiser" without clearly indicating that the certification is limited to residential property. The use of the full title "Certified Residential Appraiser" will satisfy this requirement.

R4-46-206 R4-46-205. Hearing on Denial of a License Licensure or Certificate Certification

Pursuant to A.R.S. § 41-1065, any applicant denied a license licensure or certificate certification by the Board may file a written request for hearing, within 15 days after issuance receipt of the notice of the denial. Any hearing shall be conducted pursuant to the procedures prescribed in Article 3 of these Rules. A written request for hearing.

R4-46-207 R4-46-206. Renewal of License or Certificate

- A. No later than 30 days before expiration of an Appraiser's license or certificate, an Appraiser seeking to renew the license or certificate shall submit a completed application accompanied by the appropriate renewal application fees. Once the application has been filed, fees are non-refundable. To be eligible for a renewal of a license or certificate, an applicant shall comply with:
 1. The requirements of A.R.S. Title 32, Chapter 36;
 2. The Uniform Standards of Appraisal Practice; and
 3. The continuing education requirements set forth in the Appraiser Qualification Criteria incorporated by reference in R4-46-201(A).
- B. The renewal and biennial federal registry fees.
- C. If the last day for filing falls on a Saturday, Sunday, or legal holiday, the Appraiser may file the renewal form on the next business day.
- D. Once the renewal application has been filed, the fees are non-refundable.

A licensed or certified appraiser seeking to renew a license or certificate must submit a properly completed renewal form evidencing compliance with the Standards of Appraisal Practices set forth in R4-46-401 and the continuing education requirements set forth in the Appraiser Qualification Criteria previously adopted and incorporated by reference in these rules, along with the renewal fee, not later than 30 days before the appraiser's license or certificate is scheduled to expire. If the last day for filing falls on a Saturday, Sunday, or legal holiday, the application must be received by the 1st business day thereafter. Once the renewal application has been filed, no fees will be refunded to the appraiser.

R4-46-208. Renewal of an Expired License or Certificate

- A. An Appraiser may renew a license or certificate which has expired within 90 days of expiration. If the last day falls on a Saturday, Sunday, or legal holiday, the Appraiser may file a renewal on the next business day.
- B. To apply for renewal of an expired license within the 90 day period, an Appraiser shall comply with the requirements of R4-46-207 and submit the delinquent renewal fee prescribed by R4-46-106. Once an application for renewal of an expired license or certificate has been filed, fees are non-refundable.

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- C. An Appraiser who fails to seek renewal within the time prescribed by this rule shall re-apply, meeting the requirements of R4-46-202(B).

R4-46-209 R4-46-207. Replacement License or Certificate

If an original license or certificate has been lost, damaged, or destroyed, or if the name of a licensee or certificate holder has been legally changed, the Appraiser a licensee or certificate holder may obtain a replacement duplicate license or certificate to replace the original license or certificate by filing the applicable a-prescribed form and paying a copying the appropriate fee to the Board.

R4-46-210 R4-46-208. Change of Address

Licensed or certified Appraisers appraisers and applicants for a license or certificate shall must notify the Board in writing of any change in permanent business or residence address within 10 working days of the such change.

ARTICLE 3. HEARINGS AND DISCIPLINARY PROCEEDINGS

R4-46-301. Investigations, Informal Proceedings and Summary Suspensions Disciplinary Proceedings, Board Action, Notice Requirements

- A. The Board shall may investigate alleged any apparent violations of A.R.S. Title 32, Chapter 36 or any of these rules.
- B. If, after completing its investigation, the Board finds that further action against the Respondent appraiser is not merited, the matter shall be dismissed.
- C. Any time after disciplinary proceedings have been initiated against a Respondent, but not later than 15 days prior to a scheduled formal hearing, the matter may be resolved by a settlement in which the Respondent agrees to accept discipline by consent in lieu of a disciplinary order. Discipline may include, but is not limited to, surrender or suspension of a license or certificate, a requirement that the Respondent successfully completed education courses, a requirement that the Respondent limit his or her scope of practice, or requirement that the Respondent submit work product for professional peer review. If the Board determines the proposed settlement will adequately protect the public, the Board may accept the offer and enter an order of discipline consented to by the Respondent, incorporating the proposed settlement. If the Board finds that suspension or revocation may be warranted, it shall issue a notice of hearing for formal disciplinary proceedings.
- D. If, in the opinion of the Board, it appears the Respondent is or may be in violation of the Board's Rules or statutes, the Board may request an informal hearing with the Respondent. If the Board finds a violation of the Rules or statutes, but the violation is not of sufficient seriousness to merit suspension or revocation of the Respondent's license or certificate, it may take any or all of the following actions:
1. Issue a decree of censure;
 2. Set a time period in terms of probation sufficient to protect the public welfare and safety and to educate the Respondent concerned. The Board may require the Respondent to:
 - a. Submit to an examination.
 - b. Obtain training or education.
 - c. Submit to supervision or peer review, and
 - d. Accept restrictions on the nature and scope of the Respondent's practice.
- E. If the Board finds that the public welfare or safety imperatively requires emergency action and incorporates a finding to that effect in its order, the Board may order a summary

suspension of a license or certificate pending proceedings for revocation or other action. If in the event that such an order of summary suspension is issued, the Board shall serve the Respondent appraiser shall be served with a written notice of summary suspension and formal hearing, listing setting forth the charges made against the Respondent appraiser, and setting a formal hearing within 30 days.

R4-46-302. Informal Disposition

At any time after formal disciplinary proceedings have been instituted against a licensed or certified appraiser, the appraiser may submit to the Board an offer of settlement whereby the appraiser agrees to accept sanctions in lieu of formal disciplinary action. Sanctions may include, but are not limited to, license or certificate suspension, a requirement that the appraiser enroll in continuing education courses, a requirement that the appraiser limit his/her scope of practice, or a requirement that the appraiser submit work product for professional peer review. If the Board determines that the proposed settlement will adequately protect the public, the Board may accept the offer and enter a decision consented to by the appraiser incorporating the proposed settlement.

R4-46-302 R4-46-303. Formal Hearing Procedures

- A. The Board shall issue a notice of hearing and complaint for formal disciplinary proceedings if:
1. The Respondent refuses an invitation to an informal hearing;
 2. After an informal hearing, the Board determines suspension or revocation may be warranted;
 3. The Respondent is aggrieved by the Board's decision in an informal hearing; or
 4. After completing its investigation, the Board finds that suspension or revocation may be warranted.
- B. Notice procedures: Except as provided in R4-46-301(E),(D), the Board shall provide notice of a formal hearing to a Respondent, including but not limited to disciplinary hearings, shall be given to the license or certificate holder at least 20 30 days prior to the date set for the hearing. The Board shall notify the Respondent Notice shall be served personally or by certified mail or personal service at the Respondent's to the address last known address of record by the Board. Notice is complete upon deposit in the U.S. mail or by service as permitted under the Arizona Rules of Civil Procedures.
- C. In its discretion, the Board may hear a case or have the case heard by an administrative law judge. The administrative law judge shall submit a written recommendation of findings of fact and conclusions of law to the Board. The Board may approve or modify the administrative law judge's recommendation and shall issue a final order. Hearing Officer: The Board may appoint a hearing officer to hear any contested case before the Board. The hearing officer shall submit to the Board a written recommendation of findings of fact, conclusions of law, and order. The recommendation of the hearing officer may be approved or modified by the Board. The Board's decision approving or modifying the hearing officer's recommendation shall be the final decision of the Board, subject to the filing of a motion for rehearing.
- D. Board Hearings:
1. The Board may conduct a hearing without adherence to the rules of evidence used in civil proceedings. The Board shall include the Respondent's application and disciplinary records as evidenced in the hearing record.
 2. In all other types of hearings required or permitted by statute, order of the Board of these Rules, the Party seeking relief has the burden of proof and will present

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~~his or her evidence 1st. Conduct of hearings: Hearings may be conducted without adherence to the Rules of Evidence required in civil proceedings. All witnesses at a hearing shall testify under oath or affirmation. The parties may make an opening and closing statement. In the case of a disciplinary proceeding, evidence in support of the charges or of the Board's order shall be presented 1st, then the respondent may present evidence in support of the respondent's position, and then there may be rebuttal surrebuttal evidence. The appraiser's licensure or certification records on file with the Board shall be included as evidence in the hearing record. In the case of all types of hearings required or permitted by statute, order of the Board, or these rules, the party seeking relief shall have the burden of proof and will present the party's evidence 1st.~~

E. ~~D.~~ Failure to answer or appear:

1. ~~The failure~~ Failure of a the Respondent to answer may be deemed an admission by the Respondent of the commission of the ~~acts~~ act charged in the complaint. The Board may then vacate the hearing and impose any sanction provided by this Article.
2. ~~The failure~~ Failure of a party parties to appear for a hearing shall leave the Board free to act upon the evidence and other information at hand without further notice to the appraiser applicant.

E. ~~The Board shall make and keep record of a hearing and in the case of disciplinary hearings or where requested by a Party or ordered by the Board, a transcript shall be prepared and filed with the Board. If the transcript is prepared at the request of a Party, the cost of the transcript shall be paid by the Party making the request, unless the Board, for good cause shown waives assessment of this cost.~~

B. ~~A record of the hearing shall be made and kept by the Board and, in the case of disciplinary hearings or where requested by a party or ordered by the Board, a transcript shall be prepared and filed with the Board. If the transcript is prepared at the request of a party, the cost of the transcript shall be paid by the party making the request unless the Board, for good cause shown, waives assessment of such costs.~~

~~R4-46-303 R4-46-304.~~ Rehearing of Board's Decisions

A. ~~Except as provided in subsection G of this section, (G), any Party party in a contested case before the Board who is aggrieved by a decision rendered in a case may file with the Board, not later than 15 days after service of the decision, a written motion for rehearing or review within 15 days after service of the final administrative decision. The Party shall attach a full supporting memorandum specifying the grounds for the motion, of the decision specifying the particular grounds therefore. For the purposes of this subsection Section, a decision is shall be deemed to have been served when personally delivered or mailed by certified mail to the Party's party's last known address of record, reported residence or place of business.~~

B. ~~The opposing Party may file a response within 10 days after service of the motion for rehearing or review, or by a date ordered by the Board whichever is later. The Party shall support the response with a memorandum, discussing legal and factual issues. A response to a motion for rehearing may be filed within 10 days after service of the motion. The Board may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.~~

C. ~~Either Party may request or the Board may order oral argument. A rehearing or review of the decision may be granted~~

~~for any of the following causes materially affecting the moving party's rights:~~

~~D. The Board may grant rehearing or review for any of the following causes materially affecting a Party's rights:~~

1. Irregularity in the administrative proceedings of the Board agency, or any other abuse of discretion which ~~deprived~~, whereby the moving Party party was deprived of a fair hearing;
2. Misconduct of the Board or any Party party;
3. Accident or surprise which could not have been prevented by ordinary prudence;
4. Newly discovered material evidence which could not with reasonable diligence have been discovered and produced at the original hearing;
5. Excessive or insufficient sanction;
6. Error in the admission or rejection of evidence or other errors of law ~~occurring~~ at the administrative hearing or ~~during the progress of the proceedings;~~
7. Unjustified decision based upon the evidence, or a decision that is contrary to law.

~~E. D.~~ The Board may affirm or modify the decision or grant a rehearing to any Party party on all or part of the issues for any of the reasons set forth in subsection D. (C). An order modifying a decision or granting a rehearing shall specify with particularity the grounds for the order. The rehearing, if granted, shall be limited to matters specified by the Board, on which the rehearing is granted, and the rehearing shall cover only those matters so specified.

~~F. E.~~ Not later than 15 days after a decision is rendered, the Board may order a rehearing or review of its decision on its own initiative, for any reason for which it might have granted a rehearing or review of its decision relief on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing for a reason not stated in its original order.

~~G. F.~~ When a motion for rehearing or review is based upon affidavits, they shall be served with the motion. An opposing Party party may submit, within 10 days after service, serve opposing affidavits with the response. Reply affidavits may be permitted.

~~H. G.~~ If, in a particular decision, the Board makes specific findings that the immediate effectiveness of such a decision is necessary for the immediate preservation of the public welfare or safety and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the Board may issue decision may be issued as a final decision without an opportunity for a rehearing or review. If a decision is issued as a final administrative decision without an opportunity for a rehearing, a Party may seek an any application for judicial review of the decision shall be made within the time limits permitted by statute for the applications of for judicial review of the Board's final decisions.

~~R4-46-304 R4-46-305.~~ Conviction and Judgment Disclosure Duty to Disclose Conviction and/or Entry of Civil Judgment

~~A. When an Appraiser, Property Tax Agent or Course Provider is convicted of any act which is or would be punishable as a felony involving moral turpitude in this state, or any crime which is substantially related to the qualification functions and duties of an Appraiser, a Property Tax Agent, or Course Provider shall notify the Board within 20 days of entry of a plea of guilty or conviction.~~

~~B. When a civil judgment based on fraud, misrepresentation, or deceit in the making of any appraisal or mass appraisal, is entered against an Appraiser, Property Tax Agent, or Course~~

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Provider, the Party shall notify the Board within 20 days of entry of the civil judgment.

Upon being convicted of any act which is or would be punishable as a felony involving moral turpitude in this state, a crime which is substantially related to the qualifications, functions, and duties of a person developing appraisals and communicating appraisals to others or upon entry of a civil judgment based on fraud, misrepresentation, or deceit in the making of any appraisal, an appraiser licensed or certified in this state shall notify the Board within 20 days of the entry of a plea of guilty, conviction, or entry of a civil judgment.

R4-46-305 R4-46-306. Terms and Conditions of Reapplication after Revocation

- A. An applicant who re-applies ~~Persons reapplying after revocation of a license, certificate, certification registration, or course approval, shall must~~ submit an original application for license or certificate ~~license or certification~~ consistent with these Rules, Article 2. ~~The applicant~~ Such application shall attach have attached thereto substantial evidence to the application that the issuance of a the license, or certificate, registration, or course approval will no longer constitute a threat to the public welfare and safety.
- B. Criteria for determination of application for issuance: The Board shall make a such determination of each application that is as it deems consistent with the public safety and welfare.

ARTICLE 4. STANDARDS OF PRACTICE

R4-46-401. Standards of Appraisal Practice

Every state-licensed or certified Appraiser ~~appraiser~~, in performing the acts and services of a state-licensed or certified Appraiser ~~appraiser~~, shall comply with the 1995 Edition of the Appraisal Standards Board Uniform Standards of Professional Appraisal Practice, 1998 Edition, published by the Appraisal Foundation which are incorporated by reference and not including any subsequent amendments, restatements, revisions, and/or replacement standards, published by the Appraisal Foundation which are on file with the Board and the Office of the Secretary of State. This incorporation by reference contains no future additions or amendments. A copy of the USPAP may be obtained from the Board or the Appraisal Foundation. Copies of the Uniform Standards of Professional Appraisal Practice are available from the Board or the Appraisal Foundation.

ARTICLE 5. PREREQUISITE EDUCATION COURSE APPROVAL

R4-46-501. Prerequisite Education Course Approval

- A. A Course Provider ~~An applicant seeking approval for a prerequisite education course shall apply to the Board, using the applicable on a prescribed form and pay accompanied by the appropriate fee.~~
- B. The following requirements apply to courses submitted for approval:
1. The Course Provider ~~course shall follow be in accordance with the prerequisite education standards set forth in the Appraiser Qualification Criteria previously incorporated by reference in R4-46-201; (B), (C), and (D).~~
 2. The Course Provider ~~course shall use follow an outline, and a text or other written course materials. The Course Provider shall furnish the Board with the text or supporting documentation at the time of application. Lack of documentation may result in the delay or denial of course approval; agenda defined by a course syllabus~~

~~and shall consist of an organized program of learning which includes the use of written course materials;~~

3. For courses that are qualifying an applicant for a license or certificate, the Course Provider shall give a comprehensive examination pertinent to the topics addressed in the course.
- 4.3. The Course Provider ~~course activities shall~~ conduct the course ~~be conducted in a setting physically suitable to the educational activity of the program; and~~
5. The Course Provider shall submit proof of compliance with the following standards. The Course Provider shall:
4. Course approval shall be contingent upon submission of proof that the course sponsor complies with the following standards, monitoring methods, and systems for recording attendance:
 - a. Apply the prerequisite education criteria set forth in the Appraiser Qualification Criteria set forth in subsection (B)(1) above; previously adopted and incorporated by reference in these rules;
 - b. Provide a copy of an attendance certificate to the student after completion of the course, indicating the name of the Course Provider, the name of the student, the title of the course, the number of classroom hours completed in the course, the dates the course was taken, and whether the students successfully completed any final examination;
 - c. Maintain a record of registration, attendance and examination for each student for 6 years following the student's enrollment in the course, and provide a copy copies of the record at to the student upon request of the Board or the student;
 - d. Deny course credit to any student who does not have at least 90% attendance; Provide certificates of completion or certified transcripts to each student upon completion of a course; and
 - e. Use Utilize instructors with meeting 1 or more of the following qualifications: minimum requirements:
 - i. At least a bachelor's A-Bachelor's degree or higher in the field of instruction or in a closely related field of instruction, or
 - ii. Five years work experience in the subject taught, or
 - iii. A combination of education and work experience which the Board determines is to be substantially equivalent to the requirements in subsections (B)(4)(d)(i) and (ii).
- C. Course approval lasts for a period of 1 year, expiring at the end of the month in which approval was granted, at which time the Course Provider shall re-apply for course approval. No later than 30 days prior to the expiration date, a Course Provider may apply for renewal of course approval on the form provided by the Board and pay the appropriate fee. Any substantive change in the materials to be addressed in the classroom or instructors will require immediate re-application and approval by the Board. The Board may investigate any information which appears to show that an approved course is no longer in compliance with the prerequisite standards set forth in this Section or is no longer operating as indicated in the application for course approval. The Board may determine whether such information requires review or revocation of course approval.
- D. Out-of-state course approval: The Board shall waive the course approval fee for a course offered out of state if the course was approved by the appraisal licensing/certifying

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authority in that state and the Board determines that the course meets the standards for course approval set forth in this Section.

E. The Board shall investigate and may deny, revoke or suspend course approval for any of the following acts or omissions:

1. Failure to comply with the education requirements set forth in this Article.
2. Failure to operate as indicated in the application for course approval.
3. Failure to instruct in a manner consistent with the outline and materials previously approved by the Board.

F. If the Board finds that the public welfare or safety imperatively requires emergency action and incorporates a finding to that effect in its order, the Board shall order a summary suspension of course approval pending proceedings for revocation or other action. In the event of an order of summary suspension is issued, the Board shall serve Course Provider with a notice of summary suspension and formal hearing, setting forth the charges against the Course Provider and setting a formal hearing within 30 days.

R4-46-502. Prerequisite Education Course Equivalency Approval

A. An applicant for a license or certificate who wants to fulfill a course requirement with a course that has not been previously approved by the Board shall demonstrate that the course satisfies the requirements set forth in this Article. Applicants for original appraiser licensure or certification who desire to fulfill prerequisite education requirements with courses which have not been previously approved by the Board must demonstrate that such courses satisfy the prerequisite education standards set forth in this Article.

R4-46-503. Hearing on Denial of Prerequisite Education Course Approval

Any applicant or Course Provider denied prerequisite education course approval may file a written request for hearing within 20 15 days after service receipt of notice of the denial. The Board shall process all hearings and disciplinary matters involving course approval in the manner prescribed in Article 3.

ARTICLE 6. CONTINUING EDUCATION

R4-46-601. Continuing Education Course Approval

A. An applicant seeking approval for a continuing education course shall apply to the Board on a prescribed form accompanied by the appropriate fee.

B. The following requirements apply to courses submitted for approval:

1. The course shall be in accordance with the Continuing Education standards set forth in the Appraiser Qualification Criteria previously incorporated by reference in R4-46-201(B), (C), (D);
2. The course shall follow an agenda defined by a course syllabus and shall consist of an organized program;
3. Course activities shall be conducted in a setting physically suitable to the educational activity of the program; and
4. Course approval shall be contingent upon submission of proof that the course sponsor complies with the following standards, monitoring methods, and systems for recording attendance:
 - a. Apply the continuing education criteria set forth in the Appraiser Qualification Criteria previously adopted and incorporated by reference in these rules;

b. Provide Board approved certificates of completion or certified transcripts to each student upon completion of a course;

e. Deny continuing education credit to any student who does not have at least a 90% attendance record;

d. Maintain a record for each student for a period of 2 years following enrollment, the record to include the student's name, address, and certificate number;

e. Utilize an instructor meeting 1 or more of the following minimum requirements:

- i. A Bachelor's degree or higher in the field of instruction or in a closely related field of instruction, or
- ii. Five years of work experience in the subject taught, or
- iii. A combination of education and work experience determined by the Board to be substantially equivalent to requirements set forth in subsections (B)(4)(e)(i) and (ii).

C. The Board may investigate any information which appears to show that an approved course is no longer in compliance with the continuing education standards set forth in this Section or is no longer operating as indicated in the application for course approval. The Board may determine whether such information requires review or revocation of course approval.

D. Out-of-state course approval: The Board shall waive the course approval fee for a course offered out of state if the course was approved by the appraisal licensing/certifying authority in that state and if the Board determines that the course meets the standards for course approval set forth in the Section.

ARTICLE 6. PROPERTY TAX AGENTS

R4-46-601. Standards of Practice

A. The Board may revoke or suspend an agent's registration or otherwise discipline a Property Tax Agent to the extent permitted by A.R.S. § 32-3654 for any of the following acts or omissions:

1. Engaging in an activity that leads to a conviction for a crime involving the tax profession;
2. Operating beyond the boundaries of an agreed relationship with an employer or a client;
3. Inferring or implying representation of a person or firm that the agent does not represent, or filing a document on behalf of a taxpayer without specific authorization of the taxpayer;
4. Violating the confidential nature of the Property Tax Agent-client relationship, except as required by law;
5. Offering or accepting anything of value with the intent of inducing or in return for a specific action;
6. Offering or accepting anything of value as a share or a fee for an assignment in which the agent did not participate;
7. Assigning, accepting, or performing a tax assignment that is contingent upon producing a predetermined analysis or conclusion;
8. Filing or proceeding with any appeal which has no basis in fact;
9. Issuing an appraisal analysis or opinion, in the performance of a tax assignment, that fails to disclose bias or the accommodation of a personal interest;

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| <p>10. <u>Willfully furnishing inaccurate, deceitful, or misleading information, or willfully concealing material information in the performance of a tax assignment;</u></p> <p>11. <u>Preparing or using, in any manner, a resume or statement of professional qualifications that is misleading or false;</u></p> <p>12. <u>Promoting a tax practice and soliciting assignments by using misleading or false advertising;</u></p> | <p>13. <u>Soliciting a tax assignment by assuring a specific result or by stating a conclusion regarding that assignment without prior analysis of the facts;</u></p> <p>14. <u>Performing an appraisal as defined by A.R.S. § 32-3601 unless licensed or certified by the Board as an appraiser.</u></p> |
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R4-46-602. Disciplinary Proceedings; Board Action; Notice Requirements
The Board shall process all hearings and disciplinary matters involving Property Tax Agents in the manner prescribed by Article 3 and consistent with A.R.S. § 32-3654.

NOTICE OF PROPOSED RULEMAKING

TITLE 19: ALCOHOL, HORSE AND DOG RACING, LOTTERY, AND GAMING

CHAPTER 3: ARIZONA STATE LOTTERY COMMISSION

PREAMBLE

- | | |
|---|--|
| <p>1. <u>Sections Affected</u>
R19-3-403</p> | <p><u>Rulemaking Action</u>
New Section</p> |
|---|--|
2. **The specific authority for rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):**
Authorizing statute: A.R.S. § 5-504(B).
3. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**
Name: Mr. Geoffrey Gonsler, Executive Director
Address: Arizona State Lottery Commission
4740 East University
Phoenix, Arizona 85034
Telephone: (602) 921-4514
FAX: (602) 921-4488
4. **An explanation of the rule, including the agency's reason for initiating the rule:**
R19-3-403 sets forth provisions unique to the conduct of the Arizona Lottery's on-line 3-digit game. The provisions of this rule are necessary to implement the requirements of A.R.S. § 5-504(B) which have not been specified generically in Article 9. The unique provisions described in these rules are how to play PICK 3™, ticket characteristics, drawings, how to identify a winning ticket, ticket ownership and responsibilities, ticket validation requirements, procedures for claiming prizes, claim period, and disputes concerning a ticket.
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:**
- A. The Arizona State Lottery.
Additional costs to the Lottery are minimal and are included in the agency's appropriated budget.
- B. Political Subdivisions.
Political subdivisions of this are not directly affected by the adoption of this rule.
- C. Businesses Directly Affected by the Rulemaking.
Lottery retailers are the only businesses affected by this rule. The only impact this rule has upon Lottery retailers is to specify how they determine if a ticket is a winning ticket, and, if so, the prize amount. Currently, for each \$1 on-line transaction, retailers receive \$.065. An increase of approximately \$15 million per year in sales is expected from on-line 3-digit game. As a result, retailers could earn an additional \$1 million in sales commission annually.
- D. Private and Public Employment.
Private and public employees are not directly affected by the adoption of this rule.

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E. Consumers and the Public.

There are no costs to the public associated with the adoption of this rule. This game will provide players with an additional on-line game from which to choose.

F. State Revenues.

The on-line 3-digit game revenue should amount to approximately \$15 million per year assuming there is no cannibalization of other on-line games. This would result in an additional \$4.5 million in distributed funds.

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: Mr. Geoffrey Gonsher, Executive Director

Address: Arizona State Lottery Commission
4740 East University
Phoenix, Arizona 85034

Telephone: (602) 921-4514

FAX: (602) 921-4488

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 20, 1998

Time: 10 a.m.

Location: Arizona State Lottery
4740 East University
Phoenix, Arizona 85034

Nature: Oral Proceeding (Close of the record is 5 p.m., M.S.T., Thursday, March 19, 1998, for written comments and at the end of the oral proceeding for verbal comments.)

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. Incorporation by reference and their location in the rules:
Not applicable.

11. The full text of the rules follows:

TITLE 19: ALCOHOL, HORSE AND DOG RACING, LOTTERY, AND GAMING

CHAPTER 3: ARIZONA STATE LOTTERY COMMISSION

ARTICLE 4. ON-LINE LOTTERY GAMES

Section

R19-3-403. "PICK 3™"

ARTICLE 4. ON-LINE LOTTERY GAMES

R19-3-403. "PICK 3™"

A. Definitions.

1. "Drawing" means the process used to randomly select winning play symbols from the defined game matrix.
2. "Game play" or "play" means the selected numbers, letters, or symbols which appear on a ticket as a single wager. More than 1 game play may appear on a ticket.
3. "Game Profile" means the written document that includes non-confidential game information including, but not limited to, the game name, game prize structure, winning game play style or styles, and special game feature or features.
4. "Multiple winners" means a situation in which more than 1 claimant redeems an individual share.
5. "On-line game" means a game that is played by entering a player's game play or plays into a lottery authorized terminal to produce a ticket. The game play or plays on the ticket are compared to winning numbers selected

during the drawing process to determine if a ticket holder is entitled to a prize or prizes.

6. "PICK 3™" means an on-line game in which 3 play symbols (numbers) between 0 and 9 are selected as a game play.
7. "Play symbols" means the numbers, letters, or characters printed on each game play of a ticket that determine if a player is entitled to a prize.
8. "Terminal" means a device which is authorized by the Lottery to function in an on-line, interactive mode with the Lottery's computer system. The terminal is functional for the purpose of issuing Lottery tickets and entering, receiving, and processing Lottery transactions. These transactions include producing and voiding ticket purchases, validating winning tickets, and transmitting reports.
9. "Ticket" means medium produced by a terminal from a licensed Lottery retailer containing 1 or more game plays with the game play data for an individual game. The game play data includes at least the caption designating the game name, individual game plays which display the selected numbers, letters, or symbols, the dates of the drawings, the price of the ticket, the number of draws, retailer number, and a unique serial number.

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10. "Winning play symbols" or "winning numbers" means the numbers, letters or symbols from the defined game matrix randomly selected at each drawing which determine winning game plays contained on a ticket.

B. Game Profile

1. The Commission shall approve the individual game profile prior to the game being introduced to the public for sale.
2. At a minimum, the Game Profile for each game shall contain the following information:
 - a. Game Name;
 - b. Prize structure, including the approximate odds and amount of prizes available, and the prize pool percentages, if applicable;
 - c. Winning play symbols;
 - d. Special feature, if any;
 - e. Retail sales price; and
 - f. Voiding of tickets, if applicable.

C. Ticket Purchase and Characteristics

1. To play the on-line PICK 3™ game, a player shall select 1 or more sets of numbers for input into a terminal. A player may select each set by:
 - a. Verbally communicating the numbers to a retailer,
 - b. Marking the numbered squares required in any 1 game board on a selection slip and submitting the selection slip to a retailer,
 - c. Requesting a "quick pick" from the retailer, or
 - d. Marking "quick pick" on a selection slip.
2. A PICK 3™ ticket, subject to the validation requirements of R19-3-907, is the only proof of any game play and the only valid receipt for claiming any prize. A selection slip has no pecuniary value and does not constitute evidence of any ticket purchased.
3. A unique serial number shall be printed on the front of the ticket and will distinguish it from every other ticket.
4. A retailer shall issue, from an authorized Lottery terminal, a ticket containing 1 or more game play areas as specified in the Game Profile, each of which shall contain 3 selected play symbols from 0 through 9.
5. A ticket holder may have a PICK 3™ ticket voided by returning the ticket to the retailer who sold it on the date of purchase and before the terminal is closed for that day, or prior to the drawing, whichever comes 1st.
6. If a ticket is voided as prescribed in this subsection, the retailer shall refund the purchase price to the ticket holder.
7. The Lottery shall not be liable for ticket errors. The ticket holder is responsible for the accuracy of ticket data. In the event of an error, the player's sole remedy is the voiding of the ticket, pursuant to subsection (C)(5).

D. Drawings

1. The objective of a PICK 3™ drawing is to randomly select 1 3-digit winning number as defined in the Game Profile. Mechanical, electrical, or computerized drawing equipment may be used to make the random selection. The 1 3-digit number will be used to determine PICK 3™ winning game plays.
2. The drawings shall be held at the times and places established by the Director and subsequently announced to the public.

E. Determination of a Winning PICK 3™ Game Play

1. A player shall win the prize amount indicated in the prize structure described in the Game Profile by matching the winning play symbols selected at the drawing to the play symbols that appear in 1 or more of the follow-

ing patterns (prize category) on each game play. Prizes shall be determined and awarded on the following basis:

<u>Division</u>	<u>Prize Category</u>	<u>Odds of Winning</u>	<u>Prize Amount</u>
<u>1</u>	<u>Straight</u>	<u>1:1000</u>	<u>\$500</u>
<u>2</u>	<u>3-Way Box</u>	<u>1:333.33</u>	<u>\$160</u>
<u>3</u>	<u>6-Way Box</u>	<u>1:166.66</u>	<u>\$ 80</u>
<u>4</u>	<u>Front Pair</u>	<u>1:100</u>	<u>\$ 50</u>
<u>5</u>	<u>Back Pair</u>	<u>1:100</u>	<u>\$ 50</u>

2. "Straight" means a play in which the player matches all 3 selected winning numbers in the exact order drawn. (Player gets 1 set of numbers for \$1).
 3. "3-way box" means a play in which the player matches all 3 selected winning numbers in any order drawn and 2 of the numbers are identical. (Player gets 3 sets of number for \$1)
 4. "6-way box" means a play in which the player matches all 3 selected winning numbers in any order drawn. (Player gets 6 sets of numbers for \$1)
 5. "3-way straight box" means a play in which the player matches all 3 numbers in any order and 2 of the numbers are identical. The player wins for both the straight and the box. (Player gets 3 sets of numbers for \$1.00. 50¢ is for the "straight" wager and 50¢ for the "box" wager)
 6. "6-way straight box" means a play in which the player matches all 3 selected winning numbers in any order drawn. The player wins for both the straight and the box. (Player gets 6 sets of numbers for \$1.00. 50¢ is for the "straight" wager and 50¢ is for the "box" wager.)
 7. "Front pair" means a play in which the player matches the 1st 2 selected winning numbers in the exact order drawn.
 8. "Back pair" means a play in which the player matches the last 2 selected winning numbers in the exact order drawn.
 9. "Lead digit" means a play in which the player matches the 1st selected winning number.
 10. Players can win on each game play on a ticket.
 11. No more than the highest division prize amount established shall be paid on a winning game play.
- F. Ticket Ownership and Responsibility; Prize Payment**
1. Until a ticket is signed, the ticket is owned by its physical possessor.
 2. When signed, the claimant whose signature appears on the ticket is entitled to the corresponding prize.
 3. If more than 1 signature appears on the ticket, the Director shall require that 1 or more of those claimants be designated to receive payment. A claim form shall be submitted by each claimant who is designated by the director to receive a portion of the prize claimed from the winning ticket.
 4. Prior to payment of a prize, a claimant who has signed the ticket may designate another claimant to receive the prize by signing a relinquishment of claim statement.
 5. When a winning ticket was purchased by a group of players, the group shall designate 1 of the claimants to sign the ticket. Each claimant shall complete a claim form to receive the claimant's portion of the prize.
 6. The Lottery shall only make payment to the claimant, less any authorized debt set-off amounts, who is also the holder of the ticket.

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- 7. Prizes shall be paid by cash or check, according to the provisions in sub-section (H) of this rule.
- 8. All prize levels are fixed amounts, and are specified in the Game Profile. Each play winning any prize entitles the winner to the prize amount specified in the Game Profile.
- 9. The Lottery is not responsible for lost or stolen tickets.
- G. Ticket Validation Requirements
 - 1. Each ticket shall be valid and validated prior to the payment of a prize.
 - 2. For a ticket to be eligible for a prize, all of the following requirements shall be satisfied:
 - a. The ticket is:
 - i. Issued by the Lottery through a retailer, from a terminal, in an authorized manner;
 - ii. Intact, and is not mutilated or tampered with in any manner;
 - iii. Not defectively printed, reprinted stating "Not for Sale" on the ticket, or produced in error;
 - iv. Not counterfeit, stolen, or voided;
 - v. Able to pass all other confidential validation requirements determined by the Director; and
 - vi. Validated in accordance with the provisions of Subsections (F) and (H).
 - b. The ticket data is:
 - i. Recorded in the on-line contractor's central computer system prior to the drawing,
 - ii. In agreement with the computer record, and
 - iii. In the Lottery's official file of winning tickets and has not been previously paid.
 - c. Any winning game play on the ticket is separately lettered or numbered and consists of a selected set of numbers from the defined game matrix.
 - 3. If a ticket fails to pass any of the requirements in Paragraph 2, the ticket is void and ineligible for any prize payment.
- H. Procedure for Claiming Prizes
 - 1. To claim a prize of up to and including \$599.00, the claimant shall present the signed ticket to any participating on-line retailer. The retailer shall pay the claimant provided that:
 - a. All of the ticket validation criteria in Subsection (G) have been satisfied, and
 - b. A proper validation ticket, which is an authorization to pay, has been issued by the terminal.
 - 2. To claim a prize that the retailer does not validate or is not authorized to pay, including all prizes \$600.00 or more, the claimant shall submit a claim form, available from any retailer, and the ticket to the Lottery.
 - 3. If the claim is:
 - a. Verified and validated by the Lottery, the Lottery shall make payment of the amount due to the claimant, less any authorized debt set-off amounts.
 - b. Denied by the Lottery, the Lottery shall notify the claimant within 15 days from the day the claim is received in the Lottery office.
 - 4. The Lottery is discharged of all liability upon payment of the prize.
- I. Claim Period
 - 1. In order for the claimant to receive payment, a winning on-line game ticket shall be received by the Lottery or a retailer no later than 5 p.m., Mountain Standard Time on the 180th calendar day following the on-line game drawing in which the prize was won or on the 180th calendar day following the announced end of game in the case of a prize determined in any manner other than by means of a drawing.
 - 2. If a claimant presents a valid winning ticket to a retailer for payment on the 180th calendar day following the announced end of game or on-line game drawing and is not paid the prize, the Director is authorized to pay the prize if the claimant presents the valid winning ticket to the Lottery no later than 5 p.m. (Phoenix time) on the following business day.
 - 3. The end of an on-line game shall be designated by the Director and on file at the Lottery.
 - 4. The Director is authorized to place any person's eligible entry that was not entered in a Grand Prize Drawing into a subsequent Grand Prize Drawing or drawings which have an equal or greater grand prize value.
- J. Disputes Concerning a Ticket
 - 1. If a dispute between the Lottery and a claimant occurs concerning a ticket, the Director is authorized to replace the disputed ticket with a ticket of equivalent sales price from any subsequent drawing from any current on-line game.
 - 2. If a defective ticket is purchased, the Lottery shall replace the defective ticket with a ticket or tickets of equivalent sales price from any current game.
 - 3. Replacement of the disputed ticket is the sole and exclusive remedy for a claimant.

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

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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. 1395
Implementing statutes: A.R.S. § 20-1133; 42 U.S.C. 1395
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/HCFHA).
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
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: April 2, 1998
Time: 2 p.m.
Address: Arizona Department of Insurance
3rd Floor Training Room
2910 North 44th Street, Suite 210
Phoenix, Arizona 85018
Nature: Oral proceeding for amendment of the rules. The Department will accept written comments which are received by 5 p.m. on April 2, 1998, 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.

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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

ARTICLE 11. MEDICARE SUPPLEMENT INSURANCE

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 pre-existing 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
 - 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. Reinstatement of coverage under subsection (B)(10)(a):

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the policyholder or certificate holder had the coverage not been suspended.

- C. Standards for basic "core" benefits common to all benefit plans. 1. 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. c. 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. 1. 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. c. 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 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 and/or digital rectal examination;
 - 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(e). \$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.

11k. 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.G. 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.G. R20-6-1105(D)(2)(k) and in A.A.G. 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" ben-

efits 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) 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) plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as described in R20-6-1105(D)(1), (2), (3), and (8) R20-6-1105(D)(1)(a), (b), (c) 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) 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) 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) 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), (c), (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) 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 (f) respectively.
- 8. Standardized Standardization Medicare supplement benefit plan "H" shall include only the following: The core benefit as described in R20-6-1105(C) 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) 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),

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(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) 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 .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.

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- 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-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."

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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.

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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 (Generally [20]% of Medicare-approved expenses).

Blood: First 3 pints of blood each year.

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

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] 157 a day	\$0
91st day and after:			
- While using 60 lifetime reserve days	All but \$[382] 314a day	\$[382] 314a 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 (CON'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 * (the Part B Deductible)	\$0	\$(100) \$0	\$0 \$(100)
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 (CON'D)

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 (CON'D)
PLAN B
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	\$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 *

Remainder of Medicare-Approved Amounts

100%

\$0

80%

\$0

\$0

20%

\$0

\$[100] (Part B Deductible)

\$0

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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]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 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 *		\$[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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APPENDIX B (CONT'D)

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[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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PLAN D

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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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]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 E
MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

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

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

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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

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]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 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 * (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	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	Balance
		\$40 a visit	
- 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 * (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	\$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]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 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	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]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 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
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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
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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

Arizona Administrative Register
Notices of Proposed Rulemaking

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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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.~~

[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~~
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 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.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE
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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.

[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.]

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~~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.

[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.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS <u>This is not Medicare Supplement Insurance</u></p>
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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.

<p>Before You Buy This Insurance</p>

- √ 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.

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

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~~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.

[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.

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

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~~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 ~~dupli-~~
~~cates 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.

[For policies providing home care benefits only.]

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~~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 ~~dupli-~~
~~cates 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.

[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.