UTAH STATE BULLETIN

OFFICIAL NOTICES OF UTAH STATE GOVERNMENT
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Inquiries concerning administrative rules or other contents of the *Bulletin* may be addressed to the responsible agency or to: Division of Administrative Rules, PO Box 141007, Salt Lake City, Utah 84114-1007, telephone (801) 538-3218, FAX (801) 538-1773. To view rules information, and on-line versions of the division's publications, visit: http://www.rules.utah.gov/

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SPECIAL NOTICES

GOVERNOR'S PROCLAMATION: CALLING THE FIFTY-FIFTH LEGISLATURE INTO A FOURTH EXTRAORDINARY SESSION (SENATE ONLY

WHEREAS, since the close of the 2003 General Session of the 55th Legislature of the State of Utah, certain matters have arisen which require immediate legislative attention; and

WHEREAS, Article VII, Section 6 of the Constitution of the State of Utah provides that the Governor may, by proclamation, convene the Legislature in Extraordinary Session;

NOW, THEREFORE, I, MICHAEL O. LEAVITT, Governor of the State of Utah, by virtue of the authority vested in me by the Constitution and the Laws of the State of Utah, do by this Proclamation call the Senate only of the 55th Legislature of the State of Utah into a Fourth Extraordinary Session at the State Capitol in Salt Lake City, Utah, on the 16th day of July, 2003, at 11:30 a.m., for the following purpose:

For the Senate to advise and consent to appointments made by the Governor to positions within state government of the State of Utah since the close of the 2003 General Session of the 55th Legislature of the State of Utah.

IN TESTIMONY WHEREOF, I have here unto set my hand and cause to be affixed the Great Seal of the State of Utah. Done at the State Capitol in Salt Lake City, Utah, this 1st day of July, 2003.

(STATE SEAL)

MICHAEL O. LEAVITT
Governor

OLENE S. WALKER
Lieutenant Governor

NATURAL RESOURCES
WILDLIFE RESOURCES

PUBLIC NOTICE OF EMERGENCY CHANGES TO THE 2003 FISHING REGULATIONS ESTABLISHED BY THE WILDLIFE BOARD FOR TAKING FISH AND CRAYFISH

I, Kevin Conway, by authority granted in Section 23-14-8 of the Wildlife Resources Code of Utah, declare an emergency amendment to the 2003 Utah Fishing Regulations. The following has been amended:

CALDER RESERVOIR (Uintah County):

Effective July 7, 2003, the daily bag and possession limits for all game fish will be increased to eight (8).

This regulatory change does **not** apply to Matt Warner Reservoir.

Except for other emergency changes made since January 1, 2003, all other rules established in the 2003 Utah Fishing Regulations remain in effect.

UTAH DIVISION OF WILDLIFE RESOURCES
By: Kevin Conway, Director
Subscribed and sworn to before me this 1st day of July 2003.

NOTICES OF
PROPOSED RULES

A state agency may file a PROPOSED RULE when it determines the need for a new rule, a substantive change to an existing rule, or a repeal of an existing rule. Filings received between June 17, 2003, 12:00 a.m., and July 1, 2003, 11:59 p.m. are included in this, the July 15, 2003, issue of the *Utah State Bulletin*.

In this publication, each PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the PROPOSED RULE is usually printed. New rules or additions made to existing rules are underlined (e.g., example). Deletions made to existing rules are struck out with brackets surrounding them (e.g., [~~example~~]). Rules being repealed are completely struck out. A row of dots in the text (· · · · · ·) indicates that unaffected text was removed to conserve space. If a PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of each rule that is too long to print is available from the filing agency or from the Division of Administrative Rules.

The law requires that an agency accept public comment on PROPOSED RULES published in this issue of the *Utah State Bulletin* until at least August 14, 2003. The agency may accept comment beyond this date and will list the last day the agency will accept comment in the RULE ANALYSIS. The agency may also hold public hearings. Additionally, citizens or organizations may request the agency to hold a hearing on a specific PROPOSED RULE. Section 63-46a-5 (1987) requires that a hearing request be received "in writing not more than 15 days after the publication date of the PROPOSED RULE."

From the end of the public comment period through November 12, 2003, the agency may notify the Division of Administrative Rules that it wants to make the PROPOSED RULE effective. The agency sets the effective date. The date may be no fewer than 31 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file a CHANGE IN PROPOSED RULE in response to comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or a CHANGE IN PROPOSED RULE, the PROPOSED RULE filing lapses and the agency must start the process over.

The public, interest groups, and governmental agencies are invited to review and comment on PROPOSED RULES. *Comment may be directed to the contact person identified on the RULE ANALYSIS for each rule.*

PROPOSED RULES are governed by *Utah Code* Section 63-46a-4 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-4, R15-4-5, R15-4-9, and R15-4-10.

The Proposed Rules Begin on the Following Page.

Commerce, Real Estate
R162-106-7
Sales and Listing History

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26427
FILED: 06/30/2003, 11:09

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: When Subsection R162-106-7 was amended recently, the amendment was incomplete and required only analyzing the listing history of the subject property. It should have required reporting the listing history of the subject property in addition to analyzing the listing history. (DAR NOTE: The earlier amendment to R162-106 is under DAR No. 26060 in the March 15, 2003, issue of the Utah State Bulletin and was effective April 23, 2003.)

SUMMARY OF THE RULE OR CHANGE: Section R162-106-7 should read analyze "and report" the listing history of the subject property.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 61-2b-6(1)(l)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The change should not cost or save the State any money. This is a minor technical change that requires appraisers to write their appraisal reports to demonstrate the results of the analysis that they are already required to perform.
❖ LOCAL GOVERNMENTS: Since this is a minor technical change in the language that appraisers are required to put in their appraisal reports, there should not be any cost or savings to local government.
❖ OTHER PERSONS: Since this is a minor technical change in the language that appraisers are required to put in their appraisal reports, there should not be any cost or savings to other persons.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--It should not cost appraisers any money to use slightly different language when they write their appraisal reports.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This rule amendment contains a minor technical change pertaining to standards for appraisers. There appears to be no fiscal impact to businesses as a result of this amendment.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
COMMERCE
REAL ESTATE
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Shelley Wismer at the above address, by phone at 801-530-6761, by FAX at 801-530-6749, or by Internet E-mail at swismer@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Klare Bachman, Deputy Director

R162. Commerce, Real Estate.
R162-106. Professional Conduct.
R162-106-7. Sales and Listing History.

In order to comply with Standard 1 of the Uniform Standards of Professional Appraisal Practice (USPAP), appraisers who are licensed or certified under this chapter shall analyze and report the listing history of the subject property for the year preceding the appraisal if such information is available to the appraiser from a multiple listing service, listing agent(s), or the property owner.

KEY: real estate appraisals, conduct
2003
Notice of Continuation March 27, 2002
61-2b-27

Education, Administration
R277-419
Pupil Accounting

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26436
FILED: 07/01/2003, 14:56

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to allow school districts to count in membership students participating in released time for appropriate individual learning activities.

SUMMARY OF THE RULE OR CHANGE: The amendment to this rule adds "individual learning activities" as an authorized release time activity in addition to the already approved release time for religious instruction. There are also some minor wording changes.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53A-1-402(1)(e)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There is no anticipated cost or savings to the state budget. This amendment simply allows for release time for individual learning activities in addition to release time for religious instruction as would be required by the Constitution.

❖ LOCAL GOVERNMENTS: There is no anticipated cost or savings to school districts. This formal change reflects the current practice in most school districts.

❖ OTHER PERSONS: There is no anticipated cost or savings to other persons because the amendment applies only to school district accounting practices.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There is no anticipated cost or savings to other persons because the amendment applies only to school district accounting practices.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule, and I see no fiscal impact on businesses. Steven O. Laing

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY UT 84111-3272, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Carol Lear at the above address, by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at clear@usoe.k12.ut.us

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

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R277. Education, Administration.
R277-419. Pupil Accounting.
R277-419-1. Definitions.

[~~M~~]A. "Add-on WPU" means additional weighted pupil units earned in accordance with the Minimum School Program Act, 53A-17a-104 in the areas of special education, applied technology education, adult education, youth-in-custody, and necessarily existent small schools.

[~~D~~]B. "Adult education" means organized public educational programs, other than regular full-time and summer elementary and secondary day school, which provide opportunities for adult and out-of-school youth who have not graduated, to further their education.

[~~B~~]C. "Aggregate Days of Membership" means the sum of all days of membership of all students during a school year.

[~~F~~]D. "Alternative High School" means a non-standard high school for students with special needs, interests, or learning styles, which meets all of the following criteria:

(1) the local school has been officially designated as a high school by the local board of education;

(2) a principal and staff are assigned to the school as a primary assignment;

(3) extra costs are associated with the school such as counseling staff, library, and other support costs;

(4) an approved applied technology education program is operated at the school;

(5) the school is primarily for youth in continuous education who have not graduated from high school but are working toward graduation. Its programs qualify students as candidates for graduation.

[~~H~~]E. "Board" means the Utah State Board of Education.

[~~E~~]F. "Continuous education" means regular full-time and summer day school programs outlined by the Board for the purpose of students completing the education process.

[~~J~~]G. "Dropout" means an individual in grades 7-12 who leaves a public school or a district or state approved school program and is not re-enrolled in or transferred to, as evidenced by an official request for the student's records by the school or approved program, a public school or a district or state approved school program on October 1 of the next school year. This definition does not include a student who satisfies one or more of the exceptions listed in Section 5B of this rule.

[~~Q~~]H. "F.T.E." means full time enrollment of a student for computation of adult education funding.

[~~K~~]I. "LEA" means a local education agency, including public school districts and post-secondary institutions.

[~~A~~]J. "Membership" means the number of pupils on the current roll of a class or school as of a given date. A pupil is a member of a class or school from the date of entrance at the school and is placed on the current roll until official withdrawal from the class or school because of completion, dismissal, death, transfer, or administrative withdrawal. The date of withdrawal is the date on which it is officially known that the pupil has left school for one of the above reasons and is not necessarily the first day after the date of last attendance. In no case may the date of withdrawal violate the [~~"~~]Ten-day Membership Rule,[~~"~~] except for reasons of sickness, hospitalization, pending court investigation or action, prior-approved trip, or earnest and persistent efforts of two or more contact hours per week to keep a child in school with services provided by certificated school district staff.

[~~G~~]K. "Part-time student" means a student carrying less than a full course load, as determined by the Board or the local board of education.

[~~C~~]L. "Pupil in Average Daily Membership (ADM)" means a full-day equivalent pupil.

[~~O~~]M. "School day" means a minimum of two hours per day per session in kindergarten; and a minimum of four hours per day in grades one through twelve. All school day calculations shall exclude lunch periods and pass time between classes.

[~~I~~]N. "School Year" means a minimum of 990 hours of instruction in a minimum of 180 school days required to qualify for full minimum funding. The 180 school days shall be scheduled during the 12 month period beginning July 1, 1995 with the following exceptions:

(1) The kindergarten program is a half-day program providing a minimum of 450 hours of instruction in a minimum of 180 school days during a school year to qualify for full minimum school funding.

(2) In grade one, the school shall provide a minimum of 810 hours of instruction in a minimum of 180 school days during a school year to qualify for full minimum school funding.

(3) An exception for schools using a modified 45-day 15-day year round schedule is provided for in [Subsection]R277-419-8D[of this rule].

[P]O. "Ten-day Membership Rule" means subject to Section 1A, a student shall not be counted in membership for funding purposes after 10 consecutive school days of unexcused absences or that the date of withdrawal shall not be later than the day after 10 consecutive school days of unexcused absences. Each day a school is officially in session shall be counted as a school day, regardless of the number or length of class periods or whether or not particular classes meet such as the 8-period per day high school classes.

[L]P. "USOE" means the Utah State Office of Education.

[N]Q. "Weighted Pupil Unit (WPU)" means the unit of measure of factors that is computed in accordance with the Minimum School Program Act for the purpose of determining the costs of a program on a uniform basis for each district.

R277-419-2. Authority and Purpose.

A. This rule is authorized under Utah Constitution Article X, Section 3 which vests general control and supervision over public education in the State Board of Education, by Section 53A-1-401(3) which allows the Board to make rules in accordance with its responsibilities, Section 53A-1-402(1)([f]e) which directs the Board to establish rules and standards regarding cost-effectiveness, [the minimum school program,]school budget formats and financial, statistical, and student accounting requirements, and Section 53A-1-404(2) which directs that local school board auditing standards shall include financial accounting and student accounting[; and Section 53A-1-404 which gives the Board responsibility for verifying audits of school districts in order to allocate Uniform School Fund monies]. This rule is further authorized by S[ubs]ection 53A-1-301([2]3)(d) which directs the Superintendent to present to the Governor and the Legislature data on the funds allocated to school districts, and Section 53A-3-404 which requires annual financial reports from all school districts[and Section 53A-3-416 which requires the submission of an annual report on teachers' salaries to the Board].

B. The purpose of this rule is to specify pupil accounting procedures used in apportioning and distributing state funds for education.

R277-419-3. Operation.

A. School districts are required to conduct school for at least 990 instructional hours and 180 school days each school year. The days or hours may be offered at any time during the school year provided that each school day is consistent with [Subsection]R277-419-1([P]M), July 1 to June 30, except for Sunday. A student who is in membership in a regular school program for one full school year generates the full WPU possible under the law. No student may generate WPU monies for more than 990 hours in any school year.

B. Official records

(1) To determine membership, school districts shall ensure that records of attendance are kept in each school which clearly and accurately show the entry date, exit date and attendance record of each student. These records shall show when a student has been absent from school ten consecutive school days.

(2) All children with disabilities in the self-contained programs shall be identified with their disability code, in the individual school's records of attendance.

(3) Computerized or manually produced records for applied technology programs shall be kept by teacher, class and Classification of Instructional Program (CIP) code. These records shall clearly and accurately show the entry and exit date of each student and whether a student has been absent from school ten consecutive days.

(4) A minimum of one attendance check shall be made by the school each school day.

C. Because of school activities requiring schedule and program modification during the first days and last days of the school year, a district may report for the first five days, aggregate days of membership equal to the number recorded for the second five-day period of the school year. For the last three-day period, a district may report aggregate days of membership equal to the number recorded for the immediately preceding three-day period.

D. School District Audits

(1) An independent auditor shall be employed under contract by each school district to audit its student accounting records annually and report the findings to the district board of education;

(2) Reporting due dates and suggested forms and procedures are found in the Guidelines and Procedures for Conducting the Annual Statistical Audits of Fall Enrollment and Student Membership provided to school districts by the USOE;

(3) The USOE shall review student membership and fall enrollment audits as they relate to the allocation of state funds.

R277-419-4. Membership.

A. For purposes of funding the regular basic school program, a student can only be a pupil in average daily membership once on any day. A student may be counted in full-time membership in the regular school program, or full-time membership in some other program, or in part-time membership in the regular school program and part-time membership in some other program. If a student's day is part-time in the regular school program and part-time in some other program (e.g., Adult Basic Education, Youth in Custody), the student's membership is reported on a pro-rated basis for each program. A student shall not be funded for more than one regular WPU for any school year. However, in addition, add-on WPU[']s may be generated.

B. Full-time students in grades 2-12 may be in average daily membership whenever district-approved classes are available.

C. Minimum criteria for homebound/hospitalized services

(1) A student requiring homebound or hospitalized teacher services shall receive a[n average] minimum of two contact hours of instruction per week to qualify for full membership in the regular program.

(2) A district shall provide the minimum of two contact hours per week and document that contact or it may not claim the state WPU for the student.

(3) The circumstances requiring the services shall be clearly stated and may include specific injuries, surgery, illness, other disabilities, pregnancy, or a district determination that a student should receive home instruction and supervision for a designated period of time. The expected period of absence must be estimated.

(4) A student with disabilities meeting these requirements may be accounted for under the special education homebound instruction program and receive the appropriate special education funding.

D. A student suspended in accordance with the law may be counted in membership, after 10 consecutive days of suspension, if the school continues to provide educational services at the minimum level provided in [Subsection]R277-419-4C, above, to the student during the suspension period.

E. Student enrollment

(1) the membership of students enrolled part-time in public schools is determined by the ratio of the number of hours or periods that the student is in membership per day or week to the total number of hours or periods in the school day or week. For example, a student in membership 3 periods in a 7 period school day generates 3/7 membership;

(2) to count membership in measuring eligibility for state funds, enrollment of a public school student in either of the following shall be counted as if the student were enrolled in a public school class or classes during that portion of the school day or week:

(a) released time for religious instruction or individual learning activity, shall not [to]exceed the equivalent of one class period per day and shall be consistent with a Student Education/Occupation Plan signed by the student, parent/guardian, and school representative;

(b) a private school, not including a parochial school, under a contract between the private school and a public school district which requires the instruction to be paid for from public funds. Membership is calculated on the basis of fractional daily membership;

(3) except as provided above, a student enrolled in a public school and any of the following shall be credited for membership for state funding purposes only for the public school portion of the school day:

(a) a private school;

(b) a home school[;

(c) a parochial school;

(d) a charter school].

F. A student concurrently enrolled in a post-secondary institution and the public schools during a year may be counted in membership if the public school approves the post-secondary program and receives the progress reports and membership and attendance reports from the institution.

G. Districts may claim membership for students who are regularly enrolled in youth in custody classes, and who are also regularly enrolled during other times of the day in non-youth in custody classes. If the student is enrolled in YIC classes for up to two hours a day, the district may claim full membership; from two to four hours, 1/2 membership; for more than four hours, no membership. No subtraction in district membership shall be made for students who are enrolled in youth in custody classes for two or fewer hours per day or who receive tutoring, tracking, or other support services which do not result in a reduction in regular class enrollment.

H. The district providing the educational services for the following students may count them in full membership:

(1) students between the ages of five and eighteen who are residents of another school district in the state, who have received written permission for entry from the receiving district, and for whom the receiving district has given written notification to the board of education of the district of residence;

(2) exchange students under Section 53A-2-206 which requires the student to be sponsored by an agency approved by the Board prior to the students' arrival in the United States; and

(3) students beyond the age of eighteen remaining in continuous education.

I. High school completion options and funding

(1) Students eighteen years of age or over who have not graduated from high school with their graduating class shall not be enrolled as continuous education students, except students who do not graduate with their graduating class due to:

(a) sickness;

(b) hospitalization;

(c) pending court investigation or action or both;

(d) other extenuating circumstances beyond the control of the student; or

(e) special education students attending school in accordance with the provisions of a valid Individualized Education Program (IEP) who may be enrolled until age 22 or until graduated. School districts are encouraged to handle these students in the regular programs with approval by the local boards of education.

(2) A student under eighteen years of age who has not graduated and who is a resident of the district, may, with approval under the state administered Adult Education Standards, enroll in the Adult Basic and Adult High School Completion Program and generate regular state WPU[']s at the rate of 990 clock hours of membership per one weighted pupil unit per year, 1 F.T.E. on a yearly basis. The clock hours of students enrolled part-time must be pro-rated;

(3) A student eighteen years of age or over who has not graduated, who is domiciled in the state of Utah, and who intends to graduate from high school, may, with approval under the state administered Adult Education Standards, enroll in the State Adult High School Completion Program and attend up to 990 clock hours of membership per year, 1 F.T.E. on a yearly basis. Weighted pupil units are generated for Adult High School Completion students at the rate of 72 days or 396 clock hours of membership per WPU.

(a) The clock hours of students enrolled part-time must be pro-rated.

(b) As an alternative, equivalent weighted pupil units may be generated for competencies mastered on the basis of prior authorization of a district plan by the Adult Education and USOE School Finance and Business Sections.

(c) The ten-day membership rule of [Subsection]R277-419-1([A]O) for Adult High School Completion students is 10 clock hours.

J. Applied Technology Class Attendance

(1) A student may be in a full-time membership and generate the regular WPU even though spending part of the day at an applied technology center.

(2) Students may generate regular WPU[']s hour-for-hour spent in bus travel to and from applied technology centers, if the students are traveling during their regular school day.

(3) Add-on WPU[']s are generated during approved applied technology instruction, but not during bus travel.

K. Alternative High School Membership

(1) The following conditions shall exist in order to generate WPU[']s for Alternative High School Membership:

(a) the Alternative High School must have on file an assignment transfer from the district of residence for eligible students; and

(b) only students in continuous education generate regular WPU[~~'~~]s.

(2) Students involved only with course work at the school have ADM calculated in the same manner as part-time or full-time students in the regular school;

(3) A student whose program consists of seminars or course work part time and participating in work experience part time in the community with or without pay, has ADM computed by dividing the hours of membership by 990. For the purposes of computing ADM, work experience is limited to a maximum of ten hours per week;

(4) Students who are engaged in independent or home study have ADM calculated by dividing the student contact credits earned from independent study by the number of contact credits earned by a regular full-time student during the regular school year in the district. For example, to determine the fraction of one ADM for which a student will be counted, if in the high school a full-time student earns seven contact credits, seven is the denominator and the numerator will be the contact credits earned from independent study.

R277-419-5. Dropout Determination.

A. The Board shall use the U.S. Department of Education, National Center for Education Statistics, Common Core of Data Committee's dropout definition and reporting procedures available from the Finance Section of the USOE. School districts shall provide the data as specified in the [~~"~~]Fall Enrollment Report[~~"~~] beginning with the 1997 report.

B. A student in grades 7-12 enrolled during the school year shall be reported as a dropout for that school year if the student does not complete the school year, unless the student:

(1) is enrolled on October 1 of the following school year;

(2) is not in attendance due to suspension, illness, or other extenuating circumstances beyond the control of the student, provided that the school is officially notified and services are provided consistent with this rule;

(3) transfers to another public school, a state or district approved program, or a regularly organized private school, as evidenced by an official request for the student's records by the receiving school by October 1 of the following year;

(4) transfers to a home school, if the student receives a release annually from the public school district of residence, and the student provides verification to the school district's satisfaction that the student is being taught consistent with Section 53A-11-102;

(5) graduates early; or

(6) dies.

C. A student who completes the school year in grades 7-12, but is not enrolled on October 1 of the following year, is reported as a dropout for the year and grade for which the student fails to enroll. The student is commonly known as a [~~"~~]summer drop-out[~~"~~] or [~~"~~]fall no-show.[~~"~~]

R277-419-6. School Completion.

A. An individual is recorded as completing school when the student graduates in the traditional sense from high school or completes a state or district approved educational program and receives official recognition of graduation or completion from school administrators.

(1) State or district approved programs may be special education programs as defined by the student's IEP consistent with the law, home school when officially authorized on an annual basis by school or district administrators, GED preparation, Youth in Custody, alternative high school programs, and adult high school programs.

(2) Adult or alternative high school may be a combination of traditional high school credits, GED credits and adult or alternative high school credits.

B. Approval of programs for school completion--presentation of a high school diploma and participation in formal graduation exercises--are solely within school district discretion consistent with the law and Board rules.

R277-419-7. Student Identification and Tracking.

School districts shall request all students to provide the district with a social security number for purposes of identification and electronic record transfer.

R277-419-8. Variances.

A. An exception may be made at the discretion of the local board, in the length of the school day for students with unusual problems. The time an excepted student is required to be in school is established in view of the student's particular needs.

B. Emergency/activity time should be included in a school district's annual calendaring for each school. If school is closed for any reason, the instructional time missed shall be made up under the emergency/activity time as part of the minimum required time to qualify for full funding.

C. Staff Planning Time, Parent-Teacher and Student Education Plan (SEP) Conferences.

(1) To provide planning time for staff, districts may hold school longer some days of the week.

(2) Schools may conduct parent-teacher and student education plan conferences during the school day.

(3) Such conferences may only be held for a total of the equivalent of three full school days or a maximum of 16.5 hours for the school year. ADM is counted as that of the previous school day.

(4) The final decision and approval regarding planning time, parent-teacher and SEP conferences rests with the local board of education, consistent with Utah law and Board administrative rules.

D. A school using a modified 45-day 15-day year round schedule initiated prior to July 1, 1995 shall be considered to be in compliance with this rule if a school's schedule includes a minimum of 990 hours of instruction time in a minimum of 172 days.

KEY: education finance, school enrollment
[~~September 16, 1997~~]2003
Notice of Continuation October 18, 2002
Art X Sec 3
53A-1-401(3)
53A-1-402(1)([~~f~~]e)
53A-1-404(2)[
~~53A-1-404~~]
53A-1-301([~~2~~]3)(d)
53A-3-404[
~~53A-3-405~~]

Education, Administration
R277-454
Construction Management of School Building Projects

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26438
FILED: 07/01/2003, 14:57

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The amendment to this rule brings the rule into compliance with state law. The law now provides for tax exempt status to school districts for construction materials regardless of who installs the materials.

SUMMARY OF THE RULE OR CHANGE: The portion of the rule that provides procedures for tax exempt status when purchasing material for construction costs has been removed because state law provides for the same exemption.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53A-1-401(3)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There is no anticipated cost or savings to state budget. The statute was amended in 1995 and school districts have been complying with the law despite provisions of this rule that are more restrictive. (DAR NOTE: The change in the law (statute) was a result of H.B. 274 which is found at UT L 1995 Ch 318, and was effective July 1, 1995.)
❖ LOCAL GOVERNMENTS: There is no anticipated cost or savings to school districts. The statute was amended in 1995 and school districts have been complying with the law despite provisions of this rule that are more restrictive.
❖ OTHER PERSONS: There is no anticipated cost or savings to other persons. The statute was amended in 1995 and school districts have been complying with the law despite provisions of this rule that are more restrictive. Additionally, school districts were responsible for any taxes related to construction projects, not individuals.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. The statute was amended in 1995 and school districts have been complying with the law despite provisions of this rule that are more restrictive. Additionally, school districts were responsible for any taxes related to construction projects, not individuals.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule, and I see no fiscal impact on businesses. Steven O. Laing

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
EDUCATION
ADMINISTRATION
250 E 500 S
SALT LAKE CITY UT 84111-3272, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Carol Lear at the above address, by phone at 801-538-7835, by FAX at 801-538-7768, or by Internet E-mail at clear@usoe.k12.ut.us

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

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R277. Education, Administration.
R277-454. Construction Management of School Building Projects.
R277-454-1. Definitions.

[~~C~~]A. "Board" means the Utah State Board of Education.

B. "CM" means an individual designated as a construction manager. The CM may be an architect, engineer, general contractor, or other professional consultant. It may also be an entity which is referred to as a construction management firm. The CM works as the agent of the owner of the construction project. The CM, at the discretion of the owner, may assist in the development and implementation of any or all of the predesign, design, bidding, construction, and occupancy stages of the construction project. The CM is responsible for the effective, orderly, and acceptable completion of the construction project.

[~~A~~]C. "Construction management" means a contractual and professional working relationship between the owner of a construction project and a CM.

R277-454-2. Authority and Purpose.

A. This rule is authorized by Article X, Section 3 of the Utah Constitution which vests general control and supervision of public education in the Board, Section 53A-1-401(3)[~~, U.C.A. 1953,~~] which allows the Board to adopt rules in accordance with its responsibilities and Section 53A-20-103[~~, U.C.A. 1953,~~] which requires the Board to [~~recommend minimum requirements for contracts and agreements between architects, engineers, and local boards, and for advertising, bidding, and contractual procedures for school plant construction~~]prepare an annual school plant capital outlay report of all school districts, which includes information on the number and size of building projects completed and under construction.

B. The purpose of this rule is to specify the standards local boards of education [~~must~~]shall follow in using construction management for school construction projects.

R277-454-3. Standards.

A. A construction management contract [~~must~~]shall clearly specify the duties of the CM with respect to the building project.

B. A local school district [~~must~~]shall bid each component part of the building project in accordance with advertising, public

opening, performance bond, payment bond, and other statutory requirements.[
~~C. A school district may use a tax exempt status in purchasing material for a construction project only if it purchases material from a supplier and makes the installation itself or issues a contract to a third party for installation. If the seller and installer are the same, tax exempt status may not be used. To ensure that the seller and installer are not the same, the original project bid, specifications, and contracts must specify which materials are furnished by the school district and which are furnished by the contractors.~~]

KEY: educational facilities, education finance
[~~1987~~]2003
Notice of Continuation October 18, 2002
Art X Sec 3
53A-1-401(3)
53A-20-103

Education, Administration
R277-508
Employment of Substitute Teachers

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26434
FILED: 07/01/2003, 14:55

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to provide for student teachers and paraprofessionals to be used as substitute teachers; and to provide language to protect the integrity of the student teaching experience so that the student teacher is not taken out of their student teaching assignment and reassigned to cover another classroom simply for convenience. This rule has not been amended in 10 years so further amendments have been made to bring the rule up to date.

SUMMARY OF THE RULE OR CHANGE: The changes include adding and deleting definitions; updating language; revising hiring priorities and eligibility; and revising employment procedures.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 53A-1-402(1)(a)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There is no anticipated cost or savings to state budget because the amendments to the rule provide for procedural changes that do not relate to money.
❖ LOCAL GOVERNMENTS: There is no anticipated cost or savings to local government. The procedural changes that now allow student teachers and paraprofessionals to substitute teach will only provide school districts with a greater choice of individuals they may use to substitute teach.
❖ OTHER PERSONS: There is no anticipated cost or savings to other persons. The procedural changes to this rule will now give opportunities for student teachers and paraprofessionals to substitute teach.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs for affected persons. The changes are only procedural and allow greater flexibility for both individuals and school districts for substitute teaching and does not have any cost associated for complying with this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule, and I see no fiscal impact on businesses. Steven O. Laing

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
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250 E 500 S
SALT LAKE CITY UT 84111-3272, or
at the Division of Administrative Rules.

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THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

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R277. Education, Administration.
R277-508. Employment of Substitute Teachers.
R277-508-1. Definitions.

A. "Board" means the Utah State Board of Education.

B. "Computer Aided Credentials of Teachers in Utah System (CACTUS)" means the electronic file maintained on all licensed Utah educators. The file includes such as:
(1) personal directory information;
(2) educational background;
(3) endorsements;
(4) employment history;
(5) professional development information; and
(6) a record of disciplinary action taken against the educator.

C. "License" means an authorization issued by the Board which permits the holder to serve in a professional capacity in the public schools.

[~~B~~]D. "Substitute teacher" means an individual employed to take the place of a regular teacher temporarily absent.

[~~C~~]E. "Temporarily absent" means a period not to exceed eight consecutive weeks.[
~~D. "Certificate" means a license issued by the State Board of Education which permits the holder to be employed as an educator in the public schools.~~]

R277-508-2. Authority and Purpose.

A. This rule is authorized by Utah Constitution, Article X, Section 3 [of the Utah Constitution]which vests general control and supervision of public education in the Board, Section 53A-1-402(1)(a)[, U.C.A. 1953,] which [allows]directs the Board to make rules regarding the qualifications of [personnel]educators and ancillary personnel providing direct student services, and Section 53A-1-401(3)[, U.C.A. 1953,] which allows the Board to adopt rules in accordance with its responsibilities.

B. The purpose of this rule is to establish eligibility requirements and employment procedures for substitute teachers.

R277-508-3. Duration of Teaching Assignment.

A substitute teacher may not serve in a teaching position for more than eight weeks in one academic year in either the same class or with the same group of students. Individuals serving in the same teaching position for longer than eight weeks shall hold [proper certification]an appropriate license or be replaced by a person with [proper certification]an appropriate license.

R277-508-4. Hiring Priorities and Eligibility.

A. The first priority in hiring substitute teachers [is]shall be given to those who hold a valid [certificate]license in the subject matter they will be teaching as a substitute. Second priority is to hire persons who have a valid [certificate]license in a field commonly taught in public schools.

B. It is desirable that a [S]substitute teacher[s] [must]hold a valid [certificate]license or a college degree. [These requirements may be waived in an emergency; however, the]A district [must]shall evaluate persons [so]hired as substitutes to ensure that they are capable of managing a class and carrying out the instructional program.

[C. Student teachers and aids may not be used as substitute teachers.

D]C. Persons seeking employment as a substitute teacher [must]shall furnish evidence as requested from the hiring school district that they are physically and mentally fit to [serve]work.

[E]D. School districts may not employ any individual as a substitute teacher whose [certificate]license has been revoked or is currently suspended by the Board or whose [certificate]license has been revoked or is currently suspended by another state. Individuals whose [certificates]licenses have been reinstated may be considered for employment as substitute teachers.

R277-508-5. Employment Procedures.

A. School [D]districts shall establish a [formal procedure]policy for hiring substitute teachers. The [procedure]policy shall include obtaining verification from [the Utah Certification Management System or the Utah State Office of Education Teacher Certification Office]CACTUS that an applicant's [certificate]license has not been revoked or suspended.

B. School [D]districts shall [institute a system]have a policy to evaluate substitute teachers including a salary schedule[. A salary program shall be established] to pay substitutes according to their training, experience, and competency.[The salary program shall contain provision for pay increases according to ability and length of service.]

C. Regular teachers are required to have lesson plans immediately available for use by substitute teachers.

D. Student teachers may substitute in classes consistent with the instructions and policies from the higher education institution which the student attends.

E. Paraprofessionals and Aides may substitute in classes consistent with school district or school policy.

KEY: teachers, professional competency, school personnel
[1987]2003
Notice of Continuation March 13, 1998
Art X Sec 3
53A-1-402(1)(a)
53A-1-401(3)

Education, Administration
R277-733
Adult Basic Education and Adult High School Completion Programs

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26437
FILED: 07/01/2003, 14:57

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is amended to provide for changes to the Adult Basic High School Completion Programs consistent with state and federal law, and the State Board of Education approval of a new funding formula for the distribution of adult education funds.

SUMMARY OF THE RULE OR CHANGE: The changes include amending definitions, updating federal citations, amending curriculum, establishing tuition and fees, and approving allocation of state funds.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 53A-15-401

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There is no anticipated cost or savings to state budget. The State Board of Education will distribute state-appropriated funds to school districts for Adult Education programs based on the new formula in this rule.

❖ LOCAL GOVERNMENTS: Under this amended rule, school districts may receive less funding for Adult Education programs because the funding will be based more on measurable outcomes than on census. School districts are now authorized to charge tuition and fees to students when adequate state or local funds are not available.

❖ OTHER PERSONS: Because of a reduction in funding for Adult Education programs, individuals may pay fees for services or materials where in the past they did not. There may be less individuals participating in Adult Education programs because of this financial hardship. Also, there are some changes in graduation requirements which may result in cost or savings

to individuals depending upon the individual's specific educational needs.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Because of a reduction in funding for Adult Education programs, individuals may pay fees for services or materials where in the past they did not. There may be less individuals participating in Adult Education programs because of this financial hardship. Also, there are some changes in graduation requirements which may result in cost or savings to individuals depending upon the individual's specific educational needs.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: I have reviewed this rule, and I see no fiscal impact on businesses. Steven O. Laing

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250 E 500 S
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THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Carol Lear, Coordinator School Law and Legislation

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R277. Education, Administration.
R277-733. Adult [~~Basic~~]Education [~~and Adult High School Completion~~]Programs.
R277-733-1. Definitions.

[~~E~~]A. "Adult" means a person 18 years of age or over.

[~~C~~]B. "Adult basic education (ABE)" means a program [~~funded through the state using state and federal funds to~~]that provides instruction for adults whose inability to compute or speak, read, or write the English language at or below the [~~ninth~~]eighth grade level substantially impairs their ability to find or retain employment commensurate with their real ability. The instruction is designed to help adults by:

(1) increasing their independence;

(2) improving their ability to benefit from occupational training;

(3) increasing opportunities for more productive and profitable employment; and

(4) making them better able to meet adult responsibilities.

[~~A~~]C. "Adult education" means instruction and educational services [~~below the college level for adults~~]for students age 18 and over who lack:

(1) basic education skills sufficient to enable them to function effectively in society as measured by performance at or below the [~~ninth~~]eighth grade level on standardized achievement tests;[~~ or~~]

(2) a certificate of graduation from a school providing the secondary education of grade levels nine through twelve[~~.~~];

(3) English acquisition skills for non-English language learners; or

(4) A GED Certificate of Completion.

D. "Adult high school education" means a program [~~funded with state funds to~~]that provides instruction in Board-approved subjects which leads to a high school diploma for adults.

[~~B~~]E. "Board" means the Utah State Board of Education.

[~~H. "Career option cluster" means a group of courses identified for university entry or technical/college entry not to exceed 10.5 credit hours.~~

~~N~~]F. "Consumable items" means student workbooks, student packets, computer disks, pencils, papers, notebooks, and other similar personal items over which a student retains ownership during the course of study.

[~~F~~]G. "Eligible adult education student" means a person who is a legal resident of the United States, makes his true and permanent home in Utah, and:

(1) is 17 years of age or older, and whose high school class has graduated;

(2) is under 18 years of age who is married; or

(3) has been adjudicated as an adult.

H. "Enrollees" means adult students who have 12 or more contact hours within the adult education program.

[~~M~~]I. "Fee" means any charge, deposit, rental, or other mandatory payment, however designated, whether in the form of money or goods. Admission fees, transportation charges, and similar payments to third parties are fees if the charges are made in connection with an activity or function sponsored by or through a school. All fees are subject to approval by the local school board of education.

J. "GED" means General Education Development. A program to provide instruction in subjects which leads to a GED certificate of completion.

K. "GED Certificate of Completion" means a certificate issued by the Board acknowledging competency on the part of the certificate holder in the GED test areas.

L. "Latest official census data" means statistical information used to determine the number of adults who need adult education services, and determined by:

(1) individuals 18 years of age and older with less than a ninth grade education; or

(2) individuals 18 years of age and older whose primary language is other than English; or

(3) individuals 18 years of age and older without a high school diploma -- ungraduated adults.

M. "Measurable outcomes" means education results that lead to student progress in adult education. Funding is determined by measurable outcome percentages under R277-733-9.

[~~P. "Level I" means grade content levels 3-8.~~

~~Q. "Level II" means grade content levels 9-12.~~

~~G~~]N. "Other eligible adult education student" means a person[~~s~~] 16 to 18 years of age whose high school class has not graduated and [~~are~~]is counted in the regular school program[~~;~~]. [~~t~~]The funds generated [~~by those students~~]are credited to the adult education program.

[~~O. "Pre-level I" means grade content levels 0-2.~~

~~J. "Technical/college entry option cluster" means a group of courses that has a technical training focus, such as cabinetry, automotive, cosmetology, and does not exceed 10.5 credit hours.~~

~~K. "Training cluster" means a group of courses identified in a student's student educational/occupational plan as directly related to a student's specific job training.~~

~~L~~]O. "Tuition" means the base cost of an adult education program providing services to the adult education student.

[~~I. "University entry option cluster" means a group of courses that have an academic focus and do not exceed 10.5 credit hours.~~

~~R~~]P. "USOE" means the Utah State Office of Education.

R277-733-2. Authority and Purpose.

A. This rule is authorized by Utah Constitution Article X, Section 3 which gives general control and supervision of the public school system to the Board, Section 53A-15-401 which places the general control and supervision of adult education under the Board, Section 53A-1-402(1) which allows the Board to adopt minimum standards for programs and Section 53A-1-401(3) which allows the Board to adopt rules in accordance with its responsibilities.

B. The purpose of this rule is to describe curriculum, program standards, allocation formulas, and operation procedures for the adult education program.

R277-733-3. Federal Adult Education[~~ Act~~].

The Board adopts the Adult Education and Family Literacy Act, Chapter 2, Public Law 105-220, 20 U.S.C. 1201 et seq., hereby incorporated by reference, and the related current state plan required under that statute, as the standards and procedures governing the federally-funded portion of its adult education program, available from the USOE Adult Education Section.

R277-733-4. Program Standards.

A. A written [~~s~~]Student [~~e~~]Educational/[~~o~~]Occupational [~~p~~]Plan based upon an analysis of the student's goals and objectives, prior academic achievement, [~~and~~]work experience and placement assessment data shall be developed for each adult education student and signed by the student and a designated local school official.

B. Local adult education programs shall make reasonable efforts to inform prospective students of the availability of the programs and provide enrollment information widely.

C. Only courses identified in [~~Section 7~~]R277-733-7 qualify for adult education funds. Only 25 percent of an adult education student's credits toward graduation may be electives as identified under R277-733-7.

D. Local adult education programs shall comply with state and federal requirements and Board rules. The USOE shall evaluate local programs to determine compliance.

R277-733-5. Fiscal Procedures.

A. State funds appropriated for adult education are allocated in accordance with Section 53A-17a-119.

B. No eligible school district shall receive less than its portion of a [~~six~~]seven percent base amount of the state appropriation if:

(1) instructional services approved by the USOE Adult Education Services have been provided to eligible adult students during the preceding fiscal year; or

(2) the district is preparing to offer such services--such a preparation period may not exceed two years.

C. Lapsing and nonlapsing funds

(1) Funds appropriated for adult [~~basic and adult high school~~]education programs are subject to Board accounting, auditing, and budgeting rules.

(2) State adult [~~basic and adult high school~~]education funds which are allocated to local adult education programs and are not expended in a fiscal year may be carried over to the next fiscal year with written approval by the USOE. These funds may be considered in determining the district's allocation for the next fiscal year.[

~~(3) Federal adult education funds shall lapse after July 11 of each year.~~]

D. The USOE shall develop uniform forms, deadlines, program reporting and accounting procedures, and guidelines to govern the state and federal adult basic skills and adult high school programs. The "Adult Education Guidelines for Fiscal, Student, and Program Accounting and Reporting" manual, [~~February, 1995~~]July, 2003, includes these forms, procedures and guidelines and is available from the USOE.

R277-733-6. Adult Education Pupil Accounting.

A. A student under 19 years of age who has not graduated and who is a resident of the district, may, with approval under the state administered Adult Education Program, enroll in the Adult Basic and Adult High School Completion Program and generate regular state WPUs at the rate of 990 clock hours of membership per one weighted pupil unit per year, 1 F.T.E. on a yearly basis. The clock hours of students enrolled part-time must be prorated.

B. A student 17 years of age or over, without a high school diploma but whose high school class has graduated, who resides in the state of Utah, and who intends to graduate from high school, may enroll in the State Adult High School Completion Program. Student attendance up to 990 clock hours of membership is equivalent to 1 F.T.E. per year.

(1) The clock hours of students enrolled part-time shall be prorated.

(2) As an alternative, equivalent weighted pupil units may be generated for competencies mastered on the basis of prior authorization of a district plan by the USOE.[

~~(3) The ten-day membership rule, defined in Section R277-419-1P, for Adult High School Completion students, is 10 clock hours.~~]

R277-733-7. Adult Basic Education and Adult High School Education Curriculum.

A. Adult basic education shall consist of the following prerequisite courses to subsection R277-733-7B below:

[~~(1) Pre-level I: Pre-Literacy;~~

~~(a) listening;~~

~~(b) speaking;~~

~~(c) cultural orientation.~~

~~(2) Level I: Literacy Courses;~~

~~(a) reading;~~

~~(b) writing;~~

~~(c) computation;~~

~~(d) information technology.~~](1) English for Speakers of Other Languages (ESOL) competency levels one through six.

(2) Adult Basic Education (ABE) competency levels one through four.

B. Adult [~~high school completion~~]secondary education (ASE) shall satisfy [~~Level II course content~~]ASE competency levels I and II requirements with a minimum of 24 credits as provided below:

(1) Adult High School General Core Courses: 13.5 units of credit required:

(a) English: 3.0;

(b) mathematics: 2.0, elementary algebra or above;

(c) science: 2.0, with a maximum of one credit in at least two of the following areas: (1) chemistry; (2) biological science; (3) earth science; (4) physics;

(d) social studies: 3.0, 1.0 in United States history or American government; .5 in geography; .5 in world studies; 1.0 in elective social studies;

(e) information technology: .5;

(f) applied technology: 1.0;

(g) fine arts: 1.0;

(h) healthy life styles: 1.0.

(2) [Adult High School Career Option Clusters: 10.5 additional units of credit shall be identified by the student education occupational plan with a five-credit concentration in either the technical college option cluster or the university entry option cluster, as noted below:

(a) university entry option cluster:

(i) foreign language/academic elective: 2.0;

(ii) mathematics: 1.0, intermediate algebra or above;

(iii) English: 1.0;

(iv) science: 1.0;

(v) electives: 5.5.

(b) technical/college entry option cluster:

(i) training cluster: 3.0;

(ii) career preparation: 2.0;;

(iii) electives: 5.5.]Adult High School completion shall satisfy requirements outlined in R277-600-6 and shall be consistent with R277-733-4C.[

C. Individual programs may require additional credits, but they shall be offered at no expense to the adult student or to the state or federal adult basic skills and adult high school programs.

D. Courses may be completed on a demonstrated performance basis. Assessment of completion of course requirements is the responsibility of the local program.

E. All classes leading to a high school diploma shall meet applicable Board standards.]

R277-733-8. Adult [Basic and State High School]Education Programs--Tuition and Fees.

A. Any adult may enroll in an adult education class as [specified]provided in Section 53A-15-404.

B. Tuition and fees may [not]be charged for [pre-literacy or]literacy courses, when adequate state or local funds are not available.

C. Tuition may [not]be charged for adult high school general core courses, when adequate state or local funds are not available.

D. Tuition may be charged for [career option cluster]courses that satisfy requirements outlined in R277-700-6 and subject to R277-733-4C, when adequate state or local funds are not available.

E. Fees may be charged for consumable and nonconsumable items necessary for adult high school general core courses, [career option cluster]courses that satisfy requirements outlined in R277-700-6 and subject to R277-733-4C, and adult high school general core courses, consistent with the definitions under R277-733-1[G]F and R277-733-1[H]I.[

F. To qualify for free adult high school completion course work beyond the general core, a student shall declare his intent to graduate from high school.]

R277-733-9. Allocation of Adult Education Funds.

[Adult education funds shall be allocated to school districts as follows:

(1) Adult basic education formula (levels 0 through 8):

(a) Base amount - 10 percent of appropriation to be distributed equally to each district;

(b) Latest official census data - 45 percent of appropriation determined by the following:

(i) individuals 18 years of age and older who speak a language other than English at home;

(ii) individuals 18 years of age and older with less than a ninth grade education.

(c) Enrollees - 20 percent of appropriation determined by the following:

(i) enrollees in English as a second language (ESL) courses (levels 0 through 2);

(ii) enrollees in adult basic education (ABE) courses (levels 3 through 8).

(d) Student outcomes - 25 percent of appropriation shall be determined from among the following:

(i) number of clock hours of student attendance;

(ii) number of jobs obtained by students;

(iii) number of students that obtained a better job or salary increase;

(iv) number of students removed from welfare;

(v) number of students who completed English as a second language (ESL) and adult basic education (ABE) levels, or both;

(vi) number of students who entered a higher education/training program as approved by the USOE;

(vii) number of credits awarded to students;

(2) Adult high school allocation formula (levels 9 through 12):

(a) Six percent of the allocation shall be distributed equally to the districts as a base.

(b) Of the amount remaining following distribution of the base amount, 50 percent shall be distributed to school districts according to each district's percentage of ungraduated adults determined by the latest official census; and

(c) 50 percent shall be distributed to school districts as determined by student participation as follows:

(i) enrollees in adult high school completion (levels 9 through 12) - 12.5 percent;

(ii) units of credit earned through participation in approved adult high school completion courses - 12.5 percent;

(iii) high school diplomas awarded - 12.5 percent;

(iv) clock hours of student attendance - 12.5 percent.]Adult education funds shall be distributed to school districts according to the following:

A. Base amount - 7 percent of appropriation or $13,000, whichever is greater, to be distributed equally to each district with USOE-approved plan.

B. Latest official census data, as defined in R277-733-1L, at a decreasing rate per year until reaching zero percent: 15 percent of appropriation for FY 04, 10 percent for FY 05, five percent for FY 06, zero percent for FY 07, and zero percent thereafter.

C. Measurable outcomes, as defined in R277-733-1M, on an increasing rate per year until reaching 50 percent: 35 percent of appropriation for FY 04, 40 percent for FY 05, 45 percent for FY 06, and 50 percent for FY 07 and 50 percent thereafter. Funds shall be distributed among measurable outcomes as follows:

(1) number of high school diplomas awarded - 30 percent of the total funds available;

(2) number of GED certificates awarded - 25 percent of the total funds available;
(3) number of level gains: ESOL levels 1-6 and ABE competency levels 1-4 - 30 percent of the total funds available;
(4) number of high school credits earned by students - 15 percent of the total funds available.
D. Enrollees as defined by federal regulations - 25 percent of appropriation.
E. Supplemental support, to be distributed to school districts for special program needs or professional development as determined by written request and USOE evaluation of need and approval - 2 percent or balance of appropriation whichever is smaller.
F. Student participation, total number of contact hours between adult student and adult education program - 16 percent.

KEY: adult education
[~~March 22, 1999~~]2003
Notice of Continuation October 18, 2002
Art X Sec 3
53A-15-401
53A-1-402(1)
53A-1-401(3)
53A-15-404
53A-12-101

Health, Health Care Financing, Coverage and Reimbursement Policy

R414-300

Primary Care Network, Covered-at-Work Demonstration Waiver

NOTICE OF PROPOSED RULE
(New Rule)
DAR FILE NO.: 26431
FILED: 06/30/2003, 13:29

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is necessary to implement the program to the Primary Care Network (PCN) Waiver called "Primary Care Network - Covered-at-Work". For individuals who have access to health insurance through their employer, this program will provide a reimbursement for all or part of the premium paid by those individuals to enroll themselves or their spouses in an employer-sponsored health insurance plan. This new rule describes the benefits an enrollee in the Covered-at-Work program will receive.

SUMMARY OF THE RULE OR CHANGE: This new rule describes the benefits an enrollee in the Covered-at-Work program will receive. These benefits are limited to 60 months for each new enrollee.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 18

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: This filing is a companion to a filing with amendments to Rule R414-310. Impacts for both rules combined are as follows: Covered-At-Work enrollees will be served within the 25,000 enrollee cap established for the PCN program. Therefore, funding for this group will come out of funds already appropriated for the PCN program. (DAR NOTE: The proposed amendment to Rule R414-310 is under DAR No. 26430 in this issue.)

❖ LOCAL GOVERNMENTS: This rule has no effect on local government, since it is believed that no local government employees are eligible. Therefore, there will be no cost to local government.

❖ OTHER PERSONS: This filing is a companion to a filing with amendments to Rule R414-310. Impacts for both rules combined are as follows: Enrollees in the Covered-At-Work program will be positively impacted by this rule since they will receive partial or full reimbursements of their costs to enroll in their employer-sponsored health insurance. Approximately 2,000 individuals will receive reimbursements annually. Assuming the full $50 monthly reimbursement and subtracting the enrollment fee, the aggregate savings to enrollees is $1,100,000.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This filing is a companion to a filing with amendments to Rule R414-310. Impacts for both rules combined are as follows: this rule requires no affirmative compliance by any person. Persons who choose to enroll in the program will pay a $50 annual fee, but will be reimbursed $600 annually for health insurance premium payments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The PCN program was estimated to use $3,800,000 in General Fund monies and $9,300,000 in federal matching funds in the first year. Those eligible to apply for the Covered-at-Work program are included in the estimates above. It is anticipated that through the Covered-at-Work program, currently uninsured individuals who have insurance available through their employer but were unable to afford the coverage, will save significant amounts of money by now having the opportunity to enroll in health insurance, thereby gaining the ability to get their ongoing health care needs met and avoid more costly acute health care episodes. Rod L. Betit, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Gayleen Henderson at the above address, by phone at 801-538-6135, by FAX at 801-538-6952, or by Internet E-mail at ghenderson@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Rod L. Betit, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-300 Primary Care Network, Covered-at-Work Demonstration Waiver.
R414-300-1. Introduction and Authority.

This rule describes the benefits under the Primary Care Network (PCN)Covered-at-Work Program. The PCN Covered-at-Work Program is authorized by an amendment to a waiver of federal Medicaid requirements approved by the federal Center for Medicare and Medicaid Services and allowed under Section 1115 of the Social Security Act effective January 1, 1999. This rule is authorized by Title 26, Chapter 18.

R414-300-2. Definitions.

"Spouse" means an individual who is married to an applicant or enrollee and has not legally terminated the marriage.

R414-300-3. Nature of Program and Benefits.

(1) The Covered-at-Work Program provides cash reimbursement to an enrollee who meets the eligibility requirements and application requirements of R414-310. The Covered-at-Work Program provides benefits as described in this section.

(2) The reimbursement shall not exceed the amount the employee pays toward the cost of the employee's employer-sponsored coverage for the employee and the employee's spouse if covered under the employee's plan. The employer must pay at least 50 percent of the employee's health insurance premium.

(3) The amount of reimbursement for a single person or for a married couple when only one spouse is eligible for the reimbursement, will be provided on the following schedule, in the designated amounts:

(a) Up to $50 per month for the first 24 months of eligibility.

(b) Up to $40 per month for the next 12 months (third year)of eligibility.

(c) Up to $30 per month for the next 12 months (fourth year)of eligibility.

(d) Up to $20 per month for the last 12 months (fifth year)of eligibility.

(4) The amount of reimbursement for a married couple when both spouses are eligible for the reimbursement and both are covered under the same employer sponsored plan, will be provided on the following schedule, in the designated amounts:

(a) Up to $100 per month for the first 24 months of eligibility.

(b) Up to $80 per month for the next 12 months (third year)of eligibility.

(c) Up to $60 per month for the next 12 months (fourth year)of eligibility.

(d) Up to $40 per month for the last 12 months (fifth year) of eligibility.

(5) The amount of reimbursement for a married couple when both spouses are eligible for the reimbursement but are covered under their own separate employer-sponsored plans, will be provided as described in subsection (3) for each spouse.

(6) Benefits provided to a Covered-at-Work enrollee are limited to a lifetime maximum of 60 months.

KEY: Medicaid, primary care network, covered-at-work benefits
2003
26-18-3

▼ ▼

Health, Health Care Financing, Coverage and Reimbursement Policy
R414-301
Medicaid General Provisions

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26433
FILED: 07/01/2003, 11:19

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is needed to remove language about the Qualifying Individuals Group 2 (QI-2) program in Section R414-301-1 that ended December 31, 2002, and was not reauthorized by Congress. Modifications are made to some definitions in Section R414-301-2. The amendment also clarifies the repayment requirements of applicants and recipients in Sections R414-301-3 and R414-301-6; and clarifies the agency conference rules in Section R414-301-5; and updates some citations.

SUMMARY OF THE RULE OR CHANGE: The wording about the QI-2 program is being removed from Section R414-301-1. The QI-2 program had a sunset date effective December 31, 2002, set by federal statute. Congress reauthorized the QI-1 program with Pub. L. No. 108-7, but did not reauthorize the QI-2 program. The definition of "recipient" Section in R414-301-2 is being modified because in some places in Rules R414-301 through R414-308, the word recipient is used to mean someone who receives benefits other than medical assistance. Under the definition of reportable changes, the definition of reporting health insurance changes has been modified to include reporting changes in the cost of insurance. In Subsection R414-301-3(12), language was added to clarify the client's responsibility to repay benefits provided pending a fair hearing and that benefits include direct payments to providers, and premiums paid on behalf of the client for Medicare, health insurance, Medicaid health plans, and mental health services. In Section R414-301-5, rules about agency conferences have been modified to make it clear that they are conducted at the Department's discretion and that there is no appeal process for an agency conference. The fair hearing process protects the client's appeal rights; however, the client must request a fair hearing in a timely way even if the client wants to have an agency conference. In Section R414-301-6, language is being added to clarify the repayment

requirements of an applicant or recipient and what may be included in the repayment amount.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 26-18-3

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: 42 CFR 431(F), and 431.220 through 431.246, 2001 ed.

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There is no impact to the state budget because no state dollars were involved in this program.
❖ LOCAL GOVERNMENTS: There is no impact to local governments because they are not involved in this program.
❖ OTHER PERSONS: For individuals who were eligible for QI-2, they will not receive a refund for a portion of their Part B Medicare premiums, an amount that was about $40 annually.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Individuals who were eligible for QI-2 will no longer receive a refund of part of their Part B Medicare premiums, a loss of about $40 annually.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: This change is required by Congressional action eliminating this program for Medicaid. This fiscal impact will be minimal. Rod L. Betit, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W
SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Gayle M. Six at the above address, by phone at 801-538-6895, by FAX at 801-538-6952, or by Internet E-mail at gaylesix@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Rod L. Betit, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-301. Medicaid General Provisions.
R414-301-1. Authority.

The Department of Health may contract with the Department of Workforce Services and the Department of Human Services to do eligibility determinations for one or more of the medical programs listed below. The Department of Health is responsible for the administration of these programs:

(1) Aged Medicaid (AM);
(2) Blind Medicaid (BM);
(3) Disabled Medicaid (DM);
(4) Family Medicaid (FM);
(5) Child Medicaid (CM);
(6) Title IV-E Foster Care Medicaid (FC);
(7) Medicaid for Pregnant Women (PG);
(8) Prenatal Medicaid (PN);
(9) Newborn Medicaid (NB);
(10) Transitional Medicaid (TR);
(11) Refugee Medicaid (RM);
(12) Utah Medical Assistance Program (UMAP);
(13) Qualified Medicare Beneficiary Program (QMB);
(14) Specified Low-Income Medicare Beneficiary Program (SLMB);
(15) Qualifying Individuals[~~ Programs (QI) of which there are two eligibility groups~~], Group 1 Program (QI-1)[~~ and Group 2 (QI-2)~~];
(16) Medicaid Work Incentive;
(17) Medicaid Cancer Program;
(18) Primary Care Network Demonstration, which includes the Primary Care Network and the Covered-at-Work Programs.

R414-301-2. Definitions.

The following definitions apply in rules R414-301 through R414-308:

(1) "Applicant" means any person requesting assistance under any of the programs listed in R414-301.
(2) "Assistance" means medical assistance under any of the programs listed in R414-301.
(3) "CHEC" means Child Health Evaluation and Care.
(4) "Client" means an applicant or recipient of any of the programs listed in R414-301.
(5) "Department" means the Department of Health.
(6) "Director" or "designee" means the director or designee of the Division of Health Care Financing.
(7) "Local" office means any community office location of the Department of Workforce Services, the Department of Human Services or the Department of Health where an individual may apply for medical assistance programs.
(8) "Outreach location" means any site other than a state office where state workers are located to accept applications for medical assistance programs. Locations include sites such as hospitals, clinics, homeless shelters, etc.
(9) "QI-1" means the Qualifying Individuals Group 1 program.
(10) "QMB" means Qualified Medicare Beneficiary.
(11) "Recipient" means any individual receiving assistance under any of the programs [~~discussed~~]listed in R414-301-1. It may also be used to mean someone who is receiving other assistance or benefits such as SSI, in which case the text will specify such other type of benefit or assistance.
(12) "Reportable change" means any change in circumstances which could affect a client's eligibility for Medicaid, including:
(a) change in the source of income;
(b) change of more than $25 in gross income;
(c) changes in household size;
(d) changes in residence;
(e) gain of a vehicle;
(f) change in resources;

(g) change of more than $25 in total allowable deductions;
(h) changes in marital status, deprivation, or living arrangements;
(i) pregnancy or termination of a pregnancy;
(j) onset of a disabling condition; and
(k) change in health insurance coverage including changes in the cost of coverage.

(13) "Resident of a medical institution" means a single client who is a resident of a medical institution from the month after entry into a medical institution until the month prior to discharge from the institution. Death in a medical institution is not considered a discharge from the institution and does not change the client's status as a resident of the medical institution. Married clients are residents of an institution in the month of entry into the institution and in the month they leave the institution.

(14) "SLMB" means Specified Low-Income Medicare Beneficiary.

(15) "Spenddown" means an amount of income in excess of the allowable income standard that must be paid in cash to the department or incurred through the medical services not paid by Medicaid, or some combination of these.

(16) "Spouse" means any individual who has been married to a client or recipient and has not legally terminated the marriage.

(17) "Worker" means a state employee who determines eligibility for Medicaid.

R414-301-3. Client Rights and Responsibilities.

(1) Anyone may apply or reapply any time for any program.

(2) If someone needs help to apply he may have a friend or family member help, or he may request help from the local office or outreach staff.

(3) Workers will identify themselves to clients.

(4) Clients will be treated with courtesy, dignity and respect.

(5) Workers will ask for verification and information clearly and courteously.

(6) If a client must be visited after working hours, the worker will make an appointment.

(7) Workers will not enter a client's home without the client's permission.

(8) Clients must provide requested verifications within the time limits given. The Department may grant additional time to provide information and verifications upon client request.

(9) Clients have a right to be notified about the decision made on an application or other action taken [~~which~~]that affects their eligibility for benefits.

(10) Clients may look at most information about their case.

(11) Anyone may look at the policy manuals located at any department local office.

(12) The client must repay any understated liability. The client is responsible for repayments due to ineligibility including benefits received pending a fair hearing decision. In addition to payments made directly to medical providers, benefits include Medicare or other health insurance premiums, premium payments made in the client's behalf to Medicaid Health Plans and mental health providers even if the client does not receive a direct medical service from these entities.

(13) The client must report a reportable change as defined in R414-301-2(12) to the local office within ten days of the day the change becomes known.

R414-301-4. Safeguarding Information.

(1) The department adopts 42 CFR 431(F), [~~2000~~]2001 ed., which is incorporated by reference. The department requires compliance with Sections 63-2-101 through 63-2-909.[
~~(2) Current department practices:~~]

([~~a~~]2) Workers shall safeguard all information about specific clients.

([~~b~~]3) There are no provisions for taxpayers to see any information from client records.

([~~c~~]4) The director or designee shall decide if a situation is an emergency warranting release of information to someone other than the client. The information may be released only to an agency with comparable rules for safeguarding records. The information released cannot include information obtained through an income match system.

R414-301-5. Complaints and Agency Conferences.

(1) A client may request an agency conference at any time to resolve a problem regarding the client's case. Requests shall be granted at the department's discretion. Clients may have an authorized representative attend the agency conference.

(2) Requesting an agency conference does not prevent a client from also requesting a fair hearing in the event the agency conference does not resolve the client's concerns.

(3) Having an agency conference does not extend the time period in which a client has to request a fair hearing.

(4) There is no appeal to the decisions made during an agency conference; however, if the client is not satisfied with the results of the agency conference, and makes a timely request for a fair hearing as defined in R414-306-6, the client may proceed with the formal fair hearing process.

(5) The department must provide proper notice as defined in R414-308-802 of any adverse changes in the client's eligibility that are made as a result of the agency conference. The client then has a right to request a fair hearing based on the new decision letter of an adverse action.

R414-301-6. Hearings.

(1) The department adopts 42 CFR 431.220 through 431.246, [~~2000~~]2001 ed., which is incorporated by reference. The department requires compliance with Title 63, Chapter 46b.

(2) If a client's hearing request concerns only medical assistance, the department shall conduct a formal hearing.

(3) If a client's hearing request concerns food stamps or financial assistance in addition to medical assistance, the Department of Workforce Services shall conduct an informal hearing.

(4) Hearings may be conducted by telephone [~~when~~]if the client agrees to that procedure.

(5) Clients must request a hearing in writing. The written request must include a clear expression stating a desire to present their case.

(6) Clients must ask for the hearing within 90 days of the mailing date of the notice regarding a disagreement with any proposed action.

(7) The hearing officer may schedule one or more pre-hearing conferences to clarify the issues to be heard at the hearing and to arrange exchange of relevant documents.

(8) If the hearing was conducted by the department, the client may appeal the hearing decision to the Court of Appeals.

(9) If the hearing was conducted by the Department of Workforce Services, the client may appeal a hearing decision to the director of the Division of Adjudication within the Department of Workforce Services, or to the District Court.

(10) [~~When~~]If an action requires advance notice, the recipient shall continue to receive assistance if the hearing is requested before the effective date of the action, or within ten days of the mailing date of the notice of action. If the agency action is upheld, the client [~~may be asked to~~]is responsible for repayment of benefits [~~received~~]paid by the department on behalf of the client pending a final hearing decision. The recipient may choose not to accept the benefits offered pending a hearing decision.

(11) [~~When~~]If an agency action does not require advance notice, assistance shall be reinstated if a hearing is requested within ten days of the mailing date of the notice unless the sole issue is one of state or federal law or policy.

(12) An applicant who has requested a hearing shall receive medical assistance if the hearing decision has not been issued within 21 days of the request. To receive benefits pending the hearing decision, the applicant must request the hearing within 10 days of the mailing date of the notice with which the applicant disagrees. The benefits shall begin on the same date had the application been approved but no earlier than the first day of the application month. If the agency action is upheld, the client is responsible for repayment of benefits paid by the department on behalf of the client pending a final hearing decision. Retroactive benefits shall not be approved unless the applicant would be eligible even if the [~~Agency~~]department prevailed at the hearing. The applicant may choose not to accept the benefits offered pending a hearing decision.

(13) Final administrative action shall be taken within 90 days from the request for a hearing unless the client asks for a postponement or additional time is needed to allow all parties time to present and respond to the issues. The period of postponement may be added to the 90 days.

(14) Hearings shall be conducted only at the request of a client; the client's spouse; a minor client's parent; or a guardian of the client, client's spouse, minor client or minor client's parent; or a representative chosen by the client, client's spouse, or minor client's parent.

(15) A hearing contesting resource assessment shall not be conducted until an institutionalized individual has applied for Medicaid.

KEY: client rights, Medicaid
[~~July 1, 2002~~]2003
Notice of Continuation January 31, 2003
26-18

Health, Health Care Financing, Coverage and Reimbursement Policy

R414-310

Medicaid Primary Care Network Waiver

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26430
FILED: 06/30/2003, 13:18

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rulemaking is necessary to implement an amendment to the Primary Care Network (PCN) Waiver called "Primary Care Network - Covered-at-Work". For individuals who have access to health insurance through their employer, this program will provide a cash reimbursement for all or part of the premium paid by those individuals to enroll themselves or their spouses in an employer-sponsored health insurance plan. In addition, the rulemaking clarifies that there is an upper age limit and that individuals may not participate in the PCN program or the Covered-at-Work program after they turn 65 years of age. This rulemaking includes clarification that Veterans who are eligible to enroll in the Veterans Administration (VA) Health Care System, may participate in the PCN while waiting for their enrollment in the VA Health Care System to become effective. This rule change also includes a change in the enrollment fee for PCN to $15 for individuals and couples who receive General Assistance through the Department of Workforce Services.

SUMMARY OF THE RULE OR CHANGE: There are numerous places throughout the entire rule (R414-310) where the name of the new program, Covered-at-Work, must be added. Subsection R414-310-2(12) will be changed to define both parts of the PCN program, the PCN which provides primary medical services to eligible individuals and the Covered-at-Work program which provides a cash reimbursement for premiums paid to enroll an individual and/or his spouse in employer sponsored health insurance coverage. Subsection R414-310-3(8) will be changed to distinguish between reporting requirements for the PCN program and the Covered-at-Work program. A new Subsection R414-310-3(11) is added to Section R414-310-3 to explain that enrollees in the Covered-at-Work program must continue to pay premiums and remain enrolled in their employer sponsored health insurance to be eligible for benefits. Subsection R414-310-4(4) has been reworded for clarity. Subsection R414-310-7(2) has been modified to make it clear that individuals who are covered by Part A or B Medicare, student health insurance, or the VA's Health Care System at the time of application are not eligible for the PCN program or the Covered-at-Work program. Subsection R414-310-7(3) has been changed to explain that eligibility for individuals who have access to employer-sponsored health insurance will be determined as follows: if the cost of coverage does not exceed 5% of the household's gross income, they are not eligible for the PCN program or the Covered-at-Work program. If the cost of coverage exceeds 5% but does not exceed 15% or the household's gross income, the individual may be eligible for the Covered-at-Work program but not the PCN program. If the cost of coverage

exceeds 15% of the household's gross income, the individual may choose between the PCN program and the Covered-at-Work program. To be eligible for the Covered-at-Work Program, the individual must enroll in the employer sponsored health insurance coverage. A new Subsection R414-310-7(5) has been added to Section R414-310-7 to explain that an individual who is eligible to enroll in the VA's Health Care System but who is not enrolled at the time of application can be eligible for the PCN program or Covered-at-Work program while waiting for their enrollment in the VA Health Care System to become effective. To be eligible during this time, the individual must initiate the process to enroll in the VA Health Care System. Subsections R414-310-7(5), (6), (7), and (8) have been renumbered. The new Subsection R414-310-7(7) has been changed to say the individuals who voluntarily drop coverage through a COBRA plan or the State Health Insurance Pool (HIP) can be eligible without a six-month waiting period. The new Subsection R414-310-7(9) has been reworded for clarity. The original Subsection R414-310-7(9) is being removed because it is a duplication from another section. Section R414-310-9 has been changed to explain that an individual is not eligible for the PCN program or the Covered-at-Work program after turning age 65. Eligibility will end at the end of the month of the 65th birthday. Subsection R414-310-13(5) has been changed to say that the enrollment fee for individuals or married couples who are receiving General Assistance through the Department of Workforce Services is $15. The enrollment fee for all other individuals or married couples is still $50. The wording in Subsection R414-310-13(6) has been changed from "an additional family member" to "spouse". This is because only a spouse and no other family member can be added to this program. Subsection R414-310-14(2) has been reworded for clarity. Subsection R414-310-15(4) has been changed so that the application month does not count in the first 12-month certification period. A new Subsection R414-310-15(5) has been added to explain that PCN program enrollees will lose coverage when they enroll in any type of group health plan or other creditable health insurance coverage and if they enroll in employer-sponsored coverage. They may switch to the Covered-at-Work program if they report within 10 days and meet the requirements in Subsections R414-310-7(3)(b) or (c). Subsection R414-310-7(6) has been added to explain that an enrollee in the PCN who reports within 10 days that he or she has gained access to employer-sponsored coverage may either switch to the Covered-at-Work program based on the requirements defined in Section R414-310-7 and on the requirement that the individual enroll in the employer-sponsored coverage, or may remain on the PCN through the end of the current certification period if the individual chooses not to enroll in the employer-sponsored coverage. Subsection R414-310-7(8) formerly Subsection R414-310-7(5) has been changed to say that when the PCN program or the Covered-at-Work program closes and remains closed for one or more calendar months for any reason other than going on to another Medicaid program, the individual must reapply. Subsection R414-310-7(9) has been added to explain that when the case closes because the individual has become eligible for another Medicaid program that the individual may go back on to the PCN program or the Covered-at-Work program for the remainder of the certification period. Subsection R414-310-7(10) has been added to explain that eligibility under the Covered-at-Work program is limited to 60 months for each enrollee.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 26, Chapter 18

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: This filing is a companion to a proposed new rule, R414-300. Impacts for both rules combined are as follows: Covered-At-Work enrollees will be served within the 25,000 enrollee cap established for the PCN program. Therefore, funding for this group will come out of funds already appropriated for the PCN program. (DAR NOTE: The proposed new rule of R414-300 is under DAR No. 26431 in this issue.)

❖ LOCAL GOVERNMENTS: This rule has no effect on local government, since it is believed that no local government employees are eligible. Therefore, there will be no cost to local government.

❖ OTHER PERSONS: This filing is a companion to a proposed new rule, R414-300. Impacts for both rules combined are as follows: Enrollees in the Covered-At-Work program will be positively impacted by this rule since they will receive partial or full reimbursements of their costs to enroll in their employer-sponsored health insurance. Approximately 2,000 individuals will receive reimbursements annually. Assuming the full $50 monthly reimbursement and subtracting the enrollment fee, the aggregate savings to enrollees is $1,100,000.

COMPLIANCE COSTS FOR AFFECTED PERSONS: This filing is a companion to a proposed new rule, R414-300. Impacts for both rules combined are as follows: This rule requires no affirmative compliance by any person. Persons who choose to enroll in the program will pay a $50 annual fee, but will be reimbursed $600 annually for health insurance premium payments.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The PCN program was estimated to use $3,800,000 in General Fund monies and $9,300,000 in federal matching funds in the first year. Those eligible to apply for the Covered-at-Work program are included in the estimates above. It is anticipated that through the Covered-at-Work program, currently uninsured individuals who have insurance available through their employer but were unable to afford the coverage, will save significant amounts of money by now having the opportunity to enroll in health insurance, thereby gaining the ability to get their ongoing health care needs met and avoid more costly acute health care episodes. Rod L. Betit, Executive Director

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HEALTH
HEALTH CARE FINANCING,
COVERAGE AND REIMBURSEMENT POLICY
CANNON HEALTH BLDG
288 N 1460 W

SALT LAKE CITY UT 84116-3231, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Gayleen Henderson at the above address, by phone at 801-538-6135, by FAX at 801-538-6952, or by Internet E-mail at ghenderson@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Rod L. Betit, Executive Director

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-310. Medicaid Primary Care Network Demonstration Waiver.
R414-310-1. Authority.

This rule sets forth the eligibility requirements for enrollment under the Medicaid Primary Care Network. The Primary Care Network is authorized by a waiver of federal Medicaid requirements approved by the federal Center for Medicare and Medicaid Services and allowed under Section 1115 of the Social Security Act effective January 1, 1999. This rule is authorized by Title 26, Chapter 18.

R414-310-2. Definitions.

The following definitions apply throughout this rule:

(1) "Applicant" means an individual who applies for benefits under the Primary Care Network program or the Primary Care Network - Covered-at-Work program, but who is not an enrollee.

(2) "Best estimate" means the Department's determination of a household's income for the upcoming certification period[,] based on past and current circumstances and anticipated future changes.

(3) "Co-payment and co-insurance" means a portion of the cost for a medical service for which the enrollee is responsible to pay for services received under the Primary Care Network.

(4) "Deeming" or "deemed" means a process of counting income from a spouse or an alien's sponsor to decide what amount of income after certain allowable deductions, if any, must be considered income to an applicant or enrollee.

(5) "Department" means the Utah Department of Health.

(6) "Enrollee" means an individual who has applied for and been found eligible for the Primary Care Network program or the Primary Care Network - Covered-at-Work Program and has paid the enrollment fee.

(7) "Enrollment fee" means a payment that an applicant or an enrollee must pay to the Department to enroll in and receive coverage under the Primary Care Network or the Primary Care Network - Covered-at-Work program.

(8) "Income averaging" means a process of using a history of past and current income and averaging it over a determined period of time that is representative of future income.

(9) "Income anticipating" means a process of using current facts regarding rate of pay, number of working hours, and expected changes to anticipate future income.

(10) "Income annualizing" means a process of determining the average annual income of a household, based on the past history of income and expected changes.

(11) "Local office" means any Bureau of Eligibility Services or Department of Workforce Services office location, outreach location, or telephone location where an individual may apply for medical assistance.

(12) "Primary Care Network" [means a]includes two programs under a federal waiver of Medicaid regulations. The two programs are:

(a) The Primary Care Network Program. This program[which] provides primary care medical services to uninsured adults who do not otherwise qualify for Medicaid[.], and;

(b) The Covered-at-Work Program. This program provides cash reimbursement for all or part of the insurance premium paid by an employee for health insurance coverage through an employer-sponsored health insurance plan that covers the employee and the employee's spouse if the spouse is also covered by the employee's plan.

(13) "Recertification month" means the last month of the eligibility period for an enrollee.

(14) "Spouse" means any individual who has been married to an applicant or enrollee and has not legally terminated the marriage.

(15) "Verifications" means the proofs needed to decide if an individual meets the eligibility criteria to be enrolled in the program. Verifications may include hard copy documents such as a birth certificate, computer match records such as Social Security benefits match records, and collateral contacts with third parties who have information needed to determine the eligibility of the individual.

(16) "Student health insurance plan" means a health insurance plan that is offered to students directly through a university or other educational facility or through a private health insurance company that offers coverage plans specifically for students.

R414-310-3. Applicant and Enrollee Rights and Responsibilities.

(1) Any person may apply or reapply any time for any program.

(2) If a person needs help to apply, he may have a friend or family member help, or he may request help from the local office or outreach staff.

(3) Applicants and enrollees must provide requested information and verifications within the time limits given. The Department may grant additional time to provide information and verifications upon request of the applicant or enrollee.

(4) Applicants and enrollees have a right to be notified about the decision made on an application, or other action taken which affects their eligibility for benefits.

(5) Applicants and enrollees may look at information in their case file that was used to make an eligibility determination.

(6) Anyone may look at the policy manuals located at any Department local office.

(7) An individual must repay any benefits received under the Primary Care Network program or the Covered-at-Work program if the Department determines that the individual was not eligible to receive such benefits[coverage under the Primary Care Network].

(8) Applicants and enrollees must report certain changes to the local office within ten days of the day the change becomes known. The Department shall notify the applicant at the time of application of the changes that the enrollee must report. Some examples of reportable changes include:

(a) An enrollee in the Primary Care Network program begins to receive coverage under a group health plan or other health insurance coverage.

(b) An enrollee in the Primary Care Network program begins to have access to coverage under a group health plan or other health insurance coverage.

(c) An enrollee in the Covered-at-Work program no longer pays for coverage under an employer-sponsored health plan.

(d) An enrollee in the Primary Care Network program or the Covered-at-Work program begins to receive coverage under, or begins to have access to student health insurance, Medicare Part A or B, or the Veteran's Administration Health Care System.

(e) An enrollee in the Covered-at-Work program has a change in the amount the enrollee pays for coverage under an employer-sponsored health plan.

([~~c~~]f) An enrollee leaves the household or dies.

([~~d~~]g) An enrollee or the household moves out of state.

([~~e~~]h) Change of address of an enrollee or the household.

([~~f~~]i) An enrollee enters a public institution or an institution for mental diseases.

(9) An applicant or enrollee has a right to request an agency conference or a fair hearing as described in R414-301.

(10) An enrollee in the Primary Care Network program is responsible for paying any required co-payments or co-insurance amounts to providers for medical services the enrollee receives which are covered under the Primary Care Network program.

(11) An enrollee in the Covered-at-Work program must continue to pay premiums and remain enrolled in the employer-sponsored health plan to be eligible for benefits.

R414-310-4. General Eligibility Requirements.

(1) The provisions of R414-302-1, R414-302-2, R414-302-3, R414-302-5, and R414-302-6 apply to applicants and enrollees of the Primary Care Network program and the Covered-at-Work program..

(2) An individual who is not a U.S. citizen and does not meet the alien status requirements of R414-302-1 is not eligible for any services or benefits under the Primary Care Network program or the Covered-at-Work program.

(3) Applicants and enrollees are not required to provide Duty of Support information to enroll in the Primary Care Network program or the Covered-at-Work program. An individual who would be eligible for Medicaid but fails to cooperate with Duty of Support requirements required by the Medicaid program cannot enroll in the Primary Care Network program or the Covered-at-Work program.

(4) [~~Medically needy clients can participate in the Primary Care Network in any month they do not pay their spenddown to participate in the Medically Needy Program.~~]Individuals who must pay a spenddown or premium to receive Medicaid can enroll in the Primary Care Network program or the Covered-at-Work program if they meet the program eligibility criteria in any month they do not receive Medicaid.

R414-310-5. Verification and Information Exchange.

The provisions of R414-307-4 apply to applicants and enrollees of the Primary Care Network program and the Covered-at-Work program.

R414-310-6. Residents of Institutions.

The provisions of R414-302-4(1), (3) and (4) apply to applicants and enrollees of the Primary Care Network program and the Covered-at-Work program.

R414-310-7. Creditable Health Coverage.

(1) The Department adopts 42 CFR 433.138(b) and 435.610, 2000 ed., and Section 1915(b) of the Compilation of the Social Security Laws, in effect January 1, 1999, which are incorporated by reference.

(2) An individual who is covered under a group health plan or other creditable health insurance coverage, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), at the time of application is not eligible for enrollment in the Primary Care Network program or the Covered-at-Work program. This includes coverage under Part A or B Medicare, student health insurance, and the Veteran's Administration Health Care System.

(3) Eligibility for the Primary Care Network program or the Covered-at-Work program for[~~A~~] an individual who has access to but has not yet enrolled in health insurance coverage through an employer or a spouse's employer [~~where the employer would pay 50% or more of the applicable insurance premium is not eligible for the Primary Care Network program.~~]will be determined as follows:

(a) If the cost of the employer-sponsored coverage does not exceed 5% of the household's gross income, the individual is not eligible for the Primary Care Network program or the Covered-at-Work program.

(b) If the cost of the employer-sponsored coverage exceeds 5% but does not exceed 15% of the household's gross income, the individual is not eligible for the Primary Care Network program. These individuals may be eligible for the Covered-at-Work program if they choose to enroll in the employer-sponsored coverage.

(c) If the cost of the employer-sponsored coverage exceeds 15% of the household's gross income, the individual may choose to enroll in either the Primary Care Network program or the Covered-at-Work program. To enroll in the Covered-at-Work program, the individual must enroll in the employer-sponsored coverage.

(d) The individual is considered to have access to coverage even if the employer offers coverage only during an open enrollment period.

(4) An individual who is covered under Medicare Part A or Part B, or who could enroll in Medicare Part B coverage, is not eligible for enrollment in the Primary Care Network or the Covered-at-Work program.

(5) An individual who is enrolled in the Veteran's Administration (VA) Health Care System is not eligible for enrollment in the Primary Care Network program or the Covered-at-Work program. An individual who is eligible to enroll in the VA Health Care System, but who has not yet enrolled, may be eligible for the Primary Care Network program or the Covered-at-Work program while waiting for enrollment in the VA Health Care System to become effective. To be eligible during this waiting period, the individual must initiate the process to enroll in the VA Health Care System. Eligibility for the Primary Care Network program or the Covered-at-Work program ends once the individual becomes enrolled in the VA Health Care System.

([~~5~~]6) Individuals who are full-time students at a university or college, and who [~~have access to~~]can enroll in student health insurance coverage [~~from the university or college~~]are not eligible to enroll in the Primary Care Network program or the Covered-at-Work program.

([~~6~~]7) The Department shall deny eligibility if the applicant or spouse has voluntarily terminated health insurance coverage within the six months immediately prior to the application date for enrollment under the Primary Care Network program or the Covered-at-Work program. Eligibility for the Primary Care Network or the Covered-at-Work program may begin six months after the prior insurance coverage

expires. An applicant or applicant's spouse who voluntarily discontinues health insurance coverage under a COBRA plan or under the state Health Insurance Pool, or who is involuntarily terminated from an employer's plan may be eligible for the Primary Care Network or the Covered-at-Work program without a six month waiting period.

([~~7~~]8) Notwithstanding the limitations in this section, an individual with creditable health coverage operated or financed by the Indian Health Services may enroll in the Primary Care Network program or the Covered-at-Work program.

([~~8~~]9) [~~Each applicant~~]Individuals must report at application and recertification whether[~~each enrollee must report at certification review for~~] each individual for whom enrollment is being requested[~~, whether such individuals have~~] has access to or [~~are~~]is covered by a group health plan or other creditable health insurance coverage.[~~, including~~] This includes coverage which may be available through an employer or a spouse's employer, [~~or through~~]a student health insurance[~~university or college~~] plan, Medicare Part A or B, or the VA Health Care System.[

~~(9) An enrollee must report when any enrollee in the household begins to receive coverage under, or begins to have access to, any type of group health plan or other creditable health insurance coverage.~~]

(10) The Department shall deny an application or recertification if the applicant or enrollee fails to respond to questions about health insurance coverage for any individual the household seeks to enroll or recertify in the program.

R414-310-8. Household Composition.

(1) The following individuals are included in the household when determining household size for the purpose of computing financial eligibility for the Primary Care Network Program or the Covered-at-Work program:

(a) the individual;

(b) the individual's spouse living with the individual; and

(c) any dependent children of the individual or the individual's spouse who are under age 19 and living with the individual.

(2) A household member who is temporarily absent for schooling, training, employment, medical treatment or military service, or who will return home to live within 30 days from the date of application is considered part of the household.

R414-310-9. Age Requirement.

(1) An individual must be at least 19 and not yet 65 years of age [~~or older~~]to enroll in the Primary Care Network program or the Covered-at-Work program.

(2) The month in which an individual's 19th birthday occurs is the first month the person can be eligible for enrollment in the Primary Care Network program or the Covered-at-Work program; however, if the individual could enroll in the Children's Health Insurance Program for that month, the individual cannot enroll in the Primary Care Network program or the Covered-at-Work program until the following month.

(3) The benefit effective date for the Primary Care Network program or the Covered-at-Work program cannot be earlier than the date of the 19th birthday.

(4) The individual's 65th birthday month is the last month the person can be eligible for enrollment in the Primary Care Network program or the Covered-at-Work program.

R414-310-10. Income Provisions.

(1) To be eligible to enroll in the Primary Care Network program or the Covered-at-Work program, a household's countable gross income must be equal to or less than 150% of the federal non-farm poverty guideline for a household of the same size. An individual with income above 150% of the federal poverty guideline is not allowed to spend down income to be eligible under the Primary Care Network program or the Covered-at-Work program. All gross income, earned and unearned, received by the individual and the individual's spouse is counted toward household income, unless this section specifically describes a different treatment of the income.

(2) Any income in a trust that is available to, or is received by a household member, is countable income.

(3) Payments received from the Family Employment Program, Working Toward Employment program, refugee cash assistance or adoption support services as authorized under Title 35A, Chapter 3 are countable income.

(4) Rental income is countable income. The following expenses can be deducted:

(a) taxes and attorney fees needed to make the income available;

(b) upkeep and repair costs necessary to maintain the current value of the property;

(c) utility costs only if they are paid by the owner; and

(d) interest only on a loan or mortgage secured by the rental property.

(5) Cash contributions made by non-household members are counted as income unless the parties have a signed written agreement for repayment of the funds.

(6) The interest earned from payments made under a sales contract or a loan agreement is countable income to the extent that these payments will continue to be received during the certification period.

(7) Needs-based Veteran's pensions are counted as income. Only the portion of a Veteran's Administration check to which the individual is legally entitled is countable income.

(8) Child support payments received by a parent in the household which is in repayment of past due child support is counted as income for the parent. Current child support payments received for a dependent child living in the home are counted as that child's income.

(9) In-kind income, which is goods or services provided to the individual from a non-household member and which is not in the form of cash, for which the individual performed a service or which is provided as part of the individual's wages is counted as income. In-kind income for which the individual did not perform a service, or did not work to receive, is not counted as income.

(10) Supplemental Security Income and State Supplemental payments are countable income.

(11) Income, unearned and earned, shall be deemed from an alien's sponsor, and the sponsor's spouse, if any, when the sponsor has signed an Affidavit of Support pursuant to Section 213A of the Immigration and Nationality Act on or after December 19, 1997. Sponsor deeming will end when the alien becomes a naturalized U.S. citizen, or has worked 40 qualifying quarters as defined under Title II of the Social Security Act or can be credited with 40 qualifying work quarters. Beginning after December 31, 1996, a creditable qualifying work quarter is one during which the alien did not receive any federal means-tested public.

(12) Income that is defined in 20 CFR 416(K) Appendix, 2000 edition, which is incorporated by reference, is not countable.

(13) Payments that are prohibited under other federal laws from being counted as income to determine eligibility for federally-funded medical assistance programs are not countable.

(14) Death benefits are not countable income to the extent that the funds are spent on the deceased person's burial or last illness.

(15) A bona fide loan that an individual must repay and that the individual has contracted in good faith without fraud or deceit, and genuinely endorsed in writing for repayment is not countable income.

(16) Child Care Assistance under Title XX is not countable income.

(17) Reimbursements of Medicare premiums received by an individual from Social Security Administration or the State Department of Health are not countable income.

(18) Earned and unearned income of a child who is under age 19 is not counted if the child is not the head of a household.

(19) Educational income, such as educational loans, grants, scholarships, and work-study programs are not countable income. The individual must verify enrollment in an educational program.

(20) Reimbursements for employee work expenses incurred by an individual are not countable income.

(21) The value of food stamp assistance is not countable income.

R414-310-11. Budgeting.

This section describes methods that the Department uses to determine the household's countable monthly or annual income.

(1) The gross income of all household members is counted in determining the eligibility of the applicant or enrollee, unless the income is excluded under this rule. Only expenses that are required to make an income available to the individual are deducted from the gross income. No other deductions are allowed.

(2) The Department determines monthly income by taking into account the months of pay where an individual receives a fifth paycheck when paid weekly, or a third paycheck when paid every other week. The Department multiplies the weekly amount by 4.3 to obtain a monthly amount. The Department multiplies income paid biweekly by 2.15 to obtain a monthly amount.

(3) The Department shall determine an individual's eligibility prospectively for the upcoming certification period at the time of application and at each recertification for continuing eligibility. The Department determines prospective eligibility by using the best estimate of the household's average monthly income that is expected to be received or made available to the household during the upcoming certification period. The Department prorates income that is received less often than monthly over the certification period to determine an average monthly income. The Department may request prior years' tax returns as well as current income information to determine a household's income.

(4) Methods of determining the best estimate are income averaging, income anticipating, and income annualizing. The Department may use a combination of methods to obtain the most accurate best estimate. The best estimate may be a monthly amount that is expected to be received each month of the certification period, or an annual amount that is prorated over the certification period. The Department may use different methods for different types of income received in the same household.

(5) The Department determines farm and self-employment income by using the individual's most recent tax return forms. If tax returns are not available, or are not reflective of the individual's current farm or self-employment income, the Department may request income information from the most recent time period during which the individual had farm or self-employment income. The Department deducts 40% of the gross income as a deduction for business expenses to determine the countable income of the individual. For individuals who have business expenses greater than 40%, the Department may exclude more than 40% if the individual can demonstrate that the actual expenses were greater than 40%. The Department deducts the same expenses from gross income that the Internal Revenue Service allows as self-employment expenses.

(6) The Department may annualize income for any household and specifically for households that have self-employment income, receive income sporadically under contract or commission agreements, or receive income at irregular intervals throughout the year.

(7) The Department may request additional information and verification about how a household is meeting expenses if the average household income appears to be insufficient to meet the household's living expenses.

R414-310-12. Assets.

There is no asset test for eligibility in the Primary Care Network program or the Covered-at-Work program.

R414-310-13. Application Procedure.

(1) The Department adopts 42 CFR 435.907 and 435.908, 2000 ed., which are incorporated by reference.

(2) The applicant must complete and sign a written application or complete an application on-line via the Internet to enroll in the Primary Care Network program or the Covered-at-Work program.

(3) The Department accepts any Department-approved application form for medical assistance programs offered by the state as an application for the Primary Care Network program or the Covered-at-Work program.

(a) If an applicant cannot write, he must make his mark on the application form and have at least one witness to the signature.

(b) The date of application is the day the signed application form is received by the Department.

(c) If a legal guardian or power of attorney has been appointed, or there is a payee for the individual, the Department shall make all forms and other documents in the name of both the individual and the individual's representative.

(d) An authorized representative may apply for the applicant if unusual circumstances prevent the individual from completing the application process himself. The applicant must sign the application form if possible.

(e) The Department shall reinstate a medical case without requiring a new application if the case was closed in error. The Department shall not require a new application if the case was closed for failure to complete a recertification or comply with a request for information or verification if the enrollee complies before the effective date of the case closure or by the end of the month immediately following the month the case was closed.

(4) An applicant may withdraw an application for the Primary Care Network program or the Covered-at-Work program any time before the Department completes an eligibility decision on the application.

(5) The applicant shall pay [~~a $50~~]an annual enrollment fee to enroll in the Primary Care Network Program or the Primary Care Network - Covered-at-Work Program once the Department has determined that the individual meets the eligibility criteria for enrollment.

(a) Coverage does not begin until the Department receives the enrollment fee.

(b) The [~~$50~~]enrollment fee covers both the individual and the individual's spouse if the spouse is also requesting enrollment in the Primary Care Network or the Primary Care Network - Covered-at-Work Program.

(c) The [~~$50~~]enrollment fee is required at application, and at each recertification.

(d) The [~~$50~~]enrollment fee must be paid to the Department in cash, or by check or money order made out to the Department of Health.

(e) The enrollment fee for an individual or married couple receiving General Assistance from the Department of Workforce Services is $15. The enrollment fee for any other individual or married couple is $50.

(6) If an eligible household requests enrollment for a spouse[~~an additional family member~~], the application date for the spouse[~~additional family member~~] is the date of the request. A new application form is not required[~~ to enroll the additional family member~~]; however, the household shall provide the information necessary to determine eligibility for the spouse[~~additional family member~~], including information about access to creditable health insurance, including Part A or B Medicare, student health insurance, and the VA Health Care System[~~for that family member~~].

(a) Coverage or benefits for the spouse[~~additional family member~~] will be allowed from the date of application through the end of the current certification period.

(b) A new enrollment fee is not required to add a spouse[~~an additional household member~~] during the current certification period.

(c) A new income test is not required to add the spouse[~~new family member~~] for the months remaining in the current certification period.

(d) A spouse[~~Additional household members~~] may be added only if the Department has not stopped enrollment under section R414-310-16.

(e) Income of the spouse[~~new family member~~] will be considered and payment of the enrollment fee will be required at the next scheduled recertification.

R414-310-14. Eligibility Decisions and Recertification.

The Department adopts 42 CFR 435.911 and 435.912, 2000 ed., which are incorporated by reference.

(1) At application and recertification, the Department shall determine if the individual is eligible for Medicaid before determining eligibility for the Primary Care Network program or the Covered-at-Work program. An individual who is eligible for a Medicaid program without paying a spenddown cannot enroll in the Primary Care Network program or the Covered-at-Work program. If the individual must pay a spenddown to become eligible for Medicaid, the individual may choose to enroll in the Primary Care Network program or the Covered-at-Work program instead of paying a spenddown to receive Medicaid.

(2) To enroll, the individual must meet the eligibility criteria for enrollment in the Primary Care Network program or the Covered-at-Work program, [~~pay the enrollment fee,~~]and it must be a time when the Department has not stopped enrollment under section R414-310-16. For the Primary Care Network program, the individual must pay the enrollment fee.

(3) The Department shall complete a determination of eligibility or ineligibility for each application unless:

(a) the applicant voluntarily withdraws the application and the Department sends a notice to the applicant to confirm the withdrawal;

(b) the applicant died; or

(c) the applicant cannot be located or has not responded to requests for information within the 30 day application period.

(4) The enrollee must recertify at least every 12 months.

(5) The Department may require the applicant, the applicant's spouse, or the applicant's authorized representative to attend an interview as part of the application and recertification process. Interviews may be conducted in person or over the telephone, at the Department's discretion.

(6) The enrollee must complete the recertification process and provide the required verifications by the end of the recertification month. The case will be closed at the end of the recertification month if the enrollee does not complete the recertification process and provide required verifications by the end of the recertification month. If an enrollee does not complete the recertification by the end of the recertification month, but completes the process and provides required verifications by the end of the month immediately following the recertification month, coverage will be reinstated as of the first of that month if the individual continues to be eligible and pays the enrollment fee.

(7) The Department may extend the recertification due date if the enrollee demonstrates that a medical emergency, death of an immediate family member, natural disaster or other similar cause prevented the enrollee from completing the recertification process on time.

R414-310-15. Effective Date of Enrollment and Enrollment Period.

(1) The effective date of enrollment in the Primary Care Network program or the Covered-at-Work program is the day that a completed and signed application or an on-line application is received by the Department. The Department shall not provide any benefits or pay for any services received before the effective enrollment date.

(2) The effective date of re-enrollment for a recertification in the Primary Care Network program or the Covered-at-Work program is the first day of the month after the recertification month, if the recertification is completed [~~by the end of the recertification month or the month immediately following the recertification month, the enrollee continues to be eligible, and the enrollee pays the recertification enrollment fee~~]as described in R414-310-14, (6).

(3) If the enrollee does not complete the recertification as described in R414-310-14, (6)[~~by the end of the recertification month, or by the end of the month immediately following the recertification month~~], and the enrollee does not have good cause for missing the deadline, the effective date of re-enrollment in the Primary Care Network program or the Covered-at-Work program, shall be the day that a completed recertification form, or a new application form, is received by the Department. If a gap in enrollment occurs because an enrollee does not complete the recertification process within this time frame, the Department shall not cover medical expenses incurred before the new enrollment effective date for the Primary Care Network program or provide reimbursement for premiums paid in a month for which the individual was not enrolled in the Covered-at-Work program.

(4) An individual found eligible for the Primary Care Network program or the Covered-at-Work program shall [~~receive~~]be eligible from the date of application through the end of the application month and for the following 12 months.[~~ of coverage unless the individual dies, moves out of state, cannot be located, begins to be covered or to have access to coverage under a group health plan or other creditable health insurance coverage, becomes eligible for Medicaid, or enters a public institution or an Institute for Mental Disease.~~] If the enrollee completes the redetermination process in accordance with R414-310-14(6) and continues to be eligible, the recertification period will be for an additional 12 months. Eligibility could end before the end of a 12-month certification period for any of the following reasons:

(a) the individual turns age 65;

(b) the individual dies;

(c) the individual moves out of state or cannot be located;

(d) the individual enters a public institution or an Institute for Mental Disease.

(e) an individual on the Covered-at-Work program discontinues enrollment in employer-sponsored insurance coverage.

(5) An individual enrolled in the Primary Care Network program loses eligibility when the individual enrolls in any type of group health plan or other creditable health insurance coverage including employer-sponsored coverage. However, an individual who enrolls in an employer-sponsored plan may switch to the Covered-at-Work program if the individual reports to the Department within 10 days of enrolling that he or she has enrolled in an employer-sponsored plan, and if the requirements defined in R414-310-7(3)(b) or (c) are met.

(6) An enrollee in the Primary Care Network who reports within 10 days that he or she has gained access to enroll in employer-sponsored coverage may either switch to the Covered-at-Work program based on the requirements of R414-310-7 and on the requirement that the individual enrolls in the employer-sponsored coverage, or may remain on the Primary Care Network through the end of the current certification period if the individual chooses not to enroll in the employer-sponsored coverage.

(7) An individual enrolled in the Primary Care Network program or Covered-at-Work program loses eligibility when the individual enrolls in or gains access to student health insurance, Medicare Part A or B or the Veteran's Administration Health Care System.

([5]8) [When]If a Primary Care Network or Covered-at-Work case closes for any reason, other than to become covered by another Medicaid program, and remains closed for one or more calendar months, the individual must submit a new application to the Department to reapply. The individual must meet all the requirements of a new applicant including paying a new enrollment fee.

(9) If a Primary Care Network or Covered-at-Work case closes because the enrollee is eligible for another Medicaid program and there is no break in coverage between the programs, the individual may reenroll in the Primary Care Network or the Covered-at-Work program for the remainder of the current certification period. The individual is not required to complete a new application or have a new income eligibility determination. The individual must continue to meet the criteria defined in R414-310-7. The individual is not required to pay a new enrollment fee for the months remaining in the current certification period.

(10) Lifetime eligibility for benefits under the Covered-at-Work program is limited to 60 months for each enrollee.

R414-310-16. Enrollment Limitation.

The Department shall limit enrollment in the Primary Care Network program and the Covered-at-Work program.

(1) The Department may stop enrollment of new individuals at any time based on availability of funds.

(2) The Department shall not maintain waiting lists during a time period that enrollment of new individuals is stopped.

(3) If enrollment has not been stopped, individuals may apply for the Primary Care Network program or the Covered-at-Work program.[Eligibility will be on a first-come, first-served basis during any open enrollment period.]

R414-310-17. Notice and Termination.

(1) The department adopts 42 CFR 431.206, 431.210, 431.211, 431.213, 431.214, 435.919, 2000 ed., which are incorporated by reference.

(2) The Department shall notify an applicant or enrollee in writing of the eligibility decision made on the application or the recertification.

(3) The Department shall terminate an individual's enrollment upon enrollee request or upon discovery that the individual is no longer eligible. The Department shall terminate an individual's enrollment if the individual fails to complete the recertification process on time.

R414-310-18. Improper Medical Coverage.

(1) An individual who receives benefits under the Primary Care Network program or the Covered-at-Work program for which he is not eligible is responsible to repay the Department for the cost of the benefits received.

(2) [If the sponsor of an alien does not provide correct information, the]An alien and the alien's sponsor are jointly liable for benefits received for which the individual was not eligible.

KEY: primary care, demonstration
[July 1, 2002]2003
26-18-1

▼ ———————————————— ▼

Human Services, Administration, Administrative Hearings
R497-100
Adjudicative Proceedings

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26396
FILED: 06/17/2003, 12:09

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This amendment is made to add a new section on declaratory orders (Section R497-100-7) as required by Section 63-46b-21; to revise the record retention section (Section R497-100-6) regarding hearing tapes to more closely conform to Utah State Archive rules requiring retention for one year; and to add some language for clarification.

SUMMARY OF THE RULE OR CHANGE: The changes set out the form and process for requesting a declaratory order determining the applicability of a statute, rule, or order; and change the retention period for hearing tapes from 45 days to one year.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 63-46b-21 and Subsection 63-2-905(3)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: Under $300 expense to purchase additional recording tapes. Tapes will be reused at the end of the year retention.

❖ LOCAL GOVERNMENTS: None--Parties have always been able to purchase a copy of a hearing tape for a minimal amount. Now parties have a longer period in which to purchase a copy.
❖ OTHER PERSONS: None--Parties have always been able to purchase a copy of a hearing tape for a minimal amount. Now parties have a longer period in which to purchase a copy.

COMPLIANCE COSTS FOR AFFECTED PERSONS: None--Provides a longer period of time to ask for and get a copy of a hearing tape, but does not change the cost to affected persons. Allows request for declaratory opinions at the agency level.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: No impact on businesses. Parties to the hearings have always been able to request and purchase copies of tapes from hearings for the minimal cost of $5 per tape.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
ADMINISTRATION, ADMINISTRATIVE HEARINGS
120 N 200 W 4TH FL
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Virginia S. Smith at the above address, by phone at 801-538-3902, by FAX at 801-538-4604, or by Internet E-mail at gssmith@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/20/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/22/2003

AUTHORIZED BY: Robin Arnold-Williams, Executive Director

R497. Human Services, Administration, Administrative Hearings.
R497-100. Adjudicative Proceedings.
R497-100-1. Definitions.

The terms used in this rule are defined in Section 63-46b-1. In addition,

(1) For the purpose of this section, [the]"agency" means the Department of Human Services or a division or office of the Department of Human Services includ[es]ing the Division of Child and Family Services (DCFS), the Division of Services to People with Disabilities (DSPD), the Division of Youth Corrections (DYC), the Division of Aging and Adult Services (DAAS), the Division of Mental Health (DMH), the Division of Substance Abuse (SA), the Office of Licensing (OL), the Utah State Developmental Center (USDC), the Utah State Hospital (USH), and any boards, commissions, officers, councils, committees, bureaus, or other administrative units, including the Executive Director and Director of the Department or other persons acting on behalf of or under the authority of the Executive Director or Director. For purposes of this section, the term "Department of Human Services" does not include the Office of Recovery Services (ORS). The rules regarding ORS are stated in[delineated at] R527-200.

(2) "Agency actions or proceedings" of the Department of Human Services include, but are not limited to the following:

(a) challenges to findings of abuse, neglect and dependency pursuant to Section 62A-4a-116.5;

(b) due process hearings afforded to foster parents prior to removal of a foster child from their home pursuant to Section [(]62A-4a-206[)];

(c) the denial, revocation, modification, or suspension of any Department foster home license, or group care license;

(d) the denial, revocation, modification or suspension of a license issued by the Office of Licensing pursuant to Section 62A-2-101, et seq.;

(e) challenges to findings of abuse, neglect or exploitation of a disabled or elder adult pursuant to Section 62A-3-301, et seq.;

(f) the licensure of community alternative programs by the Office of Licensing;

(g) actions by the Division of Youth Corrections and the Youth Parole Authority relating to granting or revocation of parole, discipline or, resolution of grievances of, supervision of, confinement of or treatment of residents of any youth corrections facility or institution;

(h) resolution of client grievances with respect to delivery of services by private, nongovernmental, providers within the Department's service delivery system;

(i) actions by Department owned and operated institutions and facilities relating to discipline or treatment of residents confined to those facilities;

(j) placement and transfer decisions affecting involuntarily committed residents of the Utah State Developmental Center pursuant to Sections 62A-5-313;

(k) protective payee hearings;

(l) Department records amendment hearings held pursuant to Section 63-2-603.

(3) "Aggrieved person" includes any applicant, recipient or person aggrieved by an agency action.

(4) "Declaratory Order" is an administrative interpretation or explanation of the applicability of a statute, rule, or order within the primary jurisdiction of the agency to specified circumstances.

[(4)](5) "Office" means the Office of Administrative Hearings in the Department of Human Services.

[(5)](6) "Presiding officer" means an agency head, or individual designated by the agency head, by these rules, by agency rule, or by statute to conduct an adjudicative proceeding and may include the following:

(a) hearing officers;
(b) administrative law judges;
(c) division and office directors;
(d) the superintendent of agency institutions;
(e) statutorily created boards or committees.

R497-100-2. Exceptions.

The provisions of this section do not govern the following:

(1) The procedures for promulgation of agency rules, or the judicial review of those procedures. See S[ubs]ection 63-46b-1(2)(a).

(2) Department actions relating to contracts for the purchase or sale of goods or services by and for the state or by and for the Department, including terminations of contracts by the Department.

(3) Initial applications for and initial determinations of eligibility for state-funded programs[eligibility determinations].

R497-100-3. Form of Proceeding.

(1) All adjudicative proceedings commenced by the Department of Human Services or commenced by other persons affected by the Department of Human Services' actions shall be informal adjudicative proceedings.

(2) However, any time before a final order is issued in any adjudicative proceeding, the presiding officer may convert an informal adjudicative proceeding to a formal adjudicative proceeding if:

(a) conversion of the proceeding is in the public interest; and

(b) conversion of the proceeding does not unfairly prejudice the rights of any party.

(3) If a proceeding is converted from informal to formal, the Procedure for Formal Adjudicative Proceedings in Section 63-46b-1, et seq. shall apply. In all other cases, the Procedures for Informal Proceedings in R497-100-6 shall apply.

R497-100-4. Commencement of Proceedings.

(1) All adjudicative proceedings shall be commenced by either:

(a) a notice of agency action, if proceedings are commenced by the agency; or

(b) a request for agency action, if proceedings are commenced by persons other than the agency.

(2) (a) When adjudicative proceedings are commenced by the agency, the notice of agency action shall conform to Section 63-46b-3(2)(a)[be in writing, signed by the designated presiding officer,] and shall also include:[

(i) the names and mailing addresses of all respondents and other persons to whom notice is being given by the presiding officer, and the name, title, and mailing address of any attorney or employee who has been designated to appear for the agency;

(ii) the agency's file number or other reference number;

(iii) the name of the adjudicative proceeding;

(iv) the date that the notice of agency action was mailed;]

(i)[(v)] a statement that the adjudicative proceeding is to be conducted informally;

(ii)[(vi)] if a hearing is to be held in an informal adjudicative proceeding, a statement of the time and place of any scheduled hearing, a statement of the purpose for which the hearing is to be held, and a statement that a party who fails to attend or participate in the hearing may be held in default; and

(iii)[(vii)] if the agency's rules do not provide for a hearing, a statement that the parties may request a hearing within ten working days of the notice of agency action[;].

[(viii) a statement of the legal authority and jurisdiction under which the adjudicative proceeding is to be maintained;

(ix) the name, title, mailing address, and telephone number of the presiding officer; and

(x) a statement of the purpose of the adjudicative proceeding and, to the extent known by the presiding officer, the questions to be decided.]

(b) The notice of agency action shall be mailed or published in conformance with Section 63-46b-3(2)(b).[The agency shall:

(i) mail the notice of agency action to each party; and

(ii) publish the notice of agency action if required by statute.]

(c) When adjudicative proceedings are commenced by a person other than the agency, the request for agency action shall conform to Section 63-46b-3(3)(a) and (b) and include the name of the adjudicative proceeding, if known.[Where the law applicable to the agency permits persons other than the agency to initiate adjudicative proceedings, that person's request for agency action shall be in writing and signed by the person invoking the jurisdiction of the agency, or by his representative, shall be filed and shall include:

(i) the names and addresses of all persons to whom a copy of the request for agency action is being sent;

(ii) the agency's file number or other reference number;

(iii) the name of the adjudicative proceeding, if known;

(iv) the date that the request for agency action was mailed;

(v) a statement of the legal authority and jurisdiction under which agency action is requested;

(vi) a statement of the relief sought from the agency; and

(vii) a statement of the facts and reasons forming the basis for relief.]

(d) In the case of adjudicative proceedings commenced under Subsection (2)(c) by a person other than the agency, the presiding officer shall within ten working days give notice by mail to all parties. The written notice shall:

(i) give the agency's file number or other reference number;

(ii) give the name of the proceeding;

(iii) designate that the proceeding is to be conducted informally;

(iv) if a hearing is to be held in an informal adjudicative proceeding, state the time and place of any scheduled hearing, the purpose for which the hearing is to be held, and that a party who fails to attend or participate in the hearing may be held in default;

(v) if the agency's rules do not provide for a hearing, state the parties' right to request a hearing within ten working days of the agency's response; and

(vi) give the name, title, mailing address, and telephone number of the presiding officer.

R497-100-5. Availability of Hearing.

(1) Hearings may be held in any informal adjudicative proceedings conducted in connection with an agency action if the aggrieved party requests a hearing and if there is a disputed issue of fact. If there is no disputed issue of fact, the presiding officer may deny a request for a hearing and determine all issues in the adjudicative proceeding, if done in compliance with the policies and standards of the applicable agency. If the aggrieved person objects to the denial of a hearing, that person may raise that objection as grounds for relief in a request for reconsideration.

(2) There is no issue of fact if:

(a) the aggrieved person tenders facts which on their face establish the right of the agency to take the action or obtain the relief sought in the proceeding;

(b) the aggrieved person tenders facts upon the request of the presiding officer and the fact does not conflict with the facts relied upon by the agency in taking its action or seeking its relief.

R497-100-6. Procedures for Informal Proceedings.

In compliance with Section 63-46b-5, the procedure for the informal adjudicative proceedings is as follows:

(1) (a) The respondent to a notice of agency action or request for agency action may, but is not required to, file an answer or responsive pleading to the allegations contained in the notice of agency action or the request for agency action within 10 working days following receipt of the adverse party's pleading.

(b) A hearing shall be provided to any party entitled to request a hearing in accordance with Section 63-46b-5.

(c) In the hearing, the party named in the notice of agency action or in the request for agency action may be represented by counsel and shall be permitted to testify, present evidence and comment on the issues.

(d) Hearings will be held only after a timely notice has been mailed to all parties.

(e) Discovery is prohibited, but[and] the office may issue subpoenas or other orders to compel production of nec[e]essary evidence. The office may require that parties exchange documents prior to the hearing in order to expedite the process. All parties to the proceedings will be responsible for the appearance of witnesses.

(f) All parties shall have access to information contained in the agency's files and to all materials and information gathered in any investigation, to the extent permitted by law.

(g) Intervention is prohibited, except that intervention is allowed where a federal statute or rule require[d]s that a state permit intervention.

(h) Within a reasonable time after the close of the hearing, or after the party's failure to request a hearing within the time prescribed by the agency's rules, the presiding officer shall issue a signed order in writing that conforms to Section 63-46b-5(l)(I).[states the following:

(i) the decision;

(ii) the reasons for the decision;

(iii) a notice of any right of administrative or judicial review available to the parties; and

(iv) the time limits for filing an appeal or requesting a review.]

(i) All hearings shall be open to all parties.

(j) The presiding officer's order shall be based on the facts appearing in the agency's files and on the facts presented in evidence at the hearings.

(k) A copy of the presiding officer's order shall be promptly mailed to each of the parties.

(2) All hearings shall be tape recorded at the office's expense. A transcript of the record may be prepared pursuant to Section 63-46b-5(2)(b).[Any party, at his own expense, may have a reporter approved by the agency prepare a transcript from the office's record of the hearing.] The hearing tape will be maintained for one year[45 days] after the order[hearing decision] has been issued[pursuant to Section 63-46b-5(i)].

R497-100-7. Declaratory Orders.

(1) Who May File. Any person or governmental entity directly affected by a statute, rule or order administered, promulgated or issued by an agency, may file a petition for a declaratory order by addressing and delivering the written petition to the presiding officer of the appropriate agency.

(2) Content of Petition.

(a) The petition shall be clearly designated as a request for an agency declaratory order and shall include the following information;

(i) the statute, rule or order to be reviewed;

(ii) a detailed description of the situation or circumstances at issue;

(iii) a description of the reason or need for a declaratory order, including a statement as to why the petition should not be considered frivolous;

(iv) an address and telephone where the petitioner can be contacted during regular work days;

(v) a statement about whether the petitioner has participated in a completed or on-going adjudicative proceeding concerning the same issue within the past 12 months; and

(vi) the signature of the petitioner or an authorized representative.

(3) Exemptions from Declaratory Order Procedure. A declaratory order shall not be issued by any agency of the Department under the following circumstances:

(a) the subject matter of the petition is not within the jurisdiction and competency of the agency;

(b) the person requesting the declaratory ruling participated in an adjudicative proceeding concerning the same issue within 12 months of the date of the declaratory order request;

(c) the declaratory order procedure is likely to substantially prejudice the rights of a person who would be a necessary party, unless that person consents in writing to a determination of the matter by a declaratory proceeding;

(d) the declaratory order is trivial, irrelevant, or immaterial;

(e) a declaratory order proceeding is otherwise prohibited by state or federal law;

(f) a declaratory order is not in the best interest of the agency or the public;

(g) the subject matter is not ripe for consideration; or

(h) the issue is currently pending in a judicial proceeding.

(4) Intervention in Accordance with 63-46b-5(1)(g) and 63- 46b-21.

(a) Intervention is prohibited in informal adjudicative proceedings, except where a federal statute or rule requires that intervention be permitted.

(b) In the case of an adjudicative proceeding that has been converted to a formal adjudicative proceeding, a person may intervene in a declaratory order proceeding by filing a petition to intervene with the presiding officer of the agency within 30 days after the conversion of the proceeding.

(c) The agency presiding officer may grant a petition to intervene if the petition meets the following requirements:

(i) the intervenor's legal interests may be substantially affected by the declaratory order proceedings; and

(ii) the interests of justice and the orderly and prompt conduct of the declaratory order proceeding will not be materially impaired by allowing intervention.

(5) Review of Petition for Declaratory Order.

(a) After review and consideration of a petition for a declaratory order, the presiding officer of the agency may issue a written order that conforms to Section 63-46b-21(6)(a);

(b) If the matter is set for an adjudicative proceeding, written notice shall be mailed to all parties that shall:

(i) give the name, title, mailing address, and telephone number of the presiding officer;

(ii) give the agency's file number or other reference number;

(iii) give the name of the proceeding;

(iv) state whether the proceeding shall be conducted informally or formally;

(v) state the time and place of any scheduled hearing, the purpose for which the hearing is to be held, and that a party who fails to attend or participate in the hearing may be held in default; and

(vi) if the agency's rules do not provide for a hearing, state the parties' right to request a hearing within 10 working days of the agency's response.

(c) If the agency's presiding officer issues a declaratory order, it shall conform to Section 63-46b-21(6)(b) and shall also contain:

(i) a notice of any right of administrative or judicial review available to the parties; and

(ii) the time limits for filing an appeal or requesting review.

(d) A copy of all declaratory orders shall be mailed in accordance with Section 63-46b-21(6)(c).

(e) If the agency's presiding officer has not issued a declaratory order within 60 days after receipt of the petition, the petition is deemed denied.

R497-100-[~~7~~]8. Agency Review.

Agency review shall not be allowed. Nothing contained in this rule prohibits a party from filing a petition for reconsideration pursuant to Section 63-46b-13. If the 20th day for filing a request for reconsideration falls on a weekend or holiday the deadline will be extended until the next working day.

R497-100-[8]9. Scope and Applicability.

The provisions of this section supersede the provisions of any other Department rules which may conflict with the foregoing rules.

KEY: administrative procedure, social services
[~~August 17, 1999~~]August 30, 2003
Notice of Continuation November 27, 2000
62A-1-110
62A-1-111

Human Services, Mental Health
R523-1-20
Family Involvement in Mental Health Treatment

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26424
FILED: 06/26/2003, 11:26

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: S.B. 27, 2003 General Session, directs the State Division of Substance Abuse and Mental Health to promulgate rules concerning ways to educate families on mental illness and to promote family involvement in treatment. (DAR NOTE: S.B. 27 is found at UT L 2003 Ch 303 and was effective May 5, 2003.)

SUMMARY OF THE RULE OR CHANGE: This new section requires that each mental health authority include in their annual plan for services, a method to educate families concerning mental illness, and to promote family involvement in treatment when it is appropriate and the patient has consented. It also requires that the State Division of Substance Abuse and Mental Health monitor compliance as part of the annual quality of care site visits.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsections 62A-15-103(2) and 17A-3-602(4)(b)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There is no aggregate anticipated cost or saving to the state budget. This proposed section requires that local mental health authorities provide a plan to educate families it does not require that the state provide any material or services other that the annual site visit that is currently required under Section 62A-15-103.

❖ LOCAL GOVERNMENTS: The requirement of the rule is that each local mental health authority develop a plan to educate families and promote family involvement, how they determine to do that will impact cost. There could be a small cost for educational material on mental illness but there are also many brochures that are available at no cost.

❖ OTHER PERSONS: There is no aggregate anticipated costs or savings to other persons. The requirement is for local authorities to provide educational information consequently there will be no anticipated cost to any other person.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There could be a small cost to local mental health providers who contract with governmental entities to provide public mental health services. However, any cost will be determined based on the plan developed by each local authority to educate families on mental illness and involve them in treatment.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The department does not anticipate a fiscal impact on businesses.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
MENTAL HEALTH
120 N 200 W 4TH FL
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Janina Chilton at the above address, by phone at 801-538-4072, by FAX at 801-538-3993, or by Internet E-mail at jchilton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Randall Bachman, Director

R523. Human Services, Mental Health.
R523-1. Policies and Procedures.
R523-1-20. Family Involvement.

A. Each mental heath authority shall annually prepare and submit to the Division of Substance Abuse and Mental Health a plan for mental health funding and service delivery (17A-3-602 (4) (b), (62A-15-109). Included in the plan shall be a method to educate families concerning mental illness and to promote family involvement when appropriate, and with patient consent, in the treatment program of a family member.

B. The State Division of Substance Abuse and Mental Health will monitor for compliance as part of the annual quality of care site visits (62A-15-1003).

KEY: bed allocations, due process, prohibited items and devices, fees
[~~July 2, 2002~~]2003
Notice of Continuation December 11, 2002
62A-12-102

62A-12-104
62A-12-209.6(2)
62A-12-283.1(3)(a)(i)
62A-12-283.1(3)(a)(ii)

▼ ——— ▼

Human Services, Mental Health
R523-1-21
Declaration for Mental Health Treatment

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26425
FILED: 06/26/2003, 13:34

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: S.B. 27, 2003 General Session, directs the State Division of Substance Abuse and Mental Health to promulgate rules to provide information concerning the declaration for mental health treatment under Sections 61A-15-1003 and 62A-15-1002. (DAR NOTE: S.B. 27 is found at UT L 2003 Ch 303 and was effective May 5, 2003.)

SUMMARY OF THE RULE OR CHANGE: This new section directs the State Division of Substance Abuse and Mental Health to develop information on the declaration for mental health treatment. It directs community mental health centers and the Utah State Hospital to distribute material with consumer rights information (Section R523-1-8) at the time of intake. This new section also provides that consumers who choose to complete declarations may request to have them placed in their medical record.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Subsection 62A-15-103(2) and Section 62A-15-1003

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The Division will need to develop a brochure outlining information on the declaration for mental health treatment. It is anticipated the cost will be approximately $1,000.
❖ LOCAL GOVERNMENTS: Mental health centers will only be required to distribute the material along with other information that they currently are required to distribute under Section R523-1-8, this would not require an additional cost.
❖ OTHER PERSONS: The requirement is for local authorities to provide educational information, consequently, there will be no anticipated cost to any other person.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The requirement is for local authorities to provide educational information, consequently, there will be no anticipated cost to any person.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The department does not anticipate a fiscal impact on businesses.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
MENTAL HEALTH
120 N 200 W 4TH FL
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Janina Chilton at the above address, by phone at 801-538-4072, by FAX at 801-538-3993, or by Internet E-mail at jchilton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Randall Bachman, Director

R523. Human Services, Mental Health.
R523-1. Policies and Procedures.
R523-1-21. Declaration for Mental Health Treatment.

A. The State Division of Substance Abuse and Mental Health will make available information concerning the declaration for mental health treatment (62A-15-1003). Included will be information concerning available assistance in completing the document.

B. Each local mental health center shall have information concerning declarations for mental health treatment. Information will be distributed with consumer rights information at the time of intake. (R523-1-8)

C. Utah State Hospital will provide information concerning the declaration for mental health treatment at the time of admittance to the hospital.

D. Consumers who choose to complete a declaration for mental health treatment may deliver a copy to their mental health therapist, to be included as part of their medical record.

KEY: bed allocations, due process, prohibited items and devices, fees
[~~July 2, 2002~~]2003
Notice of Continuation December 11, 2002
62A-12-102
62A-12-104
62A-12-209.6(2)
62A-12-283.1(3)(a)(i)
62A-12-283.1(3)(a)(ii)

▼ ——— ▼

Human Services, Services for People with Disabilities
R539-1-5
Graduated Fee Schedule

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26439
FILED: 07/01/2003, 16:38

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: To comply with H.B. 308, the Division of Services for People with Disabilities is establishing a graduated fee schedule. (DAR NOTE: H.B. 308 is found at UT L 2003 Ch 246, and was effective May 6, 2003.)

SUMMARY OF THE RULE OR CHANGE: The new graduated fee schedule (under new Section R539-1-5) is used to assess and collect fees from Non-Waiver Persons. These are Persons who do not meet the Medicaid financial eligibility requirements listed in the Developmental Disabilities/ Mental Retardation Waiver, the Traumatic Brain Injury Waiver, or the Physical Disabilities Waiver. Family size and gross income shall be used to determine the fee. This section does not apply to Persons who qualify for Medicaid waiver funding but who choose to have funding reduced to the state match per Section R539-1-2 rather than participate in the Medicaid Waiver. (DAR NOTE: A corresponding 120-day (emergency) rule is under DAR No. 26440 in this issue and is effective as of July 1, 2003.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 62a-5-105

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There will be administrative costs to implement the new section that will be absorbed in the current budget. This cost will include time to train staff to implement the new schedule. These are new requirements that are being enacted in the rule, so we are unsure of the actual costs.

❖ LOCAL GOVERNMENTS: No local government funding is used in any of these activities, therefore, it is expected that there is no cost to local governments.

❖ OTHER PERSONS: Eligible Persons shall be assessed an annual fee according to the schedule established in the Division's new fee schedule. The fee is based on the formula (assets + income) / by the total number of family members. Available income below 300% of the poverty level will not be assessed a fee. Non-Waiver Persons with available income between 300% and 399% of poverty will be assessed a 1% fee, those with available income between 400% and 499% of poverty will be assessed a 2% fee and those with available income over 500% of poverty will be assessed a 3% fee. No Person shall be assessed more than 3% of available income. It is estimated that about 30-35 people will have assets or income over 300% of poverty. These individuals will need to pay a fee.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Cost will be to those persons who qualify to pay a fee (see explanation under "Other person").

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes to this rule have no fiscal impact on the providers.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
Room 411
120 N 200 W
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Meredith Mannebach at the above address, by phone at 801-538-4197, by FAX at 801-538-4279, or by Internet E-mail at mmannebach@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Robin Arnold-Williams, Executive Director

R539. Human Services, Services for People with Disabilities.
R539-1. Eligibility.
R539-1-5. Graduated Fee Schedule.

(1) Pursuant to Utah Code 62a-5-105 the Division establishes a graduated fee schedule for use in assessing fees to individuals. The graduated fee schedule shall be applied to Persons who do not meet the Medicaid financial eligibility requirements listed in the Developmental Disabilities/ Mental Retardation Waiver, the Traumatic Brain Injury Waiver or the Physical Disabilities Waiver. Family size and gross income shall be used to determine the fee. This rule does not apply to Persons who qualify for Medicaid waiver funding but who choose to have funding reduced to the state match per R539-1-2 rather than participate in the Medicaid Waiver.

(a) Non-Waiver Persons who do not meet Waiver level of care must apply for a Medicaid Card within 30 days of the effective date of this rule. Non-Waiver Persons who meet Waiver level of care must apply for determination of financial eligibility using Form 927 within 30 days of the effective date of this rule. Non-Waiver Persons shall provide the support coordinator with the determination letter within 10 days of the receipt of such documentation. Non-Waiver Persons who fail to comply with these requirements shall have funding reduced to the state match rate.

(b) Non-Waiver Persons must report all cash assets (stocks, bonds, certified deposits, savings, checking and trust amounts), annual income and number of family members living together using Division Form 2-1G. The Person / family shall submit a new form at the time of the annual planning meeting, if there has been a change in income or assets. The Person / family shall return Form 2-1G to the support coordinator prior to delivery of new services. Persons / families currently receiving services will have 60 days to

return a completed and signed Form 2-1G. Persons / families who complete the Division fee Determination Form shall be assessed a fee no more than 3% of their income. If the form is not received within 60 days, the Person will have funding reduced to the state match rate.

(c) Cash assets, income and number of family members will be used to calculate available income (using the formula: {assets + income} / by the total number of family members = available income). Available income will be used to determine the fee percent (0 percent to 3 percent). The annual fee amount will be calculated by multiplying available income by the fee percent. Non-Waiver persons below 300 percent of the poverty level will not be assessed a fee. Persons with available income between 300 percent and 399 percent of poverty will be assessed a 1 percent fee, those with available income between 400 percent and 499 percent of poverty will be assessed a 2 percent fee and those with available income over 500 percent of poverty will be assessed a 3 percent fee.

(d) No fee shall be assessed for a Non-Waiver person who receives funding for less than 31 percent of the assessed need. A multiplier shall be applied to the fee of Non-Waiver Persons receiving at least 31 percent but less than 100% percent of the assessed need.

(e) If the Person is assessed a fee the Person shall pay the Division of Services for People with Disabilities or designee 1/12th of the annual fee by the end of each month.

(f) Only one fee will be assessed per family, regardless of the number of children in the family receiving services. Non-waiver persons under the age of 18 shall be assessed a fee based upon parent income. Non-waiver persons over the age of 18 shall be assessed a fee based upon individual income and assets.

KEY: disabled persons[~~*~~], social services
[~~November 24, 1998~~]2003
Notice of Continuation December 18, 2002
62A-5-103
62A-5-105

Insurance, Administration

R590-153

Unfair Inducements and Marketing Practices in Obtaining Title Insurance Business

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26422
FILED: 06/26/2003, 09:39

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The main reasons for initially changing this rule are to change the term "agent" to "producer" and to update code references changed as a result of legislation. In the process of making these changes, other housekeeping changes have been made to make the rule more clear.

SUMMARY OF THE RULE OR CHANGE: The changes that have been made to the rule that are other than grammatical or for clarification are as follows: 1) the reference to "title insurance agent" has been changed to "title insurance producer." This change was made to be consistent with the National Association of Insurance Commissioners (NAIC) terminology in their title rule; 2) in Section R590-153-2, adds language to clarify that unfair inducements include expenses incurred by clients; 3) in Section R590-153-3, adds wording disallowing the use of another business owned by a title agent, agency, or insurer to use that business to avoid the provisions of this rule; 4) in Section R590-153-4, makes changes to the definitions of "Producer of title business," "Business Meals," and adds a new definition for "Business Activities"; 5) in Section R590-153-5, makes three significant changes: cancellation fees for title insurance commitments, the method of donating to charitable organizations, and requirement that the underwriter's jacket accompany all title insurance commitments issued; 6) in Section R590-153-6, clarifies the type of information that can be provided without charge; 7) Section R590-153-7 has been marked for elimination from the rule since it is already in the code; and 8) a new section R590-153-7 has been added entitled "Enforcement Date".

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 31A-2-201 and 31A-23a-402

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The changes to this rule will not affect cost or savings to the state budget. No additional people will need to be hired and no additional revenue will be created.
❖ LOCAL GOVERNMENTS: The changes to this rule will not affect local government since it deals solely with the relationship of title producers, agencies, and insurers with the Insurance Department.
❖ OTHER PERSONS: Previously, title agents were required to charge cancellation fees, now they are not. None of the changes will have a fiscal impact on the consumer.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Previously, title agents were required to charge cancellation fees, now they are not. None of the changes will have a fiscal impact on the consumer.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes to this rule are mainly for clarification and will have no fiscal impact on Utah businesses. The regulation of the industry will not change.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2003

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 8/07/2003 at 10:00 AM, Room 4112, State Office Building, Salt Lake City, UT 84114.

THIS RULE MAY BECOME EFFECTIVE ON: 08/18/2003

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.
R590-153. Unfair Inducements and Marketing Practices in Obtaining Title Insurance Business.
R590-153-1. Authority.

This rule is promulgated pursuant to Section 31A-2-201(3)(a), in which the [Commissioner]commissioner is empowered to make rules to implement the Insurance Code, and pursuant to the specific authority of Section [31A-23-302(8)]31A-23a-402(8), which authorizes the [Commissioner]commissioner to define unfair methods of competition or any other unfair or deceptive act or practice in the business of insurance.

R590-153-2. Purpose.

The purpose of this rule is to identify certain practices, which the commissioner finds provide unfair inducements for the placement of title insurance business and as such constitute unfair methods of competition. These practices include, but are not limited to, the payment of expenses that are considered normal, customary, reasonable and recurring in the operation of a client of a title insurer, agency or producer.

R590-153-3. Scope.

This [Rule]rule applies to all title insurers, title insurance agencies and title insurance [agents]producers and all employees, representatives and any other party working for or on behalf of said entities whether as a full time or part time employee or as an independent contractor. Title insurers, agencies and producers who have ownership in, or control of, other business entities may not use those other business entities to enter into any agreement, arrangement, or understanding or to pursue any course of conduct, designed to avoid the provisions of this rule.

R590-153-4. Definitions.

For the purpose of this [Rule]rule the commissioner adopts the definitions as set forth in Section 31A-1-301, and the following:

A. "[Producer of title business]Client" means any person, or group, who influences, or who may influence, the placement of title insurance business or who is engaged in a business, profession or occupation of:

(1) buying or selling interests in real property;

(2) making loans secured by interests in real property; and

(3) shall include but not be limited to real estate agents, real estate brokers, mortgage brokers, lending or financial institutions, builders, developers, sub-dividers, attorneys, consumers, exchange companies, escrow companies and the employees, agents, representatives, [or]solicitors and groups or associations of any of the foregoing.

B. "Discount" means the furnishing or offering to furnish title insurance, services constituting the business of title insurance or escrow services for a total charge less than the amounts set forth in the applicable rate schedules filed pursuant to Section 31A-19a-203 or 31A-19a-209.

C. "Trade Association" means a recognized association of persons, a majority of whom are [producers of title insurance business]clients or persons whose primary activity involves real property.

D. "Business meals" shall include[drinks and tips], but are not limited to, breakfast, brunch, lunch, dinner, cocktails and tips. In no case shall such business meals rise to the level of ceremonies, for example, awards banquets, recognition events or similar activities sponsored by or for clients.

E. "Official Trade Association Publication" means:

(1) a membership directory, provided its exclusive purpose is that of providing the distribution of an annual roster of the association's members to the membership and other interested parties; or

(2) an annual, [semi-annual]semiannual, quarterly or monthly publication containing information and topical material for the benefit of the members of the association.

F. "Business Activities" shall include, but are not limited to, sporting events, sporting activities, music and art events. In no case shall such business activities rise to the level of ceremonies, for example award banquets, recognition events or similar activities sponsored by or for clients, or include travel by air, or other commercial transportation.

R590-153-5. Unfair Methods of Competition, Acts and Practices.

The commissioner finds that providing or offering to provide any of the following benefits by parties identified in Section R590-153-3 to any [producer of title insurance]client, either directly or indirectly, except as specifically allowed in Section R590-153-6 below, is a material and unfair inducement to obtaining title insurance business and constitutes an unfair method of competition in the business of title insurance prohibited under Section [31A-23-302]31A-23a-402:

A. The furnishing of a title insurance commitment [to provide title insurance without charge or at a charge discounted from an applicable rate filing. The prima facie cost of producing a commitment to insure shall be 60% of the minimum rate filed by the insurance company in the absence of a cost supported rate filing either higher or lower.]without one of the following:

(1) sufficient evidence in the file of the title insurer, agency or producer that a bona fide real estate transaction exists; or

(2) payment in full at the time the title insurance commitment is provided.

B. The paying of any charges for the cancellation of an existing title insurance commitment issued by a competing organization, unless that commitment discloses a defect which gives rise to a claim on an existing policy.

C. Furnishing escrow services pursuant to Section 31A-23-307, for a charge less than the charge filed pursuant to Section 31A-19a-209(5) or the filing of charges for escrow services with the commissioner, which are less than the actual cost of providing the services.

D. Waiving all or any part of established fees or charges for services, which are not the subject of rates filed with the [Commissioner]commissioner.

E. Deferring or waiving any payment for insurance or services otherwise due and payable, including "holding for resale".

F. Furnishing services not reasonably related to a bona fide title insurance or escrow, settlement, or closing transaction[. Examples (non exclusive):], including, but not limited to computer services, non-related delivery services, accounting assistance, legal counseling.

G. The paying for, furnishing, or waiving all or any part of the [rent]rental or lease charge for space, which is occupied by any [producer of title insurance business]client.

H. Renting or leasing space from any [producer of title business]client, regardless of the purpose, at a rate which is excessive or inadequate when compared with [rents]rental or lease charges for comparable space in the same geographic area, or paying [rent]rental or lease charges based in whole or in part on the volume of business generated by any [producer of title insurance business]client.

I. Furnishing all or any part of the time or productive effort of any employee of the title[insurance organization or]insurer, agency or producer, for example, [(i.e.,]secretary, clerk, messenger[,] or escrow officer [etc.)], to any [producer of title insurance business]client.

J. Paying for all or any part of the salary of a client or an employee of any [producer of title insurance business]client.

K. Paying, or offering to pay, either directly or indirectly, salary, commissions or any other consideration to any employee who is at the same time [engaged as]a client. [real estate agent or broker or as a mortgage broker.]

L. Paying for the fees or charges of a professional, for example, [(e.g.]an appraiser, surveyor, engineer[,] or attorney, [etc.)] whose services are required by any [producer of title insurance business]client to structure or complete a particular transaction.

M. Sponsoring, cosponsoring, subsidizing, contributing fees, prizes, gifts, food or otherwise providing anything of value for an activity, except as allowed under Subsection R590-153-6(F) of a [producer of title insurance business]client. Activities include, but are not limited to[:] "open houses" at homes or property for sale, meetings, breakfasts, luncheons, dinners, conventions, installation ceremonies, celebrations, outings, cocktail parties, hospitality room functions, open house celebrations, dances, fishing trips, gambling trips, sporting events of all kinds, hunting trips or outings, golf or ski tournaments, artistic performances and outings in recreation areas or entertainment areas.

N. Sponsoring, subsidizing, supplying prizes or labor, except as allowed under Subsection R590-153-6(C), or otherwise providing things of value for promotional activities of [producers of title insurance business]a client. Title [agents or]insurers, agencies or producers may attend activities of [producers]a client if there is no additional cost to the [agent or]title insurer, agency or producer other than their own entry fees, registration fees, meals, etc., and provided that these fees are no greater than those charged to [producers of title insurance business]clients or others attending the function.

O. Providing gifts or anything of value to a [producer of title insurance business]client in connection with social events such as birthdays[,] or job promotions[, etc.] except as provided in Subsection R590-153-6(H). A letter or card in these instances will not be interpreted as providing a thing of value.

P. Providing either directly or indirectly, a compensating balance or deposit in a lending institution either for the express or implied purpose of influencing the placement or [channeling]steering of title insurance business by such lending institution. This does not preclude transactions with lending institutions, which are in the normal course of business.

Q. Furnishing any part of a title insurer's, agency's or [insurer's]producer's facilities, for example, [(e.g.]conference rooms[,] or meeting rooms, [etc.)] to a [producer of title insurance business]client or trade association without receiving a fair rental or lease charge comparable to other rental or lease charges for facilities in the same geographic area.

R. Furnishing information packets, listing kits, "farm" packages, reports, or any [other]form of title evidence without first filing a specimen form copy with the commissioner and specifying a rate for which the form is available. The rate may not be less than the actual cost of producing the information and the material furnished.

S. Paying for any advertising on behalf of a [producer of title insurance business]client.

T. Advertising jointly with a [producer of title insurance business]client on subdivision or condominium project signs, or signs for the sale of a lot or lots in a subdivision or units in a condominium project. A title [insurance]insurer, agency or producer[company]may advertise independently that it has provided title insurance for a particular subdivision[,] or condominium project [etc.,]but may not indicate that all future title insurance will be written by that title insurer, agency or producer.[through that company.]

U. A direct or indirect benefit provided to a [producer of title insurance]client which is not specified in Section R590-153-6 below, will be investigated by the [insurance]department for the purpose of determining whether it should be defined by the commissioner as an unfair inducement under Section [31A-23-302(8)]31A-23a-402(8).

V. Donations to charitable organizations must:

(1) not be paid in cash; and

(2) if paid by negotiable instrument, be made payable only to the charitable organization; and

(3) be distributed directly to the charitable organization; and

(4) not provide any benefit to a client.

W. Providing a title insurance commitment, which does not identify the proposed insured party or which does not contain a valid commitment from a title insurer.

R590-153-6. Permitted Advertising and Business Entertainment.

A. A title insurer, agency[, agent or insurer] or producer may furnish the following without charge, and without additions, addenda or attachments which may be construed as reaching conclusions of the insurer, agency or producer regarding matters of marketable ownership or encumbrances:[a copy of any existing plat map, and tax information covering a specific parcel of real estate, (Tax identification number, assessed owner, assessed value of land and improvements and the latest tax amount) without additions or addenda or attachments which may be construed as reaching conclusions of the agency, insurer or agent regarding matters of marketable ownership or encumbrances.]

(1) A copy of an existing plat map; or

(2) Tax information covering a specific parcel of real estate, for example, tax identification number, assessed owner, assessed value of land and improvements, or the latest tax amount; or

(3) other information regarding real property which the county recorder's office provides to the public free of charge, and in the exact format and content as provided by the county recorder's office.

B. Advertisements by title insurers, agencies or [companies]producers must comply with the following:

(1) The advertisement must be purely self-promotional.

(2) Advertisements may not be placed in a publication, including an [internet]Internet web page and its links, that is hosted, published, produced for, distributed by or on behalf of a [producer or group of producers of title insurance business]client except as allowed under R590-153-6 (B)(3).

(3) Advertisements in official trade association publications are permissible as long as any [agency or]title insurer, agency or producer has an equal opportunity to advertise in the publication and at the standard rates other advertisers in the publication are charged.

C. A title[agency], insurer, agency or producer [or agent]may donate time to serve on a trade association committee and may also serve as an officer for the trade association.

D. A title [agency or]insurer, agency or producer may have two self-promotional open houses per calendar year for each of its owned or occupied facilities, [(]including branch offices[) (e.g. a Christmas party, an open house for remodeling of its facility, an open house for a new facility for the organization)]. The [agency or]title insurer, agency or producer may not expend more than $10[.00] per guest per open house. The open house may take place on or off the [agency's or]title insurer's, agency's or producer's premises but may not take place on the [producer's]client's premises.

E. A title [agency or]insurer, agency or producer may distribute self-promotional items having a value of $3 or less to [producers of title insurance business]clients, consumers and members of the general public. These self-promotional items shall be novelty gifts which are [nonedible]non-edible and may not be personalized or bear the name of the donee. Self-promotional items may only be distributed in the regular course of business. Self-promotional items may not be given to [producers of title insurance business]clients or trade associations for redistribution by these entities.

F. A title [agency or]insurer, agency or producer may make expenditures for business meals or business activities on behalf of any person, whether a [producer of title insurance]client or not, as a method of advertising, if the expenditure meets all the following criteria:

(1) The [agent]person representing the title insurer, agency or producer [or an employee of the insurer]must be present during the business meal or business activity.

(2) There is a substantial title insurance business discussion directly before, during or after the business meal or business activity.

(3) The total cost of the business meal, [and]the business activity, or both is not more than $75[.00] per person, per day.

(4) No more than three individuals from an office of a [producer of title insurance business]client may be provided a business meal or business activity by [an agency or]a title insurer, agency or producer in a single day.

(5) The entire business meal or business activity may take place on or off the [agency's or]title insurer's, agency's or producer's premises, but may not take place on the [producer's]client's premises.

G. A title [agency or]insurer, agency or producer may conduct educational programs under the following conditions:

(1) The educational program shall address only title insurance, escrow or topics directly related thereto.

(2) The educational program must be of at least one hour duration.

(3) For each hour of education $10 or less per person may be expended, including the cost of meals and refreshments.

(4) No more than one such educational program may be conducted at the office of a [producer of title insurance business]client per calendar quarter.

H. A title [agency or]insurer, agency or producer may acknowledge a wedding, birth or adoption of a child, or funeral of a [producer of title insurance business]client or members of his/her immediate family with flowers or gifts not to exceed $50[.00].

I. Any other advertising and/or business entertainment must be requested in writing and approved in advance and in writing by the commissioner.

[R590-153-7. Penalties.

Subject to the provisions of the Utah Administrative Procedures Act, violators of this rule shall be subject to forfeitures, suspension or revocation of their insurance license or Certificate of Authority, and/or any other penalties or measures as are determined by the commissioner in accordance with law.]**R590-153-7. Enforcement Date.**

The commissioner will begin enforcing the provisions of this rule 45 days from the effective date of the rule.

R590-153-8. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

KEY: title insurance
[April 11, 2000]2003
Notice of Continuation November 27, 2002
31A-2-201
[31A-23-302]31A-23a-402

Insurance, Administration
R590-187
Assessment of Title Insurance Agencies and Title Insurers for Costs Related to Regulation of Title Insurance

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26423
FILED: 06/26/2003, 10:53

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule is being changed to comply with changes made to Section 31A-23-315 by the 2002 Legislative Session in H.B. 276. Section 31A-23-315 has since been renumbered by the 2003 Legislature as per H.B. 374. (DAR NOTE: H.B. 276 is found at UT L 2002 Ch 260 and was effective July 1, 2002; and H.B. 374 is found at UT L 2003 Ch 298 and was effective May 5, 2003.)

SUMMARY OF THE RULE OR CHANGE: The following major changes were made to the rule: 1) in Section R590-187-3, the title of the job position the rule funds was changed; 2) in Section R590-187-4, the Branch Office Report form has been incorporated by reference and is due 30 days after any opening or closing of a title office; and 3) in Section R590-187-6, the deadline for payment of the title assessment was changed from 45 to 30 days of invoice. This section also expands and clarifies the type or method of payment.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 31A-2-201 and 31A-23-315

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: The "Branch Office Report" form (06/03/03)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: The changes in the rule will not affect anticipated cost or savings to the state budget. No additional people will need to be hired and no additional revenue will be created.

❖ LOCAL GOVERNMENTS: The changes to this rule will not affect local government since the rule only deals with the relationship of the title insurer and agency with the Utah Insurance Department.

❖ OTHER PERSONS: The only impact is the frequency of reporting based on opening or closing of one an office by an agency or insured. No fees are required for the form or the filing. The only impact will be on manpower to complete the simple one page reporting form when a new title office is opened or closed.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The only impact is the frequency of reporting based on opening or closing of one an office by an agency or insured. No fees are required for the form or the filing. The only impact will be on manpower to complete the simple one page reporting form when a new title office is opened or closed.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes to this rule should have little, if any impact on title insurers, producers and agencies doing business in Utah.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2003

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 8/07/2003 at 9:00 AM, State Office Building (behind the State Capitol), Room 4112, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 08/18/2003

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.
R590-187. Assessment of Title Insurance Agencies and Title Insurers for Costs Related to Regulation of Title Insurance.
R590-187-1. Authority.

This rule is promulgated by the commissioner pursuant to [~~Section~~]Subsections 31A-2-201(3) and [~~31A-23-315(2)(d)~~]31A-23a-415(2)(d).

R590-187-2. Purpose.

The purpose of this rule is:

(1) to establish the costs and expenses incurred by the department in administering, investigating and enforcing the provisions of Title 31A, Chapter 23a, Parts [~~III and~~] IV and V related to the marketing of title insurance;

(2) to determine a filing date for each title insurance agency or insurer to report to the commissioner the number of counties in which a title insurance agency or a title insurer maintains [~~an~~]offices[~~ to the commissioner~~];

(3) to establish a deadline for the payment of the assessment[~~s~~]; and

(4) to determine the premium year used in calculating the assessment of title insurers.

R590-187-3. Costs and Expenses.

(1)[~~ The amount of costs and expenses that will be covered by the assessment imposed by 31A- 23- 315 for the fiscal year 1999 will consist of the following:~~

~~(a) the salary and state paid benefits for an Insurance Department, Compliance and Enforcement Investigator I;~~

~~(b) data processing expense for the purchase of a computer and associated data processing equipment; and~~

~~(c) a capital outlay for the investigator's office space.~~

~~(2)~~] The amount of costs and expenses that will be covered by the assessment imposed by [~~31A-23- 315~~]31A-23a-415 for [~~the fiscal years 2000 and 2001~~]any fiscal year in which an assessment exists will consist of the salary and state paid benefits; travel expenses, including daily vehicle expenses; computer hardware and software expenses; e-commerce expenses and wireless communications expenses for [~~an Insurance Department,~~]a [~~Compliance and Enforcement Investigator I~~]Market Conduct Examiner I as determined by the department's budget as approved by the Utah State Legislature and would include any salary increases or increases in benefits.

R590-187-4. Reporting of Counties.

(1) A title insurance agency and title insurer shall deliver[~~report the name of each county in which the agency or insurer maintains an office~~] to the commissioner, [~~by February 1 of each year.~~]a Branch Office Report within 30 days of the opening or closing of any office, of any change of address, or a change in branch manager.

(2) [~~County~~]Branch Office Report form[~~s~~], revised 6-3-03 is incorporated by reference and is[~~are~~] available from the [~~Utah State Insurance Department~~]department, or from the department's web page. [~~and~~]This form shall be utilized in reporting the [~~names of counties~~]office information required by this rule.

R590-187-5. Title Insurer Assessment.

The title insurance assessment shall be calculated using direct premiums written during the preceding calendar year. The direct

premiums written shall be taken from the [~~insurers~~]insurer's annual statements for that year.

R590-187-6. Assessment Payment Deadline.

(1)[~~ Assessments shall be paid within 45 days of the assessment date.~~

~~(2) A fee payment for the assessment, which is delivered by mail, will be considered to have been paid as of the date of the postmark.~~

~~(3) Payment by check.~~

~~(a) Checks shall be made payable to the Utah Insurance Department.~~

~~(b) A check which is dishonored in the process of the collection will not constitute payment of the assessment. Tender of a check to the department that is subsequently dishonored is a violation of this rule.~~

~~(2)~~] Payment.

(a) Checks shall be made payable to the Utah Insurance Department. A check that is dishonored in the process of the collection will not constitute payment of the fee for which it was issued and any action taken pursuant to the fee payment will be negated. Any late fees or penalties will apply until proper payment is made. Tender of a check to the department, that is subsequently dishonored, is a violation of this rule.

(b) Cash payments. The department is not responsible for un-receipted cash that is lost or mis-delivered.

(c) Electronic payments.

(i) Credit Card. Credit cards may be used to pay any fee due to the department. Credit card payments that are dishonored will not constitute payment of the fee and any action taken based on the payment will be negated. Late fees and other penalties, resulting from the negated action, will apply until proper payment is made. A credit card payment that is dishonored is a violation of this rule.

(ii) Automated clearinghouse (ACH). Payers or purchasers desiring to use this method must contact the department for the proper routing and transit information. Payments that are made in error to another agency or that are not deposited into the department's account will not constitute payment of the fee and any action taken based on the payment will be negated. Late fees and other penalties resulting from the negated action will apply until proper payment is made. An ACH payment that is dishonored is a violation of this rule.

R590-187-7. Enforcement Date.

The commissioner will begin enforcing the revised provisions of this rule 45 days from the rule's effective date.

R590-187-[~~7~~]8. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, that invalidity will not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

KEY: title insurance
[~~September 25, 1998~~]2003
[~~31A-23-315~~]31A-2-201
31A-23a-415

Insurance, Administration

R590-217

Fiduciary and Other Responsibilities of Title Insurance Producers Providing Escrow Services as Settlement Agents

NOTICE OF PROPOSED RULE
(New Rule)
DAR FILE NO.: 26426
FILED: 06/27/2003, 08:52

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule is to define the fiduciary and other responsibilities of title insurance producers when engaging in the escrow business under the authority granted in Section 31A-23-307, and to identify those practices the commissioner finds harmful to the public interest.

SUMMARY OF THE RULE OR CHANGE: The rule: 1) requires a single title producer to handle both the documentation and the funds relating to a closing; 2) addresses false communication by title insurance producers; and 3) addresses underwriter contracts regarding an insurer's liability.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 31A-2-201 and 31-23a-406

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: Changes in the rule will not affect anticipated cost or savings to the state budget. No additional people will need to be hired and no additional revenue will be created.

❖ LOCAL GOVERNMENTS: This rule will not affect local governments financially since the regulatory authority of this rule just deals with the relationship between the title insurer, producer and agency, and the Utah Insurance Department.

❖ OTHER PERSONS: The rule itself does not impose any requirement that has a specific cost, fee, or savings related to it. This rule will only allow one title licensee to handle a transaction rather than multiple licensees as previously allowed. This change could either increase or decrease a licensees title business. This increase or decrease is based on whether their client gets to choose where the transaction goes. For an agent who gets the business, it will be for the same amount of work at twice the income.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The rule itself does not impose any requirement that has a specific cost, fee, or savings related to it. This rule will only allow one title licensee to handle a transaction rather than multiple licensees as previously allowed. This change could either increase or decrease a licensees title business. This increase or decrease is based on whether their client gets to choose where the transaction goes. For an agent who gets the business, it will be for the same amount of work at twice the income.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The rule itself does not impose any requirement that has a specific cost, fee, or savings related to it. It all depends on how the industry responds to the changes.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2003

INTERESTED PERSONS MAY ATTEND A PUBLIC HEARING REGARDING THIS RULE: 8/07/2003 at 11:00 AM, State Office Building (behind the State Capitol), Room 4112, Salt Lake City, UT.

THIS RULE MAY BECOME EFFECTIVE ON: 08/18/2003

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance Administration.

R590-217. Fiduciary and Other Responsibilities of Title Insurance Producers Providing Escrow Services as Settlement Agents.

R590-217-1. Authority.

This rule is promulgated pursuant to Subsection 31A-2-201(3)(a), in which the commissioner is empowered to make rules to implement the Insurance Code, and pursuant to the specific authority granted in Subsection 31A-23a-406(7)(b), which authorizes the commissioner to establish rules that govern title insurance producers engaging in escrows.

R590-217-2. Purpose.

The purpose of this rule is to define the fiduciary and other responsibilities of title insurance producers when engaging in the escrow business under the authority granted in Section 31A-23a-406 and to identify those practices, which the commissioner finds are harmful to the public interest.

R590-217-3. Scope.

This Rule applies to title insurers, title insurance agencies, title insurance producers and their employees, representatives and any other party working for or on behalf of said entities whether as a full time or part time employee or as an independent contractor.

R590-217-4. Definitions.

For the purpose of this rule the commissioner adopts the definitions as set forth in Section 31A-1-301 and the following:

(1) "Escrow Services" are those services specifically used to conduct an escrow as defined in Subsection 31A-1-301(54).

(2) "Settlement Agent" means any person who provides or offers to provide escrow services to the public and who acts as a neutral third party for a particular escrow.

(3) "Settlement" means all acts by a settlement agent to disburse funds, record documents, deliver escrow items, or other acts necessary to conclude the escrow upon completion of all required conditions precedent by the parties to the escrow.

R590-217-5. Title Insurance Producers Acting as Settlement Agents.

The commissioner finds that in providing escrow services, a settlement agent assumes a fiduciary role to all parties to the escrow and is held to a high standard of care in dealing with all of the parties to the escrow. The commissioner further finds that a settlement agent's failure to realize and fulfill the fiduciary and other duties outlined below constitutes a material threat to the public and violates the purposes of the insurance code as outlined in Section 31A-1-102.

(1) A title insurer, agency or producer engaging in the escrow business pursuant to Section 31A-23a-406, must:

(a) be solely designated as the settlement agent for the specific escrow by a written agreement, executed by the parties, and must retain a copy of that agreement; and

(b) have a contract, or be designated by an agency that has a contract, with a title insurer qualified to transact title insurance business in Utah which acknowledges that Insurer's liability imposed by Sections 31A-23a-407 and 31A-23a-410; and

(c) act as the neutral third party; exercise proper fiduciary responsibility to all of the parties to the escrow; and maintain the transaction file; and

(2) The designated settlement agent has the duty to ensure that all conditions of the escrow have been met prior to settlement.

(3) When the terms of the escrow require the preparation of documents by the escrow agent, closing agent, or other similar term, the preparation of the documents must be done by the designated settlement agent.

(4) When the terms of the escrow require that the parties deliver or entrust to an escrow agent, closing agent, or other similar term, any money, certificate of deposit, security, negotiable instrument, deed or other property or asset, those items must be delivered to and held by the designated settlement agent prior to settlement.

(5) The designated settlement agent must follow all applicable guidelines set forth in the Real Estate Settlement Procedures Act, 12 U.S.C. Section 2601 et seq., as amended, and related regulations of the Department of Housing and Urban Development.

(6) A settlement agent may not make or cause to be made any communication that contains false or misleading information relating to the escrow, including information that is false or misleading because it is incomplete.

(7) A settlement agent may not make or caused to be made a false entry in a record or willfully refrain from making a proper entry in a record.

(8) All funds deposited into the escrow shall be sent to, and received directly by, the designated settlement agent.

(9) All documents necessary to settle the escrow must be in the possession of the designated settlement agent prior to settlement.

R590-217-6. Enforcement Date.

The commissioner will begin enforcing the provisions of this rule 45 days from the effective date of the rule.

R590-217-7. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

KEY: title escrow insurance
2003
31A-2-201
31A-23a-406

Labor Commission, Industrial Accidents
R612-2-22
Medical Records

NOTICE OF PROPOSED RULE
(Amendment)
DAR FILE NO.: 26406
FILED: 06/20/2003, 15:19

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule change is to provide medical providers with direction on what records need to be released, to whom, and under what conditions when dealing with workers' compensation injury or occupational disease claims in light of the federal Health Insurance Portability and Accountability Act (HIPAA).

SUMMARY OF THE RULE OR CHANGE: The proposed rule change establishes that the Utah Workers' Compensation Program is exempt from HIPAA. The proposed changes set forth what records should be released and to whom in workers' compensation cases. The subsections of the current section have also been rearranged so that understanding is clearer. (DAR NOTE: A corresponding 120-day (emergency) rule that is effective as of 06/20/2003 is under DAR No. 26405 in this issue.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: This proposal will impose no additional costs to the state budget. By simplifying standards for information release, the proposed changes may reduce the state's compliance costs in a small indefinite amount.

❖ LOCAL GOVERNMENTS: This proposal will impose no additional costs to local governments. By simplifying standards for information release, the proposed changes may reduce local government's compliance costs in a small indefinite amount.

❖ OTHER PERSONS: This proposal will impose no additional costs to other persons. By simplifying standards for information release, the proposed changes may reduce other person's compliance costs in a small indefinite amount.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Because Utah's workers' compensation program is exempt from HIPAA, there should be no cost to persons affected by this rule. There may be a small savings attributable to simplified compliance.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Any fiscal impact on businesses affected by this rule should be positive. The rule will reduce business costs in obtaining and disseminating medical information for workers compensation purposes.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
LABOR COMMISSION
INDUSTRIAL ACCIDENTS
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Joyce Sewell at the above address, by phone at 801-530-6988, by FAX at 801-530-6804, or by Internet E-mail at jsewell@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-22. Medical Records.

A. Pursuant to 45 CFR, 164.512(1), release of medical records for use in Utah's workers' compensation system is exempt from the privacy regulations established by the federal Health Insurance Portability and Accountability Act (HIPAA). The following rules, instead of HIPAA standards, govern release of medical records for workers' compensation purposes:

B. A medical provider shall release the following medical records pertaining to treatment of an injured worker to the persons or entities listed in subsection C of this rule. The medical records shall be released regardless of whether the injured worker has authorized release of such medical records.

1. Medical records or documentation to substantiate a bill submitted for payment to an insurance carrier, third party administrator, self-insured employer, or the Labor Commission, as required by Commission rules.

2. The "Physician Initial Report of Injury/Illness" and any other forms required by Labor Commission rules.

3. Medical records related to a claim for benefits made by an injured worker for a work related injury or illness,

4. Any other medical records requested by the Labor Commission to adjudicate or settle a workers' compensation claim.

5. Upon written request, medical records of past medical treatment, including prescription drug records. These records of past medical treatment are required by the workers' compensation system to resolve issues of causation, compensability or treatment of the workers' compensation claim.

C[~~B~~]. The following[~~Those~~] persons or entities [~~who~~]are entitled to [~~copies of~~]the medical records [~~involving an industrial case are~~]described in subsection B. of this rule:

1. The injured [~~employee~~]worker or his/her dependents,

2[~~3~~]. The employer's [~~workers' compensation~~]insurance carrier, third party administrator, or an agent of the insurance carrier or third party administrator. An agent of the insurance carrier or third party administrator includes but is not limited to a case manager or a reviewing physician,

3. A self-insured employer who is duly authorized by the Labor Commission to self-administer its workers' compensation claims,

4. The Uninsured Employers' Fund,

5. The Employers' Reinsurance Fund,

6. The Labor Commission,[~~ and~~]

7. Any attorney representing any of the above in an industrial injury or occupational disease claim[~~.~~], and

8[~~2~~]. The employer of the injured worker[~~,~~]. However, except as provided in subsection C.3 of this rule, an employer's right to receive medical records is limited to information necessary to determine the injured worker's ability to return to work.

[~~C. No other person or entity is entitled to medical records unless ordered by a Court or provided with a notarized release executed by the injured worker.~~]D. On request, an injured worker seeking workers' compensation benefits shall provide the person or entities identified in subsection C.1 through 7 with the names and addresses of previous medical providers for up to the past 15 years. Labor Commission form 307 "Medical Treatment Provider List" shall be used for this purpose and will notify the injured worker that all medical records of the medical providers listed on the form may be provided to the requesting party without the injured worker's authorization or release.

E[~~A~~]. When any medical practitioner provides copies of medical records[~~ to the parties of an industrial case~~], other than the records required when submitting a bill for payment, the following charges are presumed reasonable:

1. A search fee of $15 payable in advance of the search,

2. Copies at $0.50 per page including copies of microfilm payable after the records have been prepared, and

3. Actual costs of postage payable after the records have been prepared. Actual costs of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.

F[~~D~~]. The Commission will [~~operate in the~~]release [~~of~~]its records to the parties/entities [~~as~~]specified under C above with a signed and notarized release unless the information is classified as controlled under the Government Records Access and Management Act (GRAMA).[~~unless the information is classified as confidential under the Government Records Access and Management Act (GRAMA).~~]

G[~~E~~]. No fee shall be charged when the RBRVS requires specific documentation for a procedure or when [~~physicians and surgeons~~]medical providers are required to report by statute or rule.

H[~~F~~]. An injured worker may obtain one of each of the following records related to the industrial injury or occupational disease, at no cost, when the injured worker or his/her dependents have a signed form by the division to substantiate his/her industrial injury/illness claim:

1. History and physical,

2. Operative reports of surgeries,

3. Hospital [~~D~~]discharge summary,[~~ and~~]

4. Emergency room records,

5. Radiological reports,

6. Specialized testing results, and

7. Physician SOAP notes, progress notes, or specialized reports.

(a) Alternatively, a summary of the patient's record may be made available to the claimant at the discretion of the physician.[

~~8. And such other records as may be requested by the Commission in order to make a determination of liability.~~]

KEY: workers' compensation, fees, medical practitioner
[~~August 1, 2002~~]2003
Notice of Continuation June 15, 1998
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

Workforce Services, Administration
R982-401
JTPA Fiscal Procedures

NOTICE OF PROPOSED RULE
(Repeal)
DAR FILE NO.: 26411
FILED: 06/24/2003, 16:04

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The Job Training Partnership Act (JTPA) was a federal program which was replaced by the Workforce Investment Act (WIA). JTPA no longer exists. The Economic Dislocation and Worker Adjustment Assistance Act and the Worker Adjustment and Retraining Notification Act are federal programs which are still in effect but governed by federal regulation. No state rules are needed for those programs.

SUMMARY OF THE RULE OR CHANGE: This rule is repealed in its entirety.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 35A, Chapter 5

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: JTPA was a federally-funded program which was replaced by WIA. There are no costs or savings to the state budget by this rule repeal.
❖ LOCAL GOVERNMENTS: This was a federal program and had no effect on local government. There will be no costs or savings to local government by repealing this rule.
❖ OTHER PERSONS: There are no costs or savings to other persons by repealing this rule. Any costs or savings would have been contemplated in the federal legislation and the rule is being repealed to comply with those changes to federal law.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There are no compliance costs to any person by the repeal of this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: There will be no fiscal impact by the repeal of this rule to any business in Utah.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
ADMINISTRATION
140 E BROADWAY
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/18/2003

AUTHORIZED BY: Raylene G. Ireland, Executive Director

R982. Workforce Services, Administration.
[~~R982-401. JTPA Fiscal Procedures.~~
~~R982-401-1. Authority.~~
~~(1) This rule adopts and incorporates by reference:~~
~~(a) Title 35A, Chapter 5; "Training and Workforce Improvement Act".~~
~~(b) "Job Training Partnership Act" (JTPA).~~
~~(c) "Economic Dislocation and Worker Adjustment Assistance Act" (EDWAA).~~
~~(d) Public Law 100-379, August 4, 1988; "Worker Adjustment and Retraining Notification Act" (WARN).~~
~~(e) Federal regulations 20 CFR parts 626, 627, 628, 629, 630, and 631, 1990; which apply to programs under the Job Training Partnership Act and the Economic Dislocation and Worker Adjustment Assistance Act.~~
~~(f) Federal regulation 20 CFR part 639, 1990; which applies to the Worker Adjustment and Retraining Notification Act.~~
~~(2) These laws, rules, and federal regulations govern the activities of the Department relating to programs authorized by the Job Training Partnership Act. Unless otherwise specified in a rule subsection; rules R986-603, R986-601, R986-602, R986-603, R982-401, R982-501, and R994-600 are based on these laws and federal regulations.~~

~~R982-401-2. Fiscal Accountability: Funding Sources and Limitations.~~
~~(1) General Grantee Funding Sources - Title II of the Job Training Partnership Act consists of two major sub-title funding classifications, II-A Adult and Youth, and II-B Summer Youth Employment, each restricted by various cost limitations. The Funding Classification II-A Adult and Youth consist of five funding codes of which each has respective limitations.~~
~~Title III funds are allocated for the Economic Dislocation and Worker Adjustment Assistance Act (EDWAA).~~
~~(2) Cost Limitations - The following summarizes the various cost limitations by funding code to which the Grantee will be required to adhere.~~
~~(a) Title II-A 78 Percent Adult and Youth/Youth Limitations - Grantees shall ensure that no less than 40 percent of the funds available under this source shall be expended to provide services to eligible youth. (Section 203(b)(1) JTPA) However, this minimum expenditure may be reduced or increased by a local adjustment factor to the extent that the ratio of economically disadvantaged adults in the Grantee's areas differs from the ratio of such individuals to the national ratio. The adjustment factor will be supplied by the Grantor at the beginning of each planning period.~~
~~(i) Public Sector OJT Limitations - The Grantee shall ensure that Public Sector OJT expenditures are not made when the ratio of OJT participants in the public sector to participants in such training in the private sector exceed the ratio between civilian governmental employment and nongovernmental employment in that district. (Section 203(b)(4) JTPA)~~
~~(ii) Administration, Participant Support and Training Limitation - The Grantee shall insure that not more than 15 percent of the funds available for any fiscal year will be spent for the cost of administration. Therefore, not less than 85 percent will be expended for the costs of Training and Participant Support. (Section 629.39(a)(1) JTPA), and 629.39(a)(2) Regulations). Not more than 30 percent of the funds will be expended for administration and participant support costs. Therefore, not less than 70 percent will be expended for Training Costs. (Section 629.39(a) and 629.39(c) Regulations)~~
~~Grantee expenditures for Participant Support will consist of the following four general subcategories:~~
~~(A) 50 percent of any limited Work Experience expenditures.~~
~~(B) 100 percent of any nonlimited Work Experience expenditures.~~
~~(C) Supportive services.~~
~~(D) Needs-based payments necessary for individuals to participate in the program.~~
~~(iii) Employment Generating Activities are not allowed.~~
~~(iv) Waivers - The Grantor may approve expenditures made in excess of the 30 percent combined Administrative and Participant Cost limitation if the Grantee expresses the need for a waiver in its approved Job Training Plan. The Private Industry Council must initiate the request for the costs, and these must be due to one or more of the following conditions in the Grantee's district:~~
~~(A) An unemployment rate which exceeds the national average unemployment rate by at least 3 percentage points, and the ratio of~~

current private employment to population in the Grantee's district is less than the national average of such ratio.

(B) The Job Training Plan for the Grantee proposes to serve a disproportionately high number of participants from groups requiring exceptional supportive service costs such as handicapped, offenders, and single heads of household with dependent children.

(C) The cost of providing necessary child care exceeds 1/2 of the costs of participant support.

(D) The costs of providing necessary transportation exceeds 1/3 of the costs of participant support.

(E) A substantial portion of the participants in activities are in training programs of a nine (9) months duration or more.

The approval of a 30 percent waiver will not allow the Grantee to exceed the 15 percent administrative cost limitation.

(b) Title II-A 3 Percent Older Workers.

(i) Administration, Participant Support and Training Limitations - The Grantee shall ensure that not more than 15 percent of the funds available for any fiscal year will be expended for the cost of administration. Therefore, not less than 85 percent will be expended for the costs of Training and Participant Support. (Section 629.39(a)(1) JTPA and 629.39(a)(2) Regulations)

(ii) Waivers - The Grantor may approve expenditures made in excess of the 30 percent combined Administrative and Participant Cost limitation if the Grantee expresses the need for a waiver in its approved Job Training Plan. The Private Industry Council must initiate the request for such excess cost. These costs must be due to one or more of the following conditions in the district:

(A) An unemployment rate which exceeds the national average unemployment rate by at least 3 percentage points, and the ratio of current private employment to population in the Grantee's district is less than the national average of such ratio.

(B) The Job Training Plan for the Grantee proposes to serve a disproportionately high number of participants from groups requiring exceptional supportive service costs such as handicapped, offenders, and single heads of household with dependent children.

(C) The cost of providing necessary child care exceeds 1/2 of the costs of participant support.

(D) The costs of providing necessary transportation exceeds 1/3 of the costs of participant support.

(E) A substantial portion of the participants in activities are in training programs of nine (9) months duration or more.

The approval of a waiver of the 30 percent will not allow the Grantee to exceed the 15 percent administrative cost limitation.

(iii) Public Sector OJT Limitations - The Grantee shall ensure Public Sector OJT expenditures are not made when the ratio of OJT participants in the public sector to participants in such training in the private sector exceed the ratio between civilian governmental employment and nongovernmental employment in that district. (Section 203(b)(4) JTPA)

(c) Title II-A Six Percent Incentive.

(i) Administration, Participant Support and Training Limitations -Grantees shall ensure that not more than 30 percent of the funds will be expended for the combination of administration and participant costs. Therefore, not less than 70 percent will be expended for training programs.

(ii) Waivers - Grantee waivers shall be the same as set forth under the section dealing with Title II-A, 78 percent Adult and Youth of these procedures.

(iii) Public Sector OJT Limitations - The Grantee shall ensure Public Sector OJT expenditures are not made when the ratio of OJT participants in the public sector to participants in such training in the private sector exceed the ratio between civilian governmental employment and nongovernmental employment in that district. (Section 203(b)(4) JTPA).

(d) Title II-A Six Percent Technical Assistance - Technical Assistance funds are excluded from the 15 percent Administrative Cost limitations, 85 percent Training limitation, and the 30/70 percent Participant Support and Training limitations.

(e) Title II-A Eight Percent Education - Title II-A, Eight Percent Education funds shall be used to provide financial assistance to State Education agencies for education and training. Not more than 20 percent of the available funds may be spent to facilitate a coordination of education and training services for eligible participants through cooperative agreements. These funds are excluded from JTPA cost limitations. (Section 629.34(b-1(2) and 629.39(d)(2) Regulations). The balance of the available funds, 80 percent, shall be used by the Grantee to provide services for eligible participants and have the following limitations:

(i) Administration, Participant Support, and Training Limitations - The Grantee shall ensure that no more than 15 percent of the funds available for any fiscal year will be expended for the cost of administration. Therefore, not less than 85 percent will be expended for the costs of training and participant support. (Section 629.39(a)(1) and 629.39(a)(2) Regulations).

(ii) Matching Requirement - The Grantee shall provide for the contribution from non-JTPA funding sources a total amount of funds equal to the amount provided by the Grantor.

(A) The matching contribution may consist of:

- Necessary and reasonable charges limited to allowable expenditures by an SDA to accomplish the objectives of the Eight Percent Education plan. Project costs may be cash or non-cash, such as depreciation and use charges for buildings and equipment.

- Cash donated to the SDA by non-federal entities.

- Services and real or personal property, or use thereof, donated by non-federal entities.

- Direct cost of employment and training services provided by State or local agencies, private non-profit organizations, educational institutions or private-for-profit employers, including OJT employer contributions.

- Unemployment Insurance costs (state funds expended during the first 26 weeks of the U.I. benefit period) provided to participants while enrolled in a training or retraining program for up to 50 percent of the matching requirement.

(B) In-kind contributions are considered non-cash contributions and will be accepted as part of the SDA's matching share when such contributions meet the following criteria:

- The SDA's records identify the matching source, program, activity and amount of the contribution.

- The contributions are not included as part of any other federally-assisted program.

- Volunteer work contributions are to be supported by source documents such as time sheets.

- Proper documentation is used in determining charges for materials, equipment, and land.

(C) The value of in-kind non-federal contributions are determined as follows:

- Volunteer Services - Each hour of volunteered service may be counted as a matching share if the service benefits the project and is an integral and necessary part of such project.

- Rates for volunteers should be consistent with rates paid for similar work in other activities in Utah or local governments. Where no similar skills exist in other activities of the state or local

~~governments, rates used should be consistent with those paid for similar work in the labor market of each SDA's jurisdiction.~~

~~- Services donated by other employers shall be valued at the employee's regular rate of pay (exclusive of fringe benefits and overhead cost) provided such services are in the same skill for which the employee is normally paid.~~

~~(D) Materials/expendable personal property - Items as office supplies, maintenance supplies, or workshop and classroom supplies.~~

~~- Assessed values should be reasonable and should not exceed the cost of the materials to the donor or current market prices, whichever is less, at the time they are charged to the project.~~

~~(E) Equipment, buildings and land, or use of space/nonexpendable personal property.~~

~~- Total value of property donated may be claimed as matching if the purpose of the donation is to provide a facility.~~

~~- Depreciation or use charges may be made if the purpose of the charge is to support project activities. Fair rental charges for land may be made if approved by the state.~~

~~- Equipment and buildings will be based on the donor's cost less depreciation or current market value of similar property, whichever is less.~~

~~- Land or use of space may not exceed the fair rental value of comparable space and should be established by an independent appraiser, and certified by the SDA.~~

~~- Loaned equipment may not exceed its fair rental value.~~

~~(F) Other charges.~~

~~- Necessary charges incurred specifically for and in direct benefit to the project may be accepted as matching share.~~

~~- Charges must be adequately supported and permissible under JTPA and be reasonable and properly justifiable.~~

~~(iii) Economically Disadvantaged Limitation - The Grantee shall expend not less than 75 percent of available funds for activities for economically disadvantaged individuals. (Section 123(c)(3) JTPA)~~

~~(f) State Single Head of Household Program - These funds must be used to train single heads of household who are receiving Temporary Assistance to Needy Families (TANF). Grantees will be allocated a maximum of 15% for program administration, a maximum of 10% for coordination activities and a minimum of 75% for training and support services.~~

~~(g) Title II-B Summer Youth and Employment - Administration and Training Limitations The Grantee shall ensure that not more than 15 percent of the funds available will be used for the costs of administration. Therefore, not less than 85 percent of the funds will be expended for the costs of Training and Participant Support limitation.~~

~~(h) Title III-EDWAA -~~

~~(i) Not more than 15 percent of the Governor's reserve funds expended for Title III dislocated workers assistance are used for administration.~~

~~(ii) Not more than 25 percent of the Governor's reserve funds expended for Title III dislocated works assistance are used for needs-related payments and supportive services.~~

~~(iii) No more than 40 percent of the Governor's reserve funds are reserved for state administration, technical assistance to substate areas, statewide or industrywide projects, rapid response activities, incentives for workers engaged in long-term training, needs-related payments, and discretionary grants to help substate areas confront unexpected, major layoffs.~~

~~(iv) Not less than 50 percent of the federal funds expended by a substate area for Title III dislocated workers assistance are used for retraining, unless waived by the Governor to not less than 30 percent.~~

~~(v) Not more than 15 percent of the total funds expended in a substate area (divided by 50 percent, or not less than 30 percent, if a waiver is granted by the Governor) are used for administration.~~

~~(vi) Not more than 25 percent of the total funds expended in a substate area (divided by 50 percent, or not less than 30 percent, if a waiver is granted by the Governor) are used for needs-related payments and supportive services. (Section 315 JTPA)~~

~~(vii) Title IV - Cost limitations are specified in the Solicitation of Grant Acceptance.~~

~~**R982-401-3. Fiscal Accountability: Cash Management.**~~

~~The Grantee shall have adequate written procedures established for forecasting cash needs, disbursements, reconciliation requirements, and cash control monitoring which will minimize excess cash on hand. This written procedure will be part of the Job Training Plan and will clearly identify and delineate their cash management policy and system. The Grantee shall limit cash requests for funds to actual and immediate cash needs. Immediate cash needs shall be defined as 3 days or less, of cash on hand. (This calculation comes from the "Schedule of OJTED Funds Received and Disbursed Form.) The subcontractor of the Grantee will maintain procedures for cash management which conform substantially to the standards of timing, necessity, and reasonableness imposed on the Grantee. Cash requests by funding codes shall not be more frequent than once a week. It is not permissible for Grantees to request cash monthly and disburse cash as a monthly advance to its recipients. Regardless of negotiations between the Grantor and Grantee on audit resolution, excess cash shall be returned to the Grantor within thirty days of the Grantee's termination of agreement. The Grantor will conduct ongoing monitoring of the cash system through desk and on-site reviews of cash projections and status. The Grantor may impose sanctions based upon the amount of cash maintained by the Grantee or its subcontractor in excess of reasonable cash needs, establish a debt for the amount of such excessive cash, and charge interest. If such cash abuses continue repeatedly, the Grantor may impose a cost reimbursement system.~~

~~**R982-401-4. Fiscal Accountability: Indirect Costs and Cost Allocations.**~~

~~The Grantee shall charge direct and indirect cost in accordance with Regulation Part 29-70.102 and 29-70.103 of CFR 41, which defines direct and indirect costs. Section 41 CFR 29-70.103 stipulates that indirect cost rates be established through the application of cost principles referenced in the Rules and Regulations of OMB Circular A-87, revised 1981, and by referencing the Grantee's cognizant agency plan.~~

~~The Grantee shall submit a Cost Allocation and/or an Indirect Cost Plan as part of the Job Training Plan. The Cost Plan shall be comprised of three subparts which shall each identify and delineate a fair and equitable distribution methodology of allocating allowable indirect costs.~~

~~The three parts of the plan are:~~

~~(1) An inter-title cost section which will allocate allowable indirect costs of Administration, Participant Support, and Training between various funding codes.~~

(2) An intra-title cost section which will allocate allowable indirect costs of Administration, Participant Support, and Training between various funding codes.

(3) An inter-agency section which will deal with the Grantee who is integrated with another agency and provides indirect costs to that agency. The submittal of the Indirect or Allocation Plan covering the expenditure relationship with their cognizant agency plan shall not excuse the Grantee from submitting parts 1 and 2 of this section.

R982-401-5. Fiscal Accountability: Cost Categories And Limitations.

(1) All costs are confined to those that are necessary and reasonable for proper and efficient administration of the program (20 CFR 629.37)

(a) Necessary costs: A cost is necessary if it is essential to achieve the intent of the JTPA and/or the award; and it is allowable under Federal and State laws and regulations.

(b) Reasonable costs: A cost is reasonable if, in its nature or amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the costs. In determining the reasonableness of a given cost, consideration shall be given to:

(i) Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the organization of the performance of the award.

(ii) The restraints or requirements imposed by such factors as generally accepted sound business practices, arms length bargaining, Federal and State laws and regulations, and terms and conditions of the award.

(iii) Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the organization, its members, employees and clients, the public at large, and the Government.

(iv) Significant deviations from the established practices of the organization which may unjustifiably increase the award costs.

(2) Allowable costs are costs necessary and reasonable for proper and efficient administration of the grant program, be allocable thereto under these principles, and not be a general expense to carry out the overall responsibilities of the grantee. Costs charged to the program shall be consistent with those normally allowed in like circumstances in nonfederally sponsored activities, and within applicable State and local law, rules or regulations. Allocable costs are costs that comply with the Grantee's approved cost classification plan.

(3) Allocable costs are allocable to a particular cost category to the extent that benefits are received by such category. Any cost allocable to a particular grant or cost objective may not be shifted to other Federal grant programs to overcome fund deficiencies, avoid restrictions imposed by law or grant agreements, or for other reasons.

(4) Classification Description of Cost Categories (Title II).

(a) Administrative Costs - Administrative costs consist of all direct and indirect costs that are associated with management of the program. Indirect administrative costs represent the general management and support functions of an organization. Included are salaries and fringe benefits of personnel engaged in executive, fiscal, personnel, legal audit, data processing, communications, and similar functions. Related materials, supplies, equipment, office space costs, and staff training are also included.

Direct administrative costs include salaries and fringe benefits of direct program administrative positions such as program supervisors or analysts, labor market analysts, and project directors. All costs of clerical personnel, materials, supplies, equipment, space, utilities, and travel which are identifiable with these program administration positions shall be charged directly to administration. Some examples of direct administrative costs are:

- the salary of a clerical assistant to a program supervisor; that part of an instructor's salary representing time spent supervising other instructors;

- desk top supplies used by supervisors; and, consultant services under contract not involving direct training or services to participants.

(b) Participant Support.

(i) 50 percent of any Work Experience expenditures that meet the requirements of Section 108(b)(3), JTPA.

(ii) 100 percent of the cost of any Work Experience expenditures that do not meet the requirements of Section 108(b)(3), JTPA.

(iii) Support services includes services which are necessary to enable an individual, eligible under the program, but who cannot afford to pay for such services, to participate in a training program funded under JTPA.

Such supportive services may include transportation, health care, special services and materials for the handicapped, child care, meals, temporary shelter and financial counseling.

(iv) Needs-based payments necessary to participate in accordance with a locally developed formula or procedure.

(c) Training Costs:

(i) Training costs are those which are direct costs of the training, such as on-the-job training services, salaries, fringe benefits, equipment, and supplies of personnel engaged in providing training (including remedial education, job-related counseling for participant, employability assessment, and job development, job search assistance; including preparation for work and labor market orientation). The salaries and fringe benefits of individuals who both instruct and supervise other instructors shall be prorated among the training and administration cost categories based on time records or other verifiable means.

Examples:

-Books and other teaching aids; equipment and materials used in providing training to participants.

-Classroom space and utility costs; and tuition and entrance fees that represent instruction costs which have a direct and immediate impact on participants.

-Employability assessment to include screening for eligibility, initial determination as to whether the program can benefit the individual; completion of an employability development plan; the determination of the employment and training activities and services which would be appropriate for the applicant; the determination of the availability of an appropriate employment and training activity; a decision of selection; and dissemination of information on the program.

- Orientation to the world of work.

- Counseling - employment-related counseling and testing.

- Job development.

- Job search assistance - includes transition services, such as job seeking skills instruction, individualized job search plan, labor market information, and other special activities for transition to unsubsidized employment.

~~- Job referral and placement.~~

~~- Costs which are billed as a single unit charge do not have to be allocated or prorated among the several cost categories, but may be charged entirely to training when the agreement:~~

~~- Is for training;~~

~~- Is fixed unit price; and~~

~~- Stipulates that full payment for the full unit price will be made only upon completion of training by a participant and placement of the participant into unsubsidized employment in the occupation trained for and at no less than the wage specified in the agreement.~~

~~(ii) Limitations on Costs.~~

~~(A) Costs resulting from violations or failure to comply with Federal, State or local laws and regulations are not allowable.~~

~~(B) Entertainment costs are not allowable.~~

~~(C) Insurance policies offering protection against debts established by the Federal Government are not allowable JTPA costs.~~

~~(D) Personal liability insurance for PIC members is allowable.~~

~~(E) The cost of legal expenses required in the administration of grant programs is allowable. Legal services furnished by the chief legal officer of a state or local government or staff solely for the purpose of discharging general responsibilities as a legal officer are unallowable. Legal expenses for the prosecution of claims against the federal government are unallowable.~~

~~(F) Benefits and working conditions for all individuals in subsidized jobs are at the same level and to the same extent as other employees working a similar length of time and doing the same type of work for that employer. (Section 143(a)(4) JTPA)~~

~~(G) Construction costs for training or participant support costs are allowable only to purchase equipment, materials, and supplies for use by participants, and to cover costs of a training program in a construction occupation. (CFR 20, 629.38(e)(7))~~

~~(H) Expenditures for duplicative facilities and services must be identified in the Job Training Plan. The Plan must establish that these alternative services or facilities would be more effective or more likely to achieve performance goals. (Section 143(b)(2) JTPA)~~

~~(I) No program shall impair existing contracts for services or collective bargaining agreements, except that no program under this Act, which would be inconsistent with the terms of a collective bargaining agreement shall be undertaken without the written concurrence of the labor organization and employer concerned. (Section 143(b)(2) JTPA)~~

~~(J) Funds are used only for activities which are in addition to those which would otherwise be available in the area in the absence of such funds. (Section 141(b) JTPA)~~

~~(K) Payments to employers for OJT during the period of training shall not average more than 50 percent of the wages paid by the employer to such participants. (Section 141(g) JTPA)~~

~~(L) Participant's wages in OJT are paid by the employer at the same rates, including periodic increases, as similarly situated employees or trainees, but in no event less than the higher of the rate specified in Section 6(a)(1) of the FLSA. (Section 142(a)(2) JTPA)~~

~~(M) Participant's wages in activities authorized under JTPA are to be paid wages which shall not be less than the highest of (A) the minimum wage under Section 6(a)(1) of the FLSA, (B) the minimum wage under the applicable State or local minimum wage law, or (C) the prevailing rates of pay for individuals employed in similar occupations by the same employer. (Section 142 (a)(3) JTPA)~~

~~(N) Funds obligated for any program year are to be expended no later than two years after the program year. (Section 161(b) JTPA)~~

~~(O) Funds are not spent for relocating establishments unless such relocation will not result in an increase in unemployment in the area of original location or in any other area. (Section 141(c) JTPA)~~

~~(P) Services to a substantial number of members of labor organizations are to be provided only after full consultation with such labor organization. (Section 306, JTPA)~~

~~(Q) Training is only for occupations for which there is a demand in the area served or in another area to which the participant is willing to relocate, and consideration given in occupations determined to be in sectors of the economy which have a high potential for sustained demand or growth. (Section 141(d)(1) JTPA)~~

~~(R) A trainee is not to receive payments for training activities in which the trainee fails to participate without good cause. (Section 142(a)(1) JTPA)~~

~~(S) Commercially available training packages are purchased at off-the-shelf prices and without requiring a breakdown of the cost components of the package, only if such packages are purchased competitively and include performance criteria. (Section 141(d)(3)(a) JTPA)~~

~~(T) Contributions to a reserve for a self-insurance program for injuries suffered by participants who are not covered by existing Worker's Compensation, are made only to the extent that the type and extent of coverage and the rates and premiums would be allowable and are chargeable to participant support or training as appropriate.~~

~~(U) Employment Generating activities are not allowed.~~

~~(5) Classification Description of Costs Categories (EDWAA) are listed in Section 631.13. All costs are to be allocated to the cost category to the extent that benefits are received in it. Allowable costs for activities under the EDWAA are to be charged against the following categories:~~

~~(a) Rapid response services as defined in EDWAA Section 314(b).~~

~~(b) Basic readjustment services as defined in EDWAA Section 314(c).~~

~~(c) Retraining services as defined in EDWAA Section 314(d).~~

~~(d) Needs-related payments as defined in EDWAA Section 314(e).~~

~~(e) Supportive services as defined in EDWAA Section 4(24).~~

~~(f) Administration is that portion of necessary and allowable costs which is not directly related to the provision of services and otherwise allocable to the other cost categories. It also includes activities conducted to coordinate and exchange information with other programs to assist eligible individuals, including coordination with the Federal-State unemployment compensation system and with Title II of the Trade Act.~~

~~R982-401-6. Fund Disbursement.~~

~~(1) System Overview - Disbursement of funds to the Grantee is accomplished through one of two systems, Electronic Fund Transfer (EFTS) or the State Finance Warrant System. The EFTS is used to disburse funds to the Grantee by funding code and when summed, will equal the Grantee's Notice of Fund Availability. The State Finance Warrant System disburses funds to non-EFTS Grantees and State agencies.~~

~~(a) Electronic Fund Transfer Systems (EFTS) - The EFTS is a computer to computer link between the Federal Entities, the Grantor and the Grantees. This system provides the capability for automated receipt and processing of fund transfers utilizing the Treasury Financial Communications System (TFCS) and the Utah Commercial Bank system. The collection and deposit components of this system provides a viable cash management tool for the Grantor and the Grantee. Within the EFTS, the Grantor will utilize the State commercial bank and transfer funds to the commercial bank chosen by the Grantee. The Grantee shall initiate fund drawdowns against their Notice of Fund Availability (NFA) by submitting a Utah Request for Funds message (URF-01). This request will be evaluated against the Grantee's Accrued Budget and Cost Report, Bank Reconciliation Report, and NFA balance. If the request is rejected, the Grantor will transmit a rejection notice to the Grantee on the day following receipt with an explanation for the rejection.~~

~~(b) State Finance Warrant Request System - The Grantor will disburse funds under the Agreement to State Agencies and other Grantees without EFTS capabilities in accordance with State of Utah, Department of Finance procedures. These procedures are detailed in four Utah Financial Information and Resource Management (Utah/FIRMS) manuals. The manuals include:~~

~~(i) Forms and Procedures~~

~~(ii) Systems Reference~~

~~(iii) Chart of Accounts~~

~~(iv) Organizational Structure, and~~

~~(v) Management Guide and Reports.~~

~~All requests, receipts and disbursements completed under this system meet the cash management standards of the Grantee.~~

~~(2) Drawdowns - The Grantee will be provided with an NFA specifying fund availability by funding code. Fund requests submitted by the Grantee are limited by four constraints:~~

~~(a) NFA fund code balance~~

~~(b) cash on hand~~

~~(c) Cash Reconciliation report, and~~

~~(d) current budget.~~

~~The Grantor will review these four factors when determining the necessity, reasonableness and allowability of their request:~~

~~(i) Electronic Fund Transfer System (EFTS) - Grantees using the EFTS shall request cash drawdowns by funding code in whole dollars only and shall submit the request by 5:00 p.m. on Thursday. Following completion of the transmittal of the cash request message, the initiator will mail a signed and dated print of the transmitted request for verification to the Grantor. If the print is not received before the next Grantee request message is initiated, the new request will not be processed. The cash request message includes two general categories of data providing present cash status and requested cash.~~

~~(ii) State Finance Warrant Request System - The Grantee using the State Finance Warrant Request System shall submit cash drawdowns according to funding codes in whole dollars only. Cash request messages must be received by the Grantor by 5:00 pm on Thursday. By close of business on that day, the Grantor will have initiated a Warrant Request to State Finance based on the request of the Grantee. Warrant payment will be made to the Grantee directly from State Finance.~~

~~The cash request message, under Warrant Request System, will consist of two general categories of data providing present cash status and requested cash.~~

~~(3) Notice of Fund Availability.~~

~~(a) General Purpose - The Notice of Fund Availability (NFA) is a unilateral document issued by the Grantor after completion of the Grant Agreement and provides authority to the Grantee to expend funds. The NFA identifies changes and balances by funding code as a result of new obligations, cash drawdowns, and modifications. At the beginning of each new fiscal period, an original NFA will be issued to the Grantee obligating new funds.~~

~~(b) NFA Item Description:~~

~~(i) Identification~~

~~(A) Grant Period - the beginning and ending dates of the period during which services are provided in accordance with the Grant Agreement.~~

~~(B) Grant Number - is assigned by the Grantor.~~

~~(C) NFA Number - a four digit number assigned by the Grantor to identify the Grantee and the NFA sequence number.~~

~~(ii) Funding Summary~~

~~(A) Funding Code # - is assigned by the Grantor and will identify the funding source.~~

~~(B) Description - is required to identify the funding code.~~

~~(C) Prior Balance - on the first NFA this column will show "O" (zero) for all entries. On all subsequent NFAs, this column will show the previous NFA balance.~~

~~(D) Increase - will reflect dollar increases to the NFA.~~

~~(E) Decrease to NFA - will reflect all dollar decreases to the NFA by funding code.~~

~~(F) New Balance - is the current NFA Balance subsequent to all increases and decreases known at issuance date.~~

~~(G) Total Grantee Availability - this column will total all prior balances, increases, decreases, and new balances.~~

~~(iii) Notification - This box is checked at the end of the Grant period after the Grantee's final accrued expenditures and net disbursements are in balance with adjusted availability. It indicates that the Grantor accepts the amount as the final account settlement. The NFA date associated with this action, is the beginning of the record retention requirement for the Grant period.~~

~~(iv) Approved for the Grantor by: - the NFA will be signed by an authorized official. The date shown will be the effective date for changes in the availability of funds.~~

~~R982-401-7. Fiscal Reporting.~~

~~(1) Management Systems, Reporting and Recordkeeping~~

~~(a) The grantee is required to establish and maintain, on a current basis, an adequate accrual accounting system sufficient to permit preparation of required reports; permit the tracing of funds to a level expenditure adequate to establish that funds have not been used in violation of the restrictions on the used of such funds; and demonstrate compliance with the matching requirements. (Section 165(a)(1) JTPA)~~

~~(b) The financial management system and the participant data system shall provide federally required records and reports that are uniform in definition, accessible to authorized Federal and State staff, and verifiable for monitoring reporting, audit and evaluation purposes. (Section 165(a)(1) JTPA)~~

~~(2) Reporting requirements - The grantee shall maintain such records and submit reports, in the form, and containing the information, as the grantor requires regarding the performance of its programs. The required reports are:~~

~~(a) The Monthly Expenditure Report which reports the accrued monthly expenditures, by program, of the grantee. The due dates are: July and August reports are due the last working day of September. October, November, January, February, and April~~

~~reports will be due the last working day of the following month. September December and March will be due the closest working day to the 5th of November, February and May respectively. The monthly expenditures for May and June will be reported on the year-end settlement package.~~

~~(b) The Monthly Schedule of OJTED Funds Received and Disbursed, which includes all funds received from the grantor, and all funds disbursed. The funds disbursed will be reported on a cash basis. This report will show the grantee's cash position and number of day of cash on hand. The due dates will be the same as the Monthly Expenditure Report.~~

~~(c) The Utah Request for Funds (URF), which is used to request weekly cash receipts from the grantor. This will record the grantee's cash request.~~

~~(d) The Year-end Financial Settlement Package, which includes reports to close-out lapsing programs and finalize year-end financial records of the grantee. The annual Settlement Package is due the to OJTED on the closest working day to August 7.~~

~~(e) The Authorized Signature Card, which certifies individuals authorized to sign the URF, the Monthly Expenditure Reports, the Monthly Schedule of OJTED Funds Received and Disbursed, and the Year-end Settlement Reports.~~

~~These reports allow the grantor to fulfill DOL reporting requirements as well as perform the necessary monitoring of the grantee.~~

~~KEY: training programs, employment, unemployed workers, unemployment~~
~~1992~~
~~Notice of Continuation June 29, 1998~~
~~35A-5~~]

▼ ▼

Workforce Services, Administration
R982-501
JTPA Procurement/Property Management Procedures

NOTICE OF PROPOSED RULE
(Repeal)
DAR FILE NO.: 26412
FILED: 06/24/2003, 16:18

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule was enacted under the Job Training Partnership Act (JTPA) which was a federal program and has been replaced with the Workforce Investment Act (WIA). The rules for JTPA are no longer needed. The Economic Dislocation and Worker Adjustment Assistance Act and the Worker Adjustment and Retraining Notification Act are still in effect but are governed by federal regulation. No state rules are needed for those two programs. The guidelines for the WIA are found in Rule R986-600.

SUMMARY OF THE RULE OR CHANGE: This rule is repealed in its entirety.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 34A, Chapter 5

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be no costs or savings to the state budget as all of the programs covered by this rule were federally funded and no state funding was ever used for these programs.
❖ LOCAL GOVERNMENTS: This rule only dealt with federally-funded programs and had no effect on local government. There will be no costs or savings to local government.
❖ OTHER PERSONS: There will be no costs or savings to any other persons because this rule is being repealed to comply with federal legislation. Any costs or savings to other persons, if any, were contemplated by the federal legislation and the repeal of this rule will have no effect on that.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There will be no compliance costs to any affected persons from the repeal of this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of this rule will have no fiscal impact on any business in Utah.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
ADMINISTRATION
140 E BROADWAY
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/18/2003

AUTHORIZED BY: Raylene G. Ireland, Executive Director

R982. Workforce Services, Administration.
[~~R982-501. JTPA Procurement/Property Management Procedures.~~
~~R982-501-1. Authority.~~
~~(1) This rule adopts and incorporates by reference:~~
~~(a) Title 35A, Chapter 5; "Training and Workforce Improvement Act".~~
~~(b) "Job Training Partnership Act" (JTPA).~~
~~(c) "Economic Dislocation and Worker Adjustment Assistance Act" (EDWAA).~~
~~(d) Public Law 100-379, August 4, 1988; "Worker Adjustment and Retraining Notification Act" (WARN).~~

~~(e) Federal regulations 20 CFR parts 626, 627, 628, 629, 630, and 631, 1990; which apply to programs under the Job Training Partnership Act and the Economic Dislocation and Worker Adjustment Assistance Act.~~

~~(f) Federal regulation 20 CFR part 639, 1990; which applies to the Worker Adjustment and Retraining Notification Act.~~

~~(2) These laws, rules, and federal regulations govern the activities of the Department relating to programs authorized by the Job Training Partnership Act. Unless otherwise specified in a rule subsection; rules R986-603, R986-601, R986-602, R986-603, R982-401, R982-501, and R994-600 are based on these laws and federal regulations.~~

~~R982-501-2. Scope And Purpose.~~

~~(1) These procedures set forth the standards and guidelines required by the Grantor for establishing consistency and uniformity among the various entities engaged in property management and procurement for the Job Training Partnership Act (JTPA).~~

~~(2) Basic policies and procedures are incorporated herein to implement the provisions of: The Job Training Partnership Act - (JTPA), (Public Law 97-300), and Federal regulations promulgated as published in the Federal Register, Volume 48, No. 51, Tuesday, March 15, 1983, and other generally accepted principles concerning property management and procurement published in various Federal and State documents.~~

~~R982-501-3. Policy.~~

~~All property which is either purchased with JTPA funds and is totally owned or which is purchased on a "Lease Purchase Agreement" with JTPA funds, or is transferred into the JTPA Program is covered by these procedures. For the purposes of these procedures, "transferred" shall be defined as property which is inducted into the inventory of capital assets for which JTPA funds were not expended in order to acquire the item(s).~~

~~(1) Property Management.~~

~~(a) The SDA shall use all property, personal or real, purchased with JTPA funds or acquired through CETA transfer, or other transfer means into JTPA for purposes authorized under the JTPA Program.~~

~~(b) It shall be the responsibility of each SDA to maintain inventory records which adequately identify the fixed assets.~~

~~(c) All property records maintained must comply with the requirements of these procedures and are subject to audit by Federal, State, and independent auditors, and review by the Grantor.~~

~~(d) Each SDA shall ensure that all fixed assets acquired under JTPA, or transferred into the JTPA Program are tagged for identification and inventory control purposes.~~

~~(e) Each SDA shall take a 100% physical inventory every twelve months, and thirty (30) days prior to the end of the grant period. Any changes in the inventory during the period from the 30 day inventory to the close of the grant period shall be reflected in the year-end settlement.~~

~~(f) The SDA shall maintain an inventory control system which ensures adequate safeguards against property damages, loss, or theft. Immediately upon discovery of a loss of property where theft is suspected, the SDA shall notify the local law enforcement agency requesting an investigation. The SDA must also file an incident report with the Regional Office of the Department of Labor, as outlined in Subsection R986-602-13(a), and provide a copy to the Department of Workforce Services. After proper notification has been provided to the Grantor regarding any asset which has been misplaced, stolen, or otherwise lost, the Grantor will authorize the SDA, in writing, to remove the asset from the inventory. Items lost, misplaced, or stolen cannot be removed from the inventory at the discretion of the SDA.~~

~~(g) When JTPA acquired property is no longer needed or is no longer being used in a JTPA Program, title may be transferred to a non-JTPA program or sold to private parties or entities. In any case, the JTPA program will be reimbursed for the property item(s) at the fair market value. The proceeds from the sale of any property shall be used for purposes authorized under JTPA.~~

~~(h) Depreciation is allowed on JTPA acquired fixed assets.~~

~~(2) Procurement.~~

~~(a) Proposed procurements with a purchase price of $1,000.00 or more, for fixed asset items; and $10,000.00 or more, for capital improvements, shall be reviewed by the Grantee to determine consolidation of requirements for greater economy and to avoid unnecessary or duplication of purchases; and where appropriate, shall analyze lease purchase or other purchase alternatives to determine which method will provide the best use of JTPA funds.~~

~~(b) Each SDA shall use the type of procuring instrument, i.e., Sealed Bid, Request for Proposal, or Purchase Order, etc., which is appropriate to the Grantee organization for procurement, and which is in the best interest of the JTPA Program.~~

~~(c) A "cost-plus-a-percentage-of-cost" contract involving JTPA funds shall not be used.~~

~~(d) Sealed bid or proposals shall be used according to the specific needs and requirements of the procurement being made.~~

~~(e) The Grantee may use negotiated procurement procedures if competitive procurement is not feasible for one or more of the following reasons:~~

~~(i) Emergency purchases. Emergency purchase shall be defined as any purchase which is necessary as a result of a threat to public health, welfare, or safety under emergency conditions.~~

~~(ii) Sole source procurement. Sole source procurement shall be defined as the procurement of any goods or services which are only available from a single vendor.~~

~~(iii) Purchases where the aggregate cost is less than $8,000.00.~~

~~(iv) Procurements for professional services to be rendered by a university, college, or other educational institution.~~

~~(v) Procurement for which no acceptable bid is received after formal advertising or bid procedures are completed.~~

~~(vi) The procurement of highly perishable materials, or services where the price may be established by law.~~

~~(vii) Procurement of technical items or equipment requiring standardization and interchangeability with existing equipment.~~

~~(viii) Procurement for which negotiation is otherwise regulated by local law, rules, or regulations.~~

~~(f) Competition for all "negotiated" procurements shall be to the maximum extent practicable, and shall be documented in writing by no less than two bids whenever possible. Documentation shall be inclusive of such items as the date of the bid, the name of the bidding company, the individual providing the bid; along with the bid prices and the method of the bid.~~

~~(g) The Grantee shall only award contracts to responsible contractors (bidders) who appear to possess the ability to perform successfully under the terms and conditions of the proposed procurement "agreement."~~

~~(h) The first priority in selecting a bid for the delivery of services to a Grantee or participant in the JTPA Program shall be the effectiveness of the agency or organization in delivering comparable or related services based on demonstrated performance, (in terms of~~

~~the likelihood of meeting performance goals, cost, and quality of services). In compliance with the Act, Sec. 107(d), and the Governor's Special Services Coordination Plan, "proper consideration shall be given to community based organizations as service providers."~~

~~(i) JTPA funds shall not be used to duplicate facilities or services available from federal, state, or local sources, unless it is demonstrated that alternative services or facilities would be more effective or more likely to achieve the Grantee's performance goals.~~

~~(j) Educational agencies shall be given first opportunity to provide educational services, unless it can be demonstrated that alternative agencies or organizations would be more effective, or have a greater potential to enhance the participant's continued occupational and career growth.~~

~~(k) The Grantee shall not procure any occupational skill training program unless the level of skills provided in the training are in accordance with guidelines established by the Private Industry Council.~~

~~(l) The following procurements will require prior Grantor approval:~~

~~(i) All capital improvements costing $10,000.00 or more. A 100% Performance Bond shall be required for all capital improvements. Supporting documents will be required.~~

~~(ii) The purchase of all motor vehicles regardless of value.~~

~~(3) Property Disposition.~~

~~(a) Cannibalization is not an acceptable form of property disposition under the JTPA Program, unless all other resources for disposition have been exhausted; and then only with written permission of the Grantor.~~

~~(b) Property items may be disposed of under the JTPA Program by sale of items to private entities or other governmental agencies at the fair market value on the date of disposition. Documentation of fair market value will be required.~~

~~**R982-501-4. Fixed Asset and Inventory Control.**~~

~~(1) Each Grantee or subcontractor shall designate a staff member who will be responsible for coordination of property management activities and to serve as the contact person with the Grantor. This person shall be thoroughly familiar with the requirements of these procedures and shall:~~

~~(a) Review all property requirements prior to anticipated purchases of "assets" with a unit acquisition cost of $1,000.00 or more; and any anticipated cost of capital improvements with an cost of $10,000.00.~~

~~(b) Acquire prior approval from the Grantor to purchase assets.~~

~~(c) Be responsible for inventory requirements.~~

~~(d) Maintain property records in accordance with the guidelines of these procedures.~~

~~(e) Mark or "tag" all JTPA fixed assets.~~

~~(2) When a fixed asset is purchased or is in a lease-purchase status, and the Grantee has received delivery, a Fixed Asset and Inventory Control Record shall be initiated.~~

~~(a) The Fixed Asset and Inventory Control Record is a three-part carbon-packed form, available from the grantor, which describes the asset. This form must be typewritten; hand-written copies will not be accepted. The purpose of the Inventory Control Record is to accurately record and maintain historical data relative to each capitalized asset.~~

~~(b) In conjunction with the Inventory Control Record, a pre-numbered Inventory Control Tag (unnumbered tags are also supplied) is necessary for the operation of the JTPA inventory control system.~~

~~(c) One Inventory Control Record and one Inventory Control Tag will be used for each asset. The location of the Inventory Control Tag will be affixed to only fixed, permanent portions of assets, using pre-numbered tags provided by the Grantor, assigned in sequence.~~

~~(d) Whenever possible, without damaging the asset, all prior Federal identification tags should be removed from the asset so that only the JTPA Inventory Control Tag may be affixed to the asset. If it is not possible to remove prior inventory control tags, paint over the prior tag with a similar colored paint. Do not, at any time, place the JTPA Inventory Control Tag over any other identification tag.~~

~~(e) Any inventory tag which is erroneously destroyed or damaged will be replaced with a "stenciled" type of tag as stated in above information in these instructions. The Grantee is requested to "stencil" all necessary unnumbered tags with a typewriter--do not hand write the tags.~~

~~(f) Upon completion of the Fixed Asset and Inventory Control Record, and the tagging of the fixed asset with the JTPA Inventory Control Tag, the white copy of the Inventory Record will be forwarded to the Grantor. The white copy is the officially recognized master copy and will remain in the possession of the Grantor.~~

~~(g) The two carbon copies will be retained by the Grantee. The Pink copy will be the Grantee master record and will not be altered or changed at any time other than to correct induction or exit errors. This copy will be the Grantee historical record of account for each Inventory Control Tag used or assigned, as well as a master record of all assets purchased or otherwise acquired at the Grantee or subcontractor level.~~

~~(h) The yellow copy is a status change form. At any time at which the condition of the asset changes significantly, the location of the asset is changed, the asset is placed in storage or is otherwise not used, or is determined to be damaged beyond repair; a photographic copy of the yellow copy (Status Change Form) shall be made, and appropriate information corrected on the Status Change Form. The copy shall then be forwarded to the Grantor. The yellow copy will only be sent in original form to the grantor when the item is totally exited from the grantee. At that time, the Final Disposition section of the form will be completed and the yellow copy will be submitted to the Grantor.~~

~~(i) Any time an error of updated information is discovered, immediate action is required. The property officer at the Grantee Organization will notify the Grantor, in writing, of the necessary changes to correct the data.~~

~~(j) At any point that an Inventory Control Tag is be affixed to an asset that should never have been tagged, the following procedures must be followed:~~

~~(k) Prepare a Capital Asset and Inventory Control Record indicating the tag number assigned to the item.~~

~~(ii) Also indicate "Item," "Where located," the "Grantee Name," and type in large bold letters in the "Explanation" section VOIDED.~~

~~(iii) Distribution of the copies of the Inventory Record will be the same as stated above. However, both the white and yellow copies will be submitted to the Grantor at the same time.~~

~~(iv) A letter from an authorized individual at the Grantee Organization must accompany the completed white and yellow copy of the Inventory Control Record explaining in detail the reason the tag was voided.~~

KEY: training programs, employment, unemployed workers, unemployment
1992
Notice of Continuation June 29, 1998
35A-5]

▼ ▼

Workforce Services, Workforce Information and Payment Services
R994-600
Dislocated Workers

NOTICE OF PROPOSED RULE
(Repeal)
DAR FILE NO.: 26413
FILED: 06/24/2003, 16:24

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This rule was enacted under the Job Training Partnership Act (JTPA) which was a federal program and has been replaced with the Workforce Investment Act (WIA). The rules for JTPA are no longer needed. The Economic Dislocation and Worker Adjustment Assistance Act and the Worker Adjustment and Retraining Notification Act are still in effect but are governed by federal regulation. No state rules are needed for those two programs. The guidelines for the WIA are found in Rule R986-600.

SUMMARY OF THE RULE OR CHANGE: This rule is repealed in its entirety.

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Title 35A, Chapter 5

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: There will be no costs or savings to the state budget as all of the programs covered by this rule were federally funded and no state funding was ever used for these programs.

❖ LOCAL GOVERNMENTS: This was a federally-funded program and had no effect on local government. There will be no costs or savings to local government.

❖ OTHER PERSONS: There will be no costs or savings to any other persons because this rule is being repealed to comply with federal legislation. Any costs or savings to other persons, if any, were contemplated by the federal legislation and the repeal of this rule will have no effect on that.

COMPLIANCE COSTS FOR AFFECTED PERSONS: There will be no compliance costs to any affected persons from the repeal of this rule.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The repeal of this rule will have no fiscal impact on any business in Utah.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
WORKFORCE SERVICES
WORKFORCE INFORMATION
AND PAYMENT SERVICES
140 E 300 S
SALT LAKE CITY UT 84111-2333, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Suzan Pixton at the above address, by phone at 801-526-9645, by FAX at 801-526-9211, or by Internet E-mail at spixton@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/18/2003

AUTHORIZED BY: Raylene G. Ireland, Executive Director

R994. Workforce Services, Workforce Information and Payment Services.
[R994-600. Dislocated Workers.
R994-600-101. Authority.
(1) This rule adopts and incorporates by reference:
(a) "Job Training Partnership Act" (JTPA) 29 USC 1501 et seq.
(b) "Economic Dislocation and Worker Adjustment Assistance Act" (EDWAA) 29 USC 1621 et seq.
(c) "Worker Adjustment and Retraining Notification Act" (WARN) 29 USC 2101.
(d) Federal regulations 20 CFR parts 626, 627, 628, 629, 630, and 631, 1990; which apply to programs under the Job Training Partnership Act and the Economic Dislocation and Worker Adjustment Assistance Act.
(e) Federal regulation 20 CFR part 639, 1990; which applies to the Worker Adjustment and Retraining Notification Act.

R994-600-102. Definitions.
(1) Definitions that clarify the criteria used to verify dislocated worker status are:
(a) The term "terminated", means an individual has experienced an employment loss sometime during the 104 weeks (2 yrs) prior to issuance of the Certificate of Continuing Eligibility (CCE), and has been involuntarily separated or has received individual notice of layoff.
(b) The term "eligible for or have exhausted their entitlement to unemployment compensation" means the individual's wages would be considered in determining eligibility for unemployment compensation under federal or state unemployment insurance laws.
(c) The term "unlikely to return to their previous industry or occupation" means that the individual does not plan to return to his previous industry or occupation.
(d) The term "closure" means a closure of a plant, facility or enterprise, or an operating unit within a single site of employment.
(e) The term "substantial layoff" (for participant eligibility) means any reduction in force which is not the result of a plant

~~closing and which results in an employment loss at a single site of employment during any 30-day period, which includes only those employees working more than 20 hours a week for:~~

~~(i)(A) at least 33 percent of the employees and~~

~~(B) at least 50 employees; or~~

~~(ii) at least 500 employees~~

~~(f) The term "long-term unemployed" means an individual who has been unemployed for 15 or more of the 26 weeks prior to the issuance of the CCE and was employed sometime during the 104 weeks prior to the issuance of the CCE.~~

~~(g) Other considerations may be availability of rapid response funds or team at time of layoff of closure, and the possibility of conducting rapid response workshops prior to final layoff date. "Public announcement" of a closure, for the purposes of providing rapid response assistance and basic readjustment services to eligible dislocated workers who have not received a specific notification, means any mass media notification of a planned closure made by the company that indicates a planned closure date for that company or facility.~~

~~(h) "DWS" means the Department of Workforce Services.~~

~~(i) The term "involuntarily separated" means the worker did not voluntarily leave his/her employment, involuntary also includes a person who has been fired.~~

~~R994-600-103. Certification Of Dislocated Workers.~~

~~(1) Eligibility criteria and certification requirements for dislocated workers are different from the criteria and requirements for JTPA Title II clients. The following is a list of documentation required:~~

~~(a) Proof of United States citizenship or authorization papers to work in the United States;~~

~~(b) Proof of registration with the Selective Service if applicable; and~~

~~(c) A Certificate of Continuing Eligibility.~~

~~(2) A regional area may cross-certify individuals among titles. However, a dislocated worker who refuses to submit documentation that is not required for certification under EDWAA cannot be denied EDWAA certification.~~

~~R994-600-104. Dislocated Worker Criteria.~~

~~(1) DWS will verify dislocated worker status and issue the Certificate of Continuing Eligibility (CCE) on DWS form 865.~~

~~(2) DWS shall not mandate that individuals file for unemployment compensation. However, they may use the unemployment insurance process to verify dislocated worker status when questioning a discharge for cause, voluntary departure, or retirement. This process is used only to validate the employment termination, and does not require drawing unemployment insurance benefits. Use of the unemployment insurance process to determine an employment termination will be left to the professional judgment of the certifier.~~

~~(3) To document the test for unemployment insurance a copy of the UI record or monetary eligibility wage record showing the individual worked for a covered employer must be in the file.~~

~~(4) DWS may provide a displaced homemaker with a Certificate of Continuing Eligibility. Therefore, regional areas must be aware of and verify the criteria used to identify an individual as a dislocated worker. This will prevent inappropriately enrolling an individual in EDWAA before the regional area has received approval to enroll displaced homemakers.~~

~~(5) A regional area that is not expending its funds may get approval from DWS to serve displaced homemakers if they can demonstrate that such services would not adversely affect services to eligible dislocated workers. Approval must be granted before serving displaced homemakers. Serving displaced homemakers will jeopardize the state's opportunity to receive Department Of Labor National Reserve grants.~~

~~(6) If a regional area receives approval to serve displaced homemakers with EDWAA funds, the following will apply:~~

~~(a) The individual is a homemaker for a period of two or more years without significant gainful employment outside the home, and whose primary occupation during that period of time was the provision of unpaid household services for family members.~~

~~(b) The individual has found it necessary to enter the job market, but is not reasonably capable of obtaining employment sufficient to provide self-support or necessary support for dependents, due to lack of marketable job skills or other skills necessary for self-sufficiency.~~

~~R994-600-105. Certificate of Continuing Eligibility (CCE).~~

~~(1) A Certificate of Continuing Eligibility will be issued by DWS to those individuals who are identified as dislocated workers using one of the terms below:~~

~~(a) Unlikely to return to previous industry or occupation;~~

~~(b) Substantial layoff or plant closure;~~

~~(c) Long-term unemployed; or~~

~~(d) Self-employed.~~

~~(2) The CCE establishes the dislocation event. The regional area must determine program service eligibility separately. A CCE does not by itself indicate that services are necessary and reasonable.~~

~~(3) The Individual Readjustment Plan must reflect any facts relating to the dislocation event which occur after the CCE is issued. This includes validating grant specific eligibility for National Reserve Discretionary Grants.~~

~~(4) Except for Discretionary Grant-specific requirements, attempts to verify required information may be documented, then a CCE may be issued based on self declaration.~~

~~(5). CCE documents used to verify the dislocation event is listed in DRU bulletin 904 which is available for review at DWS.~~

~~R994-600-106. Allotment of EDWAA Governor's Reserve 40% Funds.~~

~~(1) This section establishes the procedure used to award governor's reserve 40% funds under EDWAA.~~

~~(2) Those 40% funds not necessary for rapid response functions will be awarded to the regional areas submitting application under the following guidelines:~~

~~(a) a regional area may request 40% funds when:~~

~~(i) Workers are dislocated by a plant closing or lay off of substantial size. "Substantial size" is equal to approximately 1/2 percent of non-farm jobs in Substate Area as determined by.~~

~~(ii) All 60% EDWAA formula funds have been obligated.~~

~~(iii) An Application For 40% Funds has been completed. submitted and approved by the Direct Response Unit (DRU);~~

~~(iv) The regional area may be requested to provide any other information that might substantiate their need for these funds.~~

~~(b) The DRU will not act on requests submitted:~~

~~(i) Prior to the receipt and review of prior year close-out packages and year end management information system information,~~

(ii) When a Department of Labor Secretary's National Reserve grant application is in process for those workers affected by the closing or lay off.
(c) The EDWAA Governor's 40% funds released to a regional area are subject to
(i) the regional area must have participants enrolled and funds fully obligated, according to the approved grant application, 30 days from the date of approval;
(ii) Funds that are not obligated may be recaptured at the administrative level;
(iii) An intervention plan developed as to the role, services, and facilities to be used in addressing the dislocation event;
(iv) funding emphasis will be given to eligible dislocated workers involved in plant closures or substantial layoffs who received rapid response services.
(v) Projects serving workers affected by multi-state or industry-wide dislocations and to areas of special need in manner that efficiently targets resources to areas of most need, encourages a direct response to economic dislocations, and promotes the effective use of funds;
(vi) dislocations where the company in cooperation with the DRU has formulated a labor-management/workforce reduction committee to provide assistance to impacted workers;
(vii) where an initial assessment of worker needs has been conducted during rapid response activities.
During times that additional increases of dislocation does not occur, an allocation of funds may be necessary.

R994-600-107. Criteria For Waiver Of 50% Retraining Expenditures.
(1) This subsection prescribes those criteria for the waiver of the 50% retraining requirement.
It must be demonstrated that dislocated workers will be prepared for employment in occupations or industries with long-term potential and one of the following criteria must be met:
(a) There is a need for additional basic readjustment or supportive services.
(b) There are insufficient training opportunities available within the regional area (indicating a need for more relocation or out of area job search, etc.).
(c) Other significant justification.

R994-600-108. The State Dislocated Worker Unit.
(1) The unit shall coordinate rapid response activities conducted within the regional area to ensure the services initiated by the rapid response team will continue and expand as funding allows.
(2) The unit shall develop an intervention plan with the assigned regional staff when there is a rapid response commitment for services not already included in the regionional area's plan of service. This intervention plan may also constitute a modification to the regional area's plan.
(3) Shall be notified by the regional area of any current or projected permanent closures or substantial layoffs.

KEY: training programs, employment, unemployed workers, unemployment
March 5, 1999
Notice of Continuation May 29, 1998
35A-1-104(4)
35A-4-502(1)(b)]

End of the Notices of Proposed Rules Section

NOTICES OF
CHANGES IN PROPOSED RULES

After an agency has published a PROPOSED RULE in the *Utah State Bulletin*, it may receive public comment that requires the PROPOSED RULE to be altered before it goes into effect. A CHANGE IN PROPOSED RULE allows an agency to respond to comments it receives.

As with a PROPOSED RULE, a CHANGE IN PROPOSED RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the CHANGE IN PROPOSED RULE including the name of a contact person, anticipated cost impact of the rule, and legal cross-references.

Following the RULE ANALYSIS, the text of the CHANGE IN PROPOSED RULE is usually printed. The text shows only those changes made since the PROPOSED RULE was published in an earlier edition of the *Utah State Bulletin*. Additions made to the rule appear underlined (e.g., example). Deletions made to the rule appear struck out with brackets surrounding them (e.g., [~~example~~]). A row of dots in the text (· · · · · ·) indicates that unaffected text was removed to conserve space. If a CHANGE IN PROPOSED RULE is too long to print, the Division of Administrative Rules will include only the RULE ANALYSIS. A copy of rules that are too long to print is available from the agency or from the Division of Administrative Rules.

While a CHANGE IN PROPOSED RULE does not have a formal comment period, there is a 30-day waiting period during which interested parties may submit comments. The 30-day waiting period for CHANGES IN PROPOSED RULES published in this issue of the *Utah State Bulletin* ends August 14, 2003. At its option, the agency may hold public hearings.

From the end of the waiting period through November 12, 2003, the agency may notify the Division of Administrative Rules that it wants to make the CHANGE IN PROPOSED RULE effective. When an agency submits a NOTICE OF EFFECTIVE DATE for a CHANGE IN PROPOSED RULE, the PROPOSED RULE as amended by the CHANGE IN PROPOSED RULE becomes the effective rule. The agency sets the effective date. The date may be no fewer than 30 days nor more than 120 days after the publication date of this issue of the *Utah State Bulletin*. Alternatively, the agency may file another CHANGE IN PROPOSED RULE in response to additional comments received. If the Division of Administrative Rules does not receive a NOTICE OF EFFECTIVE DATE or another CHANGE IN PROPOSED RULE, the CHANGE IN PROPOSED RULE filing, along with its associated PROPOSED RULE, lapses and the agency must start the process over.

CHANGES IN PROPOSED RULES are governed by *Utah Code* Section 63-46a-6 (2001); and *Utah Administrative Code* Rule R15-2, and Sections R15-4-3, R15-4-5, R15-4-7, and R15-4-9.

The Changes in Proposed Rules Begin on the Following Page.

Commerce, Occupational and Professional Licensing

R156-63

Security Personnel Licensing Act Rules

NOTICE OF CHANGE IN PROPOSED RULE
DAR File No.: 26193
Filed: 06/24/2003, 10:41

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Following a public hearing and further review by the Division and the Security Services Licensing Board, some of the proposed amendments regarding required training for armed private security officers are being deleted, as well as one deletion in the section regarding uniforms. Issues regarding additional areas of training and firearm training for armed private security officers will be sent to the Contract Security Education Advisory Peer Committee, a peer committee to the Security Services Licensing Board, for further review.

SUMMARY OF THE RULE OR CHANGE: In Subsection R156-63-603(1)(h), added the word "armed". In Subsection R156-63-603(2), changed eight hours of classroom firearms instruction back to six hours and deleted that instruction should include armed patrol techniques, and legal responsibilities of an armed private security officer. Added back that the firearms instruction should include ethical restraints on weapon use and legal restraints on weapon use. Renumbered remaining subsections. In Subsection R156-63-603(3), changed eight hours to six hours of firearms instruction on the range. In Subsection R156-63-605(2), deleted the word "prominent" regarding uniform markings. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the May 15, 2003, issue of the Utah State Bulletin, on page 16. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 58-63-101, and Subsections 58-1-106(1)(a) and 58-1-202(1)(a)

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: No additional costs will be incurred by the Division as a result of these proposed amendments beyond those costs originally identified in the first proposed rule amendment.

❖ LOCAL GOVERNMENTS: Proposed rule amendments do not apply to local governments, therefore there are no costs or savings to local governments.

❖ OTHER PERSONS: The first proposed rule amendment filing indicated that the increased hours of training time for armed private security officers would cost approximately $20 per individual for a contract security company. However, since the hours of training are no longer being increased as a result of these proposed amendments, a contract security company would no longer see the increased cost. Also, the first proposed rule amendment filing indicated a savings of $50 per individual due to the consolidation of the basic training programs for unarmed and armed private security officers. However, since the training programs are not currently being consolidated, there will be no savings of $50 per individual.

COMPLIANCE COSTS FOR AFFECTED PERSONS: The first proposed rule amendment filing indicated that the increased hours of training time for armed private security officers would cost approximately $20 per individual for a contract security company. However, since the hours of training are no longer being increased as a result of these proposed amendments, a contract security company would no longer see the increased cost. Also, the first proposed rule amendment filing indicated a savings of $50 per individual due to the consolidation of the basic training programs for unarmed and armed private security officers. However, since the training programs are not currently being consolidated, there will be no savings of $50 per individual.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Generally, this rule change includes amendments that are intended to clarify the criteria for initial licensure and the standards for conduct of licensees. The change in proposed rule eliminates a previously proposed amendment regarding increased firearm education for armed private security officers, thus eliminating the anticipated cost of $20 per armed private security officer licensee. No other fiscal impact on businesses can be foreseen from this amended rule filing. Ted Boyer, Executive Director (06/09/2003)

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
COMMERCE
OCCUPATIONAL AND PROFESSIONAL LICENSING
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Clyde Ormond at the above address, by phone at 801-530-6254, by FAX at 801-530-6511, or by Internet E-mail at cormond@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: J. Craig Jackson, Director

R156. Commerce, Occupational and Professional Licensing.
R156-63. Security Personnel Licensing Act Rules.
R156-63-603. Operating Standards - Content of Approved Basic Education and Training Program for Armed Private Security Officers.

An approved basic education and training program for armed private security officers shall have the following components:

(1) at least eight hours of basic classroom instruction to include the following:

(a) the nature and role of private security, including the limits of, scope of authority and the civil liability of a private security officer and the private security officer's role in today's society;

(b) state laws and rules applicable to private security;

(c) legal responsibilities of private security, including constitutional law, search and seizure and other such topics;

(d) situational response evaluations, including protecting and securing crime or accident scenes, notification of intern and external agencies, and controlling information;

(e) ethics;

(f) use of force, emphasizing the de-escalation of force and alternatives to using force;

(g) report writing, including taking witness statements, log maintenance, the control of information, taking field notes, report preparation and basic writing skills;

(h) armed patrol techniques, including mobile vs. fixed post, accident prevention, responding to calls and alarms, security breeches, and monitoring potential safety hazards;

(i) police and community relations, including fundamental duties and personal appearance of security officers;

(j) sexual harassment in the work place; and

(k) a final examination which competently examines the student in the subjects included in the approved program of education and training.

(2) at least [~~eight~~]six hours of classroom firearms instruction to include the following:

[~~(a) armed patrol techniques;~~
~~(b) ethical restraints on weapon use;~~
~~(c) legal responsibilities of an armed private security officer;~~
]([~~d~~]a) the weapon and its ammunition;

([~~e~~]b) the use of factory loaded ammunition only;

([~~f~~]c) the care and cleaning of the weapon;

([~~g~~]d) cleaning equipment options;

([~~h~~]e) barrel and cylinder maintenance;

([~~i~~]f) no alterations of firing mechanism;

([~~j~~]g) weapons inspection review procedures;

([~~k~~]h) firearm safety on duty;

([~~l~~]i) firearm safety at home;

([~~m~~]j) firearm safety on range;

(k) ethical restraints on weapon use;

(l) legal restraints on weapon use;

([~~n~~]m) use of deadly force under Utah law and the provisions of Title 76, Chapter 2, Part 4 and;

([~~o~~]n) the instruction that armed private security officers shall not fire their weapon unless there is an eminent threat to life and at no time will the weapon be drawn as a threat or means to force compliance with any verbal directive; and

(3) at least [~~eight~~]six hours of firearms instruction on the range to include the following:

(a) demonstration of appropriate techniques of shooting;

(b) explanation of the difference between flash sight and sight picture; and

(c) a recognized practical pistol course on which the applicant achieves a minimum score of 80%.

R156-63-605. Operating Standards - Uniforms.

(1) All unarmed and armed private security officers while on duty shall wear the uniform of their contract security company employer unless assigned to work undercover.

(2) Uniforms worn by armed or unarmed private security officers shall be marked with the name of the company or the words "Contract Security", "Security Officer", or "Security", visibly displayed on the uniform or jacket in a [~~prominent~~]manner making the uniform easily distinguishable from the uniform of any public law enforcement agency.

KEY: licensing, security guards, private security officers
2003
Notice of Continuation September 28, 2000
58-1-106(1)(a)
58-1-202(1)(a)
58-63-101

Human Services, Services for People with Disabilities
R539-1
Eligibility

NOTICE OF CHANGE IN PROPOSED RULE
DAR File No.: 26063
Filed: 07/01/2003, 16:45

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The changes to this rule are due to public comment from the original amendment related to eligibility determination for general developmental disability services and the Home and Community-Based Waiver.

SUMMARY OF THE RULE OR CHANGE: These changes apply to Sections R539-1-1 and R539-1-2. The changes in Section R539-1-1 clarify eligibility requirements for different age groups and brings this rule in line with statute; the changes are due to formatting. The changes in Section R539-1-2 clarify the requirements for the Home and Community-Based Waiver by incorporating by reference the Department of Health Rule (Rule R414-61, effective August 9, 2001). (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the March 15, 2003, issue of the Utah State Bulletin, on page 10. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 62A-5-101 and 62A-5-102

THIS RULE OR CHANGE INCORPORATES BY REFERENCE THE FOLLOWING MATERIAL: Rule R414-61 (effective August 9, 2001)

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: The changes to this rule result in cost neutrality. With the changes, there are no additional requirements, just clarification of the existing process and requirements.
❖ LOCAL GOVERNMENTS: No local government funding is used in any of these activities, therefore, it is expected that there is no cost to local governments.
❖ OTHER PERSONS: There are no additional costs for other persons. Persons applying for division services must apply for Medicaid prior to entering services, but there is no cost involved in making this application.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Persons must go to their local Department of Workforce Services (DWS) or Department of Health (DOH) to apply for Medicaid and receive a financial determination. Costs may be incurred in DWS or DOH staff time when conducting interviews and making financial determination. This is an addition to the existing process and a clarification of the applicant's role in the process.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes to this rule have no fiscal impact on the providers because this is a determination of eligibility not a determination of funding.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
Room 411
120 N 200 W
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Meredith Mannebach at the above address, by phone at 801-538-4197, by FAX at 801-538-4279, or by Internet E-mail at mmannebach@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Robin Arnold-Williams, Executive Director

R539. Human Services, Services for People with Disabilities.
R539-1. Eligibility.
R539-1-1. Eligibility for General Developmental Disability Services.

[~~A. Policy.~~
](1) The Division will serve those Applicants who meet the definition of disabled in [~~Utah Code Annotated~~]Subsections 62A-5-101(4)(a)(i) through (iv) and 62A-5-101(4)(b).[~~ These are Applicants who have a severe, chronic disability:~~]

(2) When determining limitations in the areas listed below, age appropriate abilities must be considered.

[~~a. attributable to mental or physical impairment or a combination of mental and physical impairments;~~
~~b. likely to continue indefinitely;~~
~~c. resulting in a chronic substantial functional limitation of the areas of major life activity as defined below; and~~
~~d. requiring a combination or sequence of specialized interdisciplinary or generic care, treatment, or other services that may continue throughout life and must be individually planned and coordinated.~~
~~For individuals age seven and above, substantial chronic functional limitations in at least three of the seven areas of major life functions listed below. (when determining limitations in the areas listed below, age appropriate abilities must be considered)~~
~~1.~~](a) Self-care - An Applicant who requires assistance, training and/or supervision with eating, dressing, grooming, bathing or toileting.

[~~2.~~](b) Expressive and/or Receptive Language - An Applicant who lacks functional communication skills, requires the use of assistive devices to communicate, or does not demonstrate an understanding of requests or is unable to follow two-step instructions.

[~~3.~~](c) Learning - An Applicant who has a valid diagnosis of mental retardation based on the criteria found in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

[~~4.~~](d) Mobility - An Applicant with mobility impairment who requires the use of assistive devices to be mobile and who cannot physically self-evacuate from a building during an emergency.

[~~5.~~](e) Capacity for Independent Living - An Applicant (age 7-17) who is unable to locate and use a telephone, cross streets safely, or understand that it is not safe to accept rides, food or money from strangers. An adult who lacks basic survival skills in the areas of shopping, preparing food, housekeeping, or paying bills.

[~~6.~~](f) Self-direction - A [~~child~~]Applicant (age [~~6~~](7)-17) who is significantly [~~below average~~]at risk in making age appropriate decisions. An adult who is unable to provide informed consent for medical/health care, personal safety, legal, financial, habilitative, or residential issues and/or who has been declared legally incompetent. A person who is a significant danger to self or others without supervision.

[~~7.~~](g) Economic self-sufficiency - (This area is not applicable to children under 18.) An adult who receives disability benefits and who is unable to work more than 20 hours a week or is paid less than minimum wage without employment support.

[~~For individuals six years of age or younger substantial chronic functional limitations in at least two of the four areas listed below. (Note: if only two areas are checked, one area cannot be social. Age appropriate activities must be considered.)~~
~~1. Motor Skills (gross motor, fine motor)~~
~~2. Communication/Language (expressive, receptive)~~
~~3. Cognitive Development~~
~~4. Social~~
]
(3) The Applicant or the Applicant's Representative must be a Resident[~~ (see Page 17 of this Policy Manual for definition of "Resident")~~] of the state of Utah prior to the Division's final determination of eligibility. Resident is an Applicant or Guardian who is physically present in Utah and provides a statement of intent to reside in Utah.

(4) The Applicant or Applicant's Representative shall be provided with information about Division service options and a copy of the Division's Guide to Services, Medicaid, state and local Family Councils, community resources (e.g. vocational rehabilitation, SSI, etc.). If an Applicant's Representative is interested in residential services for an Applicant who is 17 years of age and under, the Applicant's Representative shall be provided with (in addition to the [~~documents~~]information listed above) an Office of Recovery Services (ORS) Pamphlet and given instructions on how to contact ORS in order to request a required Duty of Support application.

(5) The intake process determines eligibility for Division funding as per R539-3-1.[~~ Medicaid information shall be provided to the Applicant.~~]

[~~B. Procedures.~~
~~1~~](6) It is the Applicant's or Applicant's Representative's responsibility to ensure that the appropriate documentation is provided to the Intake worker to determine eligibility.

[~~2.~~](7) The following documents are required to determine eligibility for State funded developmental disabilities services.

a. A Division Eligibility for Services Form 19 [~~(Eligibility for Services)~~]signed by a licensed physician, licensed psychologist or certified school psychologist[~~;~~]. [~~or Division Form 19C for a child six years of age or younger signed by a professional, licensed or certified in the disability field;~~]For children under seven years of age, two seperate Eligibility for Services Form 19c signed by a certified or licensed professional working in the disability field will be accepted in lieu of the Eligibility for Services Form 19. The professional will indicate on the Eligibility for Services Form 19c that the child has substantial functional limitation in three areas of major life activity or is at risk due to an existing condition associated with these limitations; that the limitations are likely to continue indefinitely; and what assessment provides the bases of this determination.

[~~b. Supporting documentation for all functional limitations identified on the Division Form 19 or Division Form 19C shall be gathered. Supporting documentation is filed in the Applicant's record. Examples of supporting documentation include, but are not limited to, an ICAP, psychological evaluation, medical health summary and a standardized developmental assessment (e.g. Batelle, Denver, Help Strands, Mullen, Developmental Profile, etc.).~~
~~c.~~](b) Inventory for Client and Agency Planning (ICAP) assessment;

[~~d.~~](c) Social History completed by or for the Applicant within one year of the date of application; [~~and~~]

[~~e.~~](d) Psychological Evaluation or, for children [~~six years of age or younger~~]under seven years of age, a Developmental Assessment[~~.~~]may be used as an alternative; and

(e) Supporting documentation for all functional limitations identified on the Division Eligibility for Services Form 19 or Division Eligibility for Services Form 19C shall be gathered and filed in applicant's record. Additional supporting documentation shall be required when eligibility is not clearly supported by the above-required documentation. Examples of supporting documentation include, but are not limited to, Mental health assessments, educational records, neuropsychological evaluations, and medical health summaries.

[~~3.~~](8) If eligibility documentation is not completed within 90 calendar days of initial contact, a [~~Form 522I (Notice of Agency Action)~~]written notification letter and Hearing Rights Form, Form 490S [~~(Hearing Rights Form)~~]shall be sent to Applicant or Applicant's Representative indicating that the intake case will be [~~closed.~~]placed in inactive status. The Applicant or Applicant's Representative may activate the application at anytime thereafter by providing the remaining required information. The Applicant or Applicant's Representative shall be required to update information.

[~~4.~~](9) When all necessary eligibility documentation is received from the Applicant or Applicant's Representative, Region staff shall:

a. determine the Applicant eligible or ineligible for funding for developmental disabilities supports; or

b. if Region staff are unable to determine eligibility, the Region staff may forward the Applicant's name and intake information to the State Eligibility Committee for placement on the Committee's next meeting agenda. The Committee shall review the Applicant's information and determine if the Applicant is eligible for funding. If the timeline goes over 90 calendar days from the date of initial referral, the Region Supervisor may grant an extension of the 90-day time frame.

[~~5.~~](10) A Notice of Agency Action, Form 522, and a Hearing Request, Form 490S, [~~are~~]shall be mailed to each Applicant or Applicant's Representative upon completion of the determination of eligibility or ineligibility for funding[~~ (see Policy 1-5, Notice of Hearing for Agency Action)~~]. The Notice of Agency Action, Form 522, [~~should~~]shall inform the Applicant or Applicant's Representative of eligibility determination and placement on the waiting list.

(11) Non-Waiver Persons who do not meet Waiver level of care must apply for a Medicaid Card prior to entering into services. Non-Waiver Persons who meet Waiver level of care must apply for determination of financial eligibility using Form 927 prior to entering into services. Non-Waiver Persons who apply for a Medicaid Card or for a determination of Waiver financial eligibility shall provide the support coordinator with the determination letter within 10 days of the receipt of such documentation. Non-Waiver Persons who fail to comply with these requirements shall have funding reduced to the state match rate. As per R539-1-5.

(12) This policy does not apply to Applicants who meet the separate eligibility criteria for personal assistance and brain injury outlined in Rule 539-1-3 and Rule 539-1-4 respectively.

R539-1-2. Eligibility for [~~Home and Community-Based~~]Developmental Disabilities/Mental Retardation Waiver Services.

[~~A. Policy.~~
](1) Matching federal Medicaid funds are available through the Home and Community-Based Waiver for People with Mental Retardation and Developmental Disabilities to provide an array of home and community-based services that an eligible individual

needs to avoid institutionalization. To be determined eligible for Waiver funding Applicants must:

[1.](a) Meet all state defined, age-appropriate eligibility requirements as listed in R539-1-1[including having a disability that results in substantial chronic functional limitation(s) in three or more of major life activities 1 through 6 (economic self-sufficiency is not allowed as a functional limitation for Waiver eligibility) for individuals seven years of age or older, or two of four major life activities 1 through 4 for children six years of age or younger (if only two substantial chronic functional limitations are checked, one cannot be social)]; and

(b) Meet eligibility requirements as detailed in the Department of Health R414-61 (August 9, 2001) which this Division incorporates by reference.

[2. Require the Level of Care provided in an Intermediate Care Facility for People with Mental Retardation, (per Code of Federal Regulations, 42 CFR Part 441 Subpart G).

3.](2) Applicants who are found eligible for Waiver funding must participate in the Medicaid Waiver. If the Applicant chooses not to participate in the Waiver, their funding will be equivalent to the State portion of the Waiver budget they would have received had they participated in the Waiver.

[This policy does not apply to Applicants who meet the separate eligibility criteria for personal assistance and brain injury outlined in Division policy 3-1 and 4-1 respectively. Applicants who have a disability due only to mental illness, hearing impairment and/or visual impairment, learning disability, behavior disorder, substance abuse, personality disorder or the aging process do not qualify for services under this policy.

Procedure

1. Applicants found eligible for the Waiver based on their disability shall be provided with an array of service options, including a list of Intermediate Care Facilities for People with Mental Retardation (ICFs/MR). (For persons under 11 years of age, see Procedure 5C below.)

A. If the Applicant chooses to receive services in an Intermediate Care Facility for People with Mental Retardation (ICF/MR), the Region Director will write a letter of referral.

B. If funding is unavailable for an Applicant who chooses to receive services from a community Provider, the Applicant's name is entered on the waiting list in accordance with Division policy 2-2, Waiting List and Needs Assessment.

C. As per Utah Code Annotated 62A-5-402 (2)(a) and 62A-5-403, children under 11 years of age should reside in a family-like environment. Exceptions to the statute require an Emergency Services Management Committee review and recommendation to the Division Director for final written approval.

2.](3) Children six years of age, who are currently receiving Division funding, must initiate a division Form 19 before a child's seventh birthday to re-determine eligibility for Division funding. If the child is determined to not be eligible or the Division Form 19 is not returned within 90 calendar days from the day a Form 19 was either given or mailed to the Applicant or Applicant's Representative, a Notice of Agency Action, Form 522I[(Notice of Agency Action)] and a Notice of Agency Action, Form 490S [(Hearing Rights Form) are]shall be sent to the Applicant or Applicant's Representative.

KEY: disabled persons, social services
2003
Notice of Continuation December 18, 2002
62A-5-103

▼ ——— ▼

Insurance, Administration
R590-126
Accident and Health Insurance Minimum Standards Rule

NOTICE OF CHANGE IN PROPOSED RULE

DAR File No.: 26111
Filed: 06/30/2003, 14:24

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: These changes are a result of comments received during the hearing and comment period for the original repeal and reenact filing.

SUMMARY OF THE RULE OR CHANGE: A summary of the changes are as follows: 1) the word "minimum" is being eliminated from the phrase "minimum standards rule"; 2) in Section R590-126-3, a definition for "disability income" and "preexisting condition" for health benefit plan has been added. The definition for "sickness" and "usual and customary" has been changed; 3) in Section R590-126-4, the list of specified diseases or conditions has been expanded. The list of limitations or exclusions allowed has been significantly expanded; 4) in Subsection R590-126-5(7), clarification was added regarding pregnancy benefit extension; and 5) in Subsection R590-126-7(7)(e), the exception for business buyout coverage was re-inserted into the rule. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed repeal and reenact that was published in the April 1, 2003, issue of the Utah State Bulletin, on page 25. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 31A-2-201, 31A-2-202, 31A-21-201, 31A-22-605, 31A-22-623, 31A-22-626, 31A-23-302, and 31A-26-301

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: As a result of the above noted changes, companies will have to file their revised policy forms with the department which will cause additional work for the department but not require an additional employee. The changes will not result in any cost savings for the state.

❖ LOCAL GOVERNMENTS: The changes to this rule will not affect local government since it deals solely with the relationship of health insurers to the department.

❖ OTHER PERSONS: Health insurers doing business in Utah will have to revise their policy forms to comply with these changes, and in addition, incur the cost of printing and mailing to their insureds. Additional help should not be required. As a result of the increased number of specified diseases or conditions allowed and the number of limitations or exclusions allowed, as noted in Section R590-126-4, insurers may need to change their claims or administrative process. As a result, fewer claims may be paid.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Health insurers doing business in Utah will have to revise their policy forms to comply with these changes and in addition incur the cost of printing and mailing to their insureds. Additional help should not be required. As a result of the increased number of specified diseases or conditions allowed and the number of limitations or exclusions allowed, as noted in Section R590-126-4, insurers may need to change their claims or administrative process. As a result, fewer claims may be paid.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Health insurers doing business in Utah will have some minor costs to change and distribute their policy forms and they may experience some cost savings in the area of claim payments.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

INSURANCE
ADMINISTRATION
Room 3110 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jilene Whitby at the above address, by phone at 801-538-3803, by FAX at 801-538-3829, or by Internet E-mail at jwhitby@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/15/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/18/2003

AUTHORIZED BY: Jilene Whitby, Information Specialist

R590. Insurance, Administration.
R590-126. Accident and Health Insurance [~~Minimum~~]Standards[~~ Rule~~].
R590-126-1. Authority.

This rule is issued by the insurance commissioner pursuant to the following provisions of the Utah Insurance Code:

(1) Subsection 31A-2-201(3)(a) authorizes rules to implement the Insurance Code;

(2) Section 31A-2-202 and Subsection 31A-23-312(2) authorizes the commissioner to request reports, conduct examinations, and inspect records of any licensee;

(3) Section 31A-22-605 requires the commissioner to adopt rules to establish [~~minimum~~]standards for disclosure in the sale of, and benefits to be provided by individual and franchise accident and health polices;

(4) Section 31A-22-623 requires coverage of inborn metabolic errors;

(5) Section 31A-22-626 requires coverage of diabetes;

(6) Subsection 31A-23-302(8) governs unfair marketing practices; and

(7) Subsection 31A-26-301(1) governs claims payment practices.

R590-126-2. Purpose and Scope.

(1) Purpose. The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.

(2) Scope.

(a) This rule shall apply to all accident and health insurance policies, including health maintenance organization contracts, and subscriber contracts of hospital, medical and dental service corporations. Conversion policies shall be subject to this rule except where Section 31A-22-701, et. seq., requires otherwise.

(b) This rule shall not apply to:

(i) Medicare supplement policies; or

(ii) group health benefit plans issued to an employer.

R590-126-3. Definitions.

In addition to the definitions of 31A-1-301 and Subsection 31A-22-605(2), the following definitions shall apply for the purposes of this rule.

(1) "Accident," "accidental injury," and "accidental means" shall be defined to employ [~~"~~]result[~~"~~] language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

(b) Unless otherwise prohibited by law, the definition may exclude injuries for which benefits are paid under worker's compensation, any employer's liability or similar law, or a motor vehicle no-fault plan.

(2) "Adult Day Care" shall mean a facility duly licensed and operating within the scope of such license, which provides a group program designed to meet the needs of functionally impaired adults for a period of fewer than 24 hours per day.

(3) "Certificate of Completion" shall mean a document issued by the Utah Board of Education to a person who completes an approved course of study not leading to a diploma, or to one who passes a challenge for that same course of study, or to one whose out-of-state credentials and certificate are acceptable to the Board.

(4) "Complications of pregnancy" shall mean diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy.

(a) "Complications of Pregnancy" include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia, [pre-eclapsia] pre-eclampsia and toxemia.

(b) This definition does not include false labor, occasional spotting, doctor prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy.

(5) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall mean a facility duly licensed and operating within the scope of such license.

(6) "Cosmetic Surgery" or "Reconstructive Surgery" shall mean any surgical procedure performed primarily to improve physical appearance.

(a) This definition does not include surgery, which is necessary:

(i) to correct damage caused by injury or sickness;

(ii) for reconstructive treatment following medically necessary surgery;

(iii) to provide or restore normal bodily function; or

(iv) to correct a congenital disorder that has resulted in a functional defect.

(b) This provision does not require coverage for preexisting conditions otherwise excluded.

(7) "Custodial Care" shall mean a Plan of Care, which does not provide treatment for sickness or injury, but is only for the purpose of meeting personal needs and maintaining physical condition when there is no prospect of effecting remission or restoration of the patient to a condition in which care would not be required. Such care may be provided by persons without nursing skills or qualifications. If a nursing care facility is only providing custodial or residential care, the level of care may be so characterized.

(8) "Disability Income" shall mean income replacement as defined in Section 31A-1-301.

([8]9) "Elimination Period" or "Waiting Period" shall mean the specified number of consecutive days at the start of each period of disability for which no benefits are payable.

([9]10) "Experimental Treatment" is defined as medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices which are not accepted as a valid course of treatment by [your state's medical association]the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

(1[0]1) "Home Health Agency" shall mean a public agency or private organization, or subdivision of a health care facility, licensed and operating within the scope of such license.

(1[1]2). "Home Health Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows performance of health care and other related services under the supervision of a registered nurse from the home health agency, or performance of simple procedures as an extension of physical, speech, or occupational therapy under the supervision of licensed therapists.

(1[2]3) "Home Health Care" shall mean services provided by a home health agency.

(1[3]4) "Homemaker" shall mean a person who cares for the environment in the home through performance of duties such as housekeeping, meal planning and preparation, laundry, shopping and errands.

(1[4]5) "Homemaker/Home Health Aide" shall mean a person who has obtained a Certificate of Completion, as required by law, which allows performance of both homemaker and home health aide services, and who provides health care and other related services under the supervision of a registered nurse from the home health agency or under the supervision of licensed therapists.

(1[5]6) "Hospice" shall mean a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of such license.

(1[6]7) "Hospital" means a facility that is licensed and operating within the scope of such license. This definition may not preclude the requirement of medical necessity of hospital confinement or other treatment.

(1[7]8) "Intermediate Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse[(R.N.)]. Such care shall be for the purpose of treating the condition for which confinement is required.

(1[8]9)"Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or it symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract;

(b) when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

([a]A) scientific evidence;

([b]B) professional standards; and

([c]C) expert opinion.

([19]20) "Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

(2[0]1) "Medicare Supplement Policy" shall mean an individual, franchise, or group policy of accident and health insurance, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act, 42 U.S.C. section 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. section 1395ss(g)(1), that is advertised, marketed, or primarily designed as a supplement to reimbursements under Medicare for hospital, medical, or surgical expenses of persons eligible for Medicare.

(2[1]2) "Mental or Nervous Disorders" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or any other mental or

emotional disease or disorder which does not have a demonstrable organic cause.

(2[~~2~~]3) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse[~~ (R.N.)~~], or licensed practical nurse[~~ (L.P.N.)~~]. If the words "nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with applicable statutes or administrative rules.

(2[~~3~~]4) "Nurse, Licensed Practical" shall mean a person who is registered and licensed to practice as a practical nurse.

(2[~~4~~]5) "Nurse, Registered" shall mean any person who is registered and licensed to practice as a registered nurse.

(2[~~5~~]6) "Nursing Care" shall mean assistance provided for the health care needs of sick or disabled individuals, by or under the direction of licensed nursing personnel.

(2[~~6~~]7) "One Period of Confinement" shall mean consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy up to a maximum of 180 days.

(2[~~7~~]8) "Partial Disability" shall be defined in relation to the individual's inability to perform one or more, but not all, of the [~~"major," "important," or "essential"~~]major, important, or essential duties of employment or occupation or may be related to a [~~"~~]percentage[~~"~~] of time worked or to a [~~"~~]specified number of hours[~~"~~] or to [~~"~~]compensation.[~~"~~] Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(2[~~8~~]9) "Personal Care" shall mean assistance, under a plan of care by a home health agency, provided to persons in activities of daily living.

([~~29~~]30) "Personal Care Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows that person to assist in the activities of daily living and emergency first aid, and who must be supervised by a registered nurse from the home health agency.

(3[~~0~~]1) "Physician" may be defined by including words such as [~~"~~]duly qualified physician[~~"~~] or [~~"~~]duly licensed physician.[~~"~~] The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws as required by Section 31A-22-618.

(3[~~1~~]2) "Plan of Care" shall mean a written plan based on assessment data or physician orders that identifies the patient's needs, who will provide needed services and how often, treatment goals, and anticipated outcomes.

(3[~~2~~]3) [~~"Preexisting Condition" may not be defined to be more restrictive than the following:~~

~~(a) Specified Disease Insurance. "Preexisting condition" shall mean a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six month period preceding the effective date of coverage of an insured person.~~

~~(b) Other Health Coverage. Unless the coverage is considered a "health benefit plan" as defined in Section 31A-1-301, "preexisting condition" shall mean the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two year period preceding the effective date of the coverage of the insured person.~~]"Preexisting Condition."

(a) Except as provided in Sections (b) and (c), a preexisting condition shall not be defined more restrictive than the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a two year period preceding the effective date of the coverage of the insured person.

(b) A specified disease insurance policy shall not define preexisting condition more restrictively than a condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(c) A health benefit plan shall not define a preexisting condition more restrictive than:

(i) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the earlier of:

(A) the enrollment date; or

(B) the effective date of coverage; or

(ii) for an individual insurance policy, a pregnancy existing on the effective date of coverage.

(3[~~3~~]4) "Probationary Period" shall mean the period of time following the date of issuance or effective date of the policy before coverage begins for all or certain conditions.

(3[4]5) "Residential Health Care Facility" shall mean a publicly or privately operated and maintained facility providing personal care to residents who require protected living arrangements.

(3[~~5~~]6) "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the [~~"major," "important," or "essential duties"~~]major, important, or essential duties of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term [~~"~~]residual disability,[~~"~~] the insurer may use [~~"~~]proportionate disability[~~"~~] or other term of similar import, which in the opinion of the commissioner adequately and fairly describes the benefit.

(3[~~6~~]7) "Respite Care" shall mean provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual insured, by taking over the tasks of that person for a limited period of time. The insured may receive care in the home, or other appropriate community location, or in an appropriate institutional setting.

(3[~~7~~]8)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(3[~~8~~]9) "Sickness[~~.~~]" means illness, disease, or disorder of an insured person.[

~~(a) The definition of this term may not be more restrictive than the following: "Sickness means sickness or disease of an insured person which manifests itself after the effective date of insurance and while the insurance is in force."~~

~~(b) A definition of sickness may provide for a probationary period, which may not exceed 30 days from the effective date of the coverage of the insured person.~~

~~(c) The definition may be further modified to exclude sickness or disease for which benefits are paid under any worker's compensation, occupational disease, employer's liability or similar law.~~]

([~~39~~]40) "Skilled Nursing Care" shall mean nursing services provided by, or under the supervision of,[~~ an R.N~~]a registered nurse. Such care shall be for the purpose of treating the condition for which the confinement is required and not for the purpose of providing intermediate or custodial care.

(4[~~0~~]1) "Therapist" may be defined as a professionally trained or duly licensed or registered person, such as a physical therapist, occupational therapist, or speech therapist, who is skilled in applying treatment techniques and procedures under the general direction of a physician.

(4[~~1~~]2) "Total Disability" may not be more restrictive than one requiring that the individual who is totally disabled not be engaged in employment or occupation for which he is or becomes qualified by reason of education, training or experience.

(a) Total disability may be defined in relation to the inability of the person to perform duties but may not be based on an individual's inability to:

(i) perform [~~"any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation,"~~]any occupation whatsoever, any occupational duty, or any and every duty of his occupation, or

(ii) engage in any training or rehabilitation program.

(b) A total disability definition or provision may not exclude benefits based on the individual's ability to engage in any employment or occupation for wage or profit.

(c) An insurer may require the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import.

(d) An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

(4[~~2~~]3)[~~ "Usual and Customary" shall mean the reasonable, usual and customary charges for services and supplies in the community where such services and supplies were provided. ~~](a) "Usual and Customary" shall mean the most common charge for similar services, medicines or supplies within the area in which the charge is incurred.

(b) In determining whether a charge is usual and customary, insurers shall consider one or more of the following factors:

(i) the level of skill, extent of training, and experience required to perform the procedure or service;

(ii) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services;

(iii) the severity or nature of the illness or injury being treated;

(iv) the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country;

(v) the cost to the provider of providing the service, medicine or supply; and

(vi) other factors determined by the insurer to be appropriate.

(4[~~3~~]4) "Waiting Period" shall mean "Elimination Period."

R590-126-4. Prohibited Policy Provisions.

(1) Probationary periods. No policy may contain provisions establishing either a probationary or a waiting period during which coverage is not provided under the policy, except as follows in Subsections (a) and (b).

(a) A probationary period of 30 days may apply under the definition of "sickness" contained in Subsection R590-126-3(38).

(b) A probationary period of up to 12 months may be applied to the following specified diseases or conditions and losses resulting from:

[~~(i) hernia;~~

~~(ii) disorder of reproductive organs;~~

~~(iii) varicose veins;~~

~~(iv) adenoids~~

~~(v) appendix; or~~

~~(vi) tonsils.~~

~~(c) The 12 month exception of Subsection (1)(b) may not be applicable where such specified diseases or conditions are treated on an emergency basis.~~

~~(d) Condition imposed waiting period in a health benefit plan must be reduced by any applicable creditable coverage.~~

~~(e) Accident policies may not contain probationary or waiting periods.~~

~~(f) Subsection (1) does not apply to specified disease policies.~~

~~(2) Dividend coverage.~~

~~(a) A policy or endorsement for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or endorsement. A dividend policy or endorsement for additional coverage shall not be issued for an initial term of less than six months.~~

~~(b) The initial renewal subsequent to the issuance of a policy or endorsement as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.~~

~~(3) Preexisting conditions. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months, six months for specified disease policies, following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate. Any preexisting condition waiting period must be reduced by any applicable creditable coverage.~~

~~(4) Return of premium. A disability income policy may contain a "return of premium" or "cash value benefit" so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy; and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to this rule shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive~~

~~waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.~~

~~(5) Hospital indemnity. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.~~

~~(6) Limitations or exclusions. Unless otherwise required, a policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:~~

~~(a) preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;~~

~~(b) mental or emotional disorders, alcoholism and drug addition;~~

~~(c) pregnancy, except for complications of pregnancy;~~

~~(d) illness, treatment or medical condition arising out of:~~

~~(i) active participation in war or act of war, whether declared or undeclared;~~

~~(ii) active participation in a felony, riot or insurrections;~~

~~(iii) service in the armed forces or units auxiliary to it;~~

~~(iv) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;~~

~~(v) aviation;~~

~~(vi) with respect to short-term nonrenewable policies, interscholastic sports; and~~

~~(vii) with respect to disability income protection policies, incarceration;~~

~~(e) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;~~

~~(f) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;~~

~~(g) treatment provided in a government hospital, except for Hospital Indemnity policies;~~

~~(h) benefits provided under:~~

~~(i) Medicare or other governmental program, except Medicaid;~~

~~(ii) a state or federal workmen's compensation; or~~

~~(iii) employers liability or occupational disease law; or~~

~~(iv) motor vehicle no-fault law. When the covered person is required by law to have no-fault coverage, the exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect;~~

~~(j) services rendered by employees of hospitals, laboratories or other institutions;~~

~~(k) services performed by a member of the covered person's immediate family;~~

~~(l) services for which no charge is normally made in the absence of insurance;~~

~~(m) dental care or treatment;~~

~~(n) corrective lenses, and examination for the prescription or fitting thereof, but policies may not exclude required lens implants following cataract surgery;~~

~~(o) hearing aids, and examination for the prescription or fitting thereof;~~

~~(p) rest cures;~~

~~(q) custodial care, except for long-term care policies;~~

~~(r) transportation;~~

~~(s) routine physical examinations;~~

~~(t) territorial limitations outside the United States; or~~

~~(u) others as may be approved by the commissioner.~~

~~(7) Acts of terrorism or nuclear release or other terms of similar import may not be excluded.~~

~~(8) Waivers. This rule shall not impair or limit, except as limited for policies or certificates subject to 31A-30, the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required.~~

~~(9) Commissioner authority. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.~~](i) adenoids;

(ii) allergy testing and treatment;

(iii) bunionectomy;

(iv) carpal tunnel surgery;

(v) cataracts;

(vi) joint replacement;

(vii) mammoplasty, reduction;

(viii) morton's neuroma, surgical treatment;

(ix) reproductive organs disorders;

(x) retained hardware removal;

(xi) sleep studies;

(xii) sterilization;

(xiii) tonsils; or

(xiv) varicose veins.

(c) The 12 month period in Subsection (1)(b) may not be applicable where such specified diseases or conditions are treated on an emergency basis.

(d) Probationary periods in a health benefit plan must be reduced by any applicable creditable coverage.

(e) Accident policies may not contain probationary or waiting periods.

(f) Subsection (1) does not apply to specified disease policies.

(2) Limitations or exclusions. Unless otherwise required, a policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(a) abortion;

(b) acupuncture and acupressure services;

(c) administrative charges for completing insurance forms, duplication services, interest, finance charges, or other administrative charges;

(d) administrative exams & services;

(e) allergy tests and treatments;

(f) axillary hyperhidrosis;

(g) benefits provided under:

(i) Medicare or other governmental program, except Medicaid;

(ii) state or federal workmen's compensation; or

(iii) employers liability or occupational disease law; or

(iv) motor vehicle no-fault law, except when the covered person is required by law to have no-fault coverage, the exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect;

(h) cardiopulmonary fitness training, exercise equipment, and membership fees to a spa or health club;
(i) charges for appointments scheduled and not kept;
(j) chiropractic;
(k) complementary and alternative medicine;
(l) corrective lenses, and examination for the prescription or fitting thereof, but policies may not exclude required lens implants following cataract surgery;
(m) cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;
(n) custodial care, except for long-term care policies;
(o) dental care or treatment;
(p) dietary products;
(q) educational and nutritional training;
(r) experimental and/or investigational services;
(s) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;
(t) gastric bypass;
(u) gene therapy;
(v) genetic testing;
(w) hearing aids, and examination for the prescription or fitting thereof;
(x) losses as a direct result of an insured person voluntarily participating in illegal activities;
(y) illness, treatment or medical condition arising out of:
(i) participation in war or act of war, whether declared or undeclared;
(ii) voluntary participation in a felony, riot or insurrections;
(iii) service in the armed forces or units auxiliary to it;
(iv) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;
(v) aviation;
(vi) with respect to short-term nonrenewable policies, interscholastic sports; and
(vii) with respect to disability income protection policies, incarceration;
(z) infertility services;
(aa) mental or emotional disorders, alcoholism and drug addictions;
(bb) preexisting conditions or diseases as allowed under subsection 4, except for congenital anomalies of a covered dependent child;
(cc) pregnancy, except for complications of pregnancy;
(dd) refractive eye surgery;
(ee) rehabilitation therapy services (physical, speech, and occupational), unless required to correct an impairment caused by a covered accident or illness;
(ff) respite care;
(gg) rest cures;
(hh) routine physical examinations;
(ii) services rendered by employees of hospitals, laboratories or other institutions;
(jj) services performed by a member of the covered person's immediate family;
(kk) services for which no charge is normally made in the absence of insurance;
(ll) sexual dysfunction;
(mm) shipping and handling;
(nn) telephone/e-mail consultations;
(oo) territorial limitations outside the United States;
(pp) transportation; and
(qq) treatment provided in a government hospital, except for hospital indemnity policies;
(3) Dividend coverage.
(a) A policy or endorsement for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or endorsement. A dividend policy or endorsement for additional coverage shall not be issued for an initial term of less than six months.
(b) The initial renewal subsequent to the issuance of a policy or endorsement as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional.
(4) Preexisting conditions. A policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months, six months for specified disease policies, following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate. Any preexisting condition waiting period must be reduced by any applicable creditable coverage.
(5) Hospital indemnity. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.
(6) Waivers. This rule shall not impair or limit, except as limited for policies or certificates subject to 31A-30, the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required.
(7) Commissioner authority. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to prohibit other policy provisions that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

R590-126-5. General Requirements.

(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in Section R590-126-3 unless such definitions comply with the requirements of that section.

(2) Rights of spouse. The following provisions apply to policies, which provide coverage to a spouse of the insured:

(a) A policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than for nonpayment of premium.

(b) A policy shall provide that in the event of the insured's death the spouse of the insured shall become the insured.

(c) The age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the noncancellation or renewal provisions of the policy. However, this requirement may not prevent termination of coverage of the older spouse upon attainment of stated age limit in the policy, so long as the policy may be continued in force as to the younger spouse to the age or for durational period as specified in said definition.

(3) Renewability.

(a) The terms "noncancellable," "guaranteed renewable," "noncancellable and guaranteed renewable," "conditionally renewable," "collectively renewable," or "optionally renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Subsection R590-126-6[~~(1)(c)~~](2).

(b) An accident and health or accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or [~~health~~]sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

(4) Cancellation and renewal.

(a) Noncancellable. The terms "noncancellable" or "noncancellable and guaranteed renewable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of 65, during which period the insurer has no right to make unilaterally any change in any provision of the policy to the detriment of the insured.

(b) Guaranteed renewable. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force, except that the insurer may make changes in premium rates by classes.

(c) Conditionally renewable. The term "conditionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal for reasons stated in the policy, or may make changes in premium rates by classes.

(d) Collectively renewable. The term "collectively renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change in any provision of the policy while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal of all policies of the same classification issued in this state, or may make changes in premium rates by classes.

(e) Optionally renewable. The term "optionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change in any provision of the policy while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal of the policy or may make changes in premium rates by classes.

(f) Notice of nonrenewal shall be given as required under 31A-30-107 if applicable, or 90 days if 31A-30-107 doesn't apply and the policy allows for nonrenewal.

(g) Health benefit plans can only be discontinued or nonrenewed as provided for in Title 31A Chapter 8, 22 and 30.

(h) A policy may not be cancelled or nonrenewed solely on the grounds of deterioration of health.

(5) Optional insureds. When accidental death and dismemberment coverage is part of the accident and health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(6) Military service. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(7) Pregnancy benefit extension. In the event the insurer cancels or refuses to renew a policy providing pregnancy benefits, the policy shall provide [~~for~~]an extension of benefits [~~as to~~]for the pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. This requirement does not apply to a policy that is canceled for the following reasons:

(a) the insured fails to pay the required premiums in accordance with the terms of the plan; or

(b) the insured person performs an act or practice that constitutes fraud in connection with the coverage or makes an intentional misrepresentation of material fact under the terms of the coverage.

(8) Post hospital admission requirement. A policy providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

(9) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(10) Recurrent disability. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than 6 months.

(11) Time limit for occurrence of loss.

(a) Accidental death and dismemberment benefits shall be payable if the loss occurs within 180 days from the date of the accident, irrespective of total disability.

(b) Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(12) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(13) Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy

was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(14) A policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

(15) Specified disease, also known as critical illness, dread disease, etc., insurance sold in conjunction with another insurance product, including but not limited to life insurance or annuities shall be in the form of a separate endorsement complying with all provisions of this rule. Specified Disease insurance shall not be incorporated into a life insurance policy or annuity contract.

(16) Notice of premium change. A notice of change in premium shall be given no fewer than 30 days before the renewal date.

R590-126-6. Required Disclosure Provisions.

(1) Applications.

(a) Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition.

(b) Completed applications shall be attached and made part of the policy.

(c) All applications for coverages specified in Section R590-126-7, except Subsection R590-126-7(5), shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides limited benefits. Review your (policy) (certificate) carefully."

(d) All applications for dental and vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides (dental) (vision) benefits only. Review your (policy) (certificate) carefully."

(2) Renewal and nonrenewal provisions. Accident and health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(3) Endorsement acceptance.

(a) Except for endorsements by which the insurer effectuates a request made in writing by the policyholder, all endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.

(b) After the date of policy issue, any endorsement that increases benefits or coverage with a concurrent increase in premium during the policy term, must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law.

(4) Additional premium. Where a separate additional premium is charged for benefits provided in connection with endorsements, the premium charge shall be set forth in the policy or certificate.

(5) Benefit payment standard. A policy or certificate that provides for the payment of benefits based on standards described as [~~"~~]usual and customary,[~~"~~] [~~"~~]reasonable and customary,[~~"~~] or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(6) Preexisting conditions. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(7) Age limitation. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage and schedule page.

(8) Conversion privilege. If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall read "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(9) Specified Disease Insurance buyers guide. An insurer[~~s~~], except a direct response insurer, shall give a person applying for specified disease insurance, a buyer's guide approved by the commissioner at the time of [~~application~~]enrollment and shall obtain recipient's written acknowledgement of the guide's delivery. A direct response insurer shall provide the buyer's guide upon request, but not later than the time that the policy or certificate is delivered.

(10)(a) An accident-only policy or certificate shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, as follows:

Notice to Buyer: This is an accident-only (policy)(certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully.

(b) Accident-only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the notice above:

This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(11) Specified disease policies or certificates shall contain on the first page or attached to it in either contrasting color or in boldface type, at least equal to the size type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:

Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage and the buyer's guide.

(12) Hospital confinement indemnity and limited benefit health policies or certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at

least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (hospital confinement indemnity) (limited benefit health) (policy)(certificate). This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(13) Basic hospital, basic medical-surgical, basic hospital-medical surgical, and basic medical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (basic hospital) (basic medical-surgical) (basic hospital/medical-surgical) (basic medical) expense (policy)(certificate). This (policy)(certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.

(14) Dental and vision plan policies and certificates shall display prominently by type or stamp on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This (policy) (certificate) provides (dental) (vision) benefits only.

R590-126-7. Accident and Health [~~Minimum~~]Standards for Benefits.

The following [~~minimum~~]standards for benefits are prescribed for the categories of coverage noted in the following subsections. An [~~Accident~~]accident and health insurance [~~policies~~]policy or [~~certificates~~]certificate subject to this rule shall not be delivered or issued for delivery [~~in this state~~]unless it meets the required [~~minimum~~]standards for the specified categories. This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in Subsections 31A-22-605(4)(b) and (5).

[~~Minimum benefits~~]Benefits for coverages listed in this section shall include coverage of inborn metabolic errors as required by Sections 31A-22-623 and R590-194, and benefits for diabetes as required by Sections 31A-22-626 and R590-200, if applicable.

(1) Basic Hospital Expense Coverage.
Basic hospital expense coverage is a policy of accident and health insurance that provides coverage for a period of not less than 31 days during a continuous hospital confinement for each person insured under the policy. Benefits provided under this subsection may be [~~provided~~]subject to a combined deductible amount not in excess of $200 and [~~provides~~]shall include at least the following:

(a) daily hospital room and board in an amount not less than:

(i) 80% of the charges for semiprivate room accommodations; or

(ii) $100 per day;

(b) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either:

(i) 80% of the charges incurred up to at least $3000; or

(ii) ten times the daily hospital room and board benefits;

(c) hospital outpatient services consisting of:

(i) hospital services on the day surgery is performed;

(ii) hospital services rendered within 72 hours after injury, in an amount not less than $250 per accident; and

(iii) x-ray and laboratory tests to the extent that benefits for the services would have been provided if rendered to an in-patient of the hospital to an extent not less than $200.

(2) Basic Medical-Surgical Expense Coverage.
Basic medical-surgical expense coverage is a policy of accident and health insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

(a) surgical services:

(i) in amounts not less than those provided on a Current Procedure Terminology [~~(CPT)~~]based relative value fee schedule, up to a maximum of at least $1000 for one procedure; or

(ii) 80% of the reasonable charges.

(b) anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician, or the physician assistant, performing the surgical services:

(i) in an amount not less than 80% of the reasonable charges; or

(ii) 15% of the surgical service benefit; and

(c) in-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than:

(i) 80% of the reasonable charges; or

(ii) $50 per day for not less than 21 days during one period of confinement.

(3) Basic Hospital/Medical-Surgical Expense Coverage.
Basic hospital/medical-surgical expense coverage is a policy of accident and health which combines coverage and must meet the requirements of both Subsections (1) and (2).

(4) Hospital Confinement Indemnity Coverage.
Hospital confinement indemnity coverage is a policy of accident and health insurance that provides daily benefits for hospital confinement on an indemnity basis.

(a) Coverage includes an indemnity amount of not less than $50 per day and not less than 31 days during each period of confinement for each person insured under the policy.

(b) Coverage shall not be excluded due to a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless:

(i) the preexisting condition is specifically and expressly excluded; and

(ii) the coverage was offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance.

(5) Major Medical Expense Coverage.
Major medical expense coverage is a policy of accident and health insurance that provides hospital, medical and surgical expense coverage.

(a) An aggregate maximum of not less than $1,000,000 may be applied and include any combination of the following:

(i) coinsurance [~~percentage per year per covered person not to exceed 50% of covered charges~~]percentage, paid by the covered person, not to exceed 50% of covered charges per covered person per year;

(ii) coinsurance out-of-pocket maximum after any deductibles not to exceed $20,000 per covered person per year; or

(iii) deductibles stated on per person, per family, per illness, per benefit period, or per year basis.

(b) A combination of the bases provided under Subsections(5)(a)(i), (ii), and (iii) may not exceed 5% of the aggregate maximum limit under the policy for each covered person.

(c) The following services must be provided:

(i) daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(ii) miscellaneous hospital services;

(iii) surgical services;

(iv) anesthesia services;

(v) in-hospital medical services;

(vi) out-of-hospital care, consisting of physician services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(vii) at least three of the following additional benefits must also be provided:

(A) in-hospital private duty registered nurse services;

(B) convalescent nursing home care;

(C) diagnosis and treatment by a radiologist or physiotherapist;

(D) rental of special medical equipment, as defined by the insurer in the policy;

(E) artificial limbs or eyes, casts, splints, trusses or braces;

(F) treatment for functional nervous disorders, and mental and emotional disorders; or

(G) out-of-hospital prescription drugs and medications.

(d) If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

(e) The [~~minimum~~]benefits required by Subsection (5) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations.

(f) A major medical expense policy may also have special or internal limitations for [~~prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and~~]those services covered under Subsection (5)(c)[~~ and other such special or internal limitations as are approved by the commissioner~~].

(g) Except as authorized by this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(6) Basic Medical Expense Coverage.

Basic medical expense coverage is a policy of accident and health insurance that provides hospital, medical and surgical expense coverage.

(a) An aggregate maximum of not less than $500,000 may be applied, and may include any combination of the following:

(i) coinsurance percentage, [~~per year per~~]paid by the covered person, not to exceed 50% of covered charges per covered person per year;

(ii) coinsurance out-of-pocket maximum after any deductibles, not to exceed $25,000 per covered person per year; or

(iii) deductibles stated on per person, per family, per illness, per benefit period, or per year basis.

(b) A combination of the bases provided in Subsection (6)(a)(i), (ii) and (iii) may not exceed 10% of the aggregate maximum limit under the policy.

(c) The following[~~Following~~] services must be covered:

(i) daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than 31 days during continuous hospital confinement;

(ii) miscellaneous hospital services;

(iii) surgical services;

(iv) anesthesia services;

(v) in-hospital medical services;

(vi) out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

(vii) three of the following additional benefits must also be provided:

(A) in-hospital private duty graduate registered nurse services;

(B) convalescent nursing home care;

(C) diagnosis and treatment by a radiologist or physiotherapist;

(D) rental of special medical equipment, as defined by the insurer in the policy;

(E) artificial limbs or eyes, casts, splints, trusses or braces;

(F) treatment for functional nervous disorders, and mental and emotional disorders; or

(G) out-of-hospital prescription drugs and medications.

(d) If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying basic coverage.

(e) The [~~minimum~~]benefits required by Subsection (6) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations.

(f) Basic medical expense policies may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Subsection (6)(c) and other such special or internal limitations as are authorized or approved by the commissioner.

(g) Except as authorized by this subsection through the application of special or internal limitations, basic medical expense policies must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(7) Disability Income Protection Coverage.

Disability income protection coverage is a policy of accident and health insurance that provides for periodic payments, weekly or

monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that:

(a) provides that periodic payments that are payable at ages after 62 and reduced solely on the basis of age are at least 50% of amounts payable immediately prior to 62;

(b) contains an elimination period no greater than:

(i) 90 days in the case of a coverage providing a benefit of one year or less;

(ii) 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(iii) 365 days in all other cases during the continuance of disability resulting from sickness or injury;

(c) has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period.

(d) Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

(e) The provisions of this Subsection do not apply to policies providing business buyout coverage.

(8) Accident Only Coverage.

Accident only coverage is a policy of accident and health insurance that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least $1,000 and a single dismemberment amount shall be at least $500. An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the policy and outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(9) Specified Accident Coverage.

Specified accident coverage is a policy of accident and health insurance that provides coverage for a specifically identified kind of accident, or accidents, for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $2,000 for accidental death, $2,000 for double dismemberment and $1000 for single dismemberment.

(10) Specified Disease Coverage.

Specified disease coverage is a policy of accident and health insurance that provides coverage for the diagnosis and treatment of a specifically named disease or diseases. Any such policy shall meet these general provisions[~~ set forth in Subsection (10)~~]. The policy shall also meet the [~~minimum~~]standards set forth in the applicable Subsections (10)(b), (c) or (d).

(a) General Provisions.

(i) Preexisting conditions. A specified disease policy, regardless of whether the basis of issuance is a detailed application form, a simplified application form, or an enrollment form, may not deny a claim for loss which occurs more than six months after the effective date of coverage due to a preexisting condition. Such policy may not define a preexisting condition more restrictively than the definition in Subsection R590-126-3(32)[~~(a)~~].

(ii) Policy designation. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this section.

(iii) Medical diagnosis. Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted.

(iv) Related conditions. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person, not only for the specified disease, but also for any other condition or disease directly caused or aggravated by the specified disease or the treatment of the specified disease.

(v) Renewability. Specified disease coverage shall be at least Guaranteed Renewable.

(vi) Probationary period. No policy issued pursuant to this section may contain either an elimination, waiting, or probationary period greater than 30 days.

(vii) Medicaid disclaimer. Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program, designated as Medicaid or any similar name. Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

(viii) Medical care and charges. Payments may be conditioned upon a covered person receiving medically necessary care, prescribed by a physician, given in a medically appropriate location, under a medically accepted Plan of Care. Payment may be limited to amounts not in excess of usual and customary charges.

(ix) Other insurance. Benefits for specified disease coverage shall be paid regardless of other coverage.

(x) Retroactive application of coverage. After the effective date of the coverage, or the conclusion of an applicable probationary period, if any, subject to Subsection (10)(a)(vi) benefits shall begin with the first day of care or confinement, if such care or confinement is for a covered disease, even though the diagnosis is made at some later date.

(b) [~~Minimum~~]Expense Incurred Benefits. The following [~~minimum~~]benefit standards apply to specified disease coverage on an expense incurred basis.

(i) Policy limits. A deductible amount not to exceed $250, an aggregate benefit limit of not less than $25,000 and a benefit period of not fewer than three years.

(ii) Copayment. Covered services provided on an outpatient basis may be subject to a copayment which may not exceed 20%.

(iii) Covered Services. Covered services shall include the following:

(A) hospital room and board and any other hospital-furnished medical services or supplies;

(B) treatment by, or under the direction of, a legally qualified physician or surgeon;

(C) private duty nursing services of a registered nurse (R.N.), or licensed practical nurse (L.P.N.);

(D) x-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

(E) blood transfusions, and the administration thereof, including expense incurred for blood donors;

(F) drugs and medicines prescribed by a physician;

(G) professional ambulance for local service to or from a local hospital;

(H) the rental of any respiratory or other mechanical apparatuses;

(I) braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;

(J) emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease;

(K) home health care with a written prescribed plan of care;

(L) physical, speech, hearing and occupational therapy;

(M) special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and eleostomy appliances;

(N) prosthetic devices including wigs and artificial breasts; and

(O) nursing home care for non-custodial services.

(c) [~~Minimum~~]Per Diem Benefits. The following [~~minimum~~]benefit standards apply to coverages written on a per diem indemnity basis.

(i) Covered services shall include the following:

(A) hospital confinement benefit with a fixed-sum payment of at least $300 for each day of hospital confinement for at least 365 days, with no deductible amount permitted;

(B) outpatient benefit with a fixed-sum payment equal to one half the hospital inpatient benefits for each day of hospital or non-hospital outpatient surgery, radiation therapy and chemotherapy, for at least 365 days of treatment; and

(C) nursing home or home health care benefit tied to confinement in a nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following:

(I) a fixed-sum payment equal to one-half the hospital inpatient benefit for each day of skilled nursing home confinement for at least 180 days; and

(II) a fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of home health care for at least 180 days.

(ii) Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in Subsections (10)(b)(i)(C)(I) and (II), whether by definition or otherwise, may not be more restrictive than those under Medicare.

(d) Principal Sum Benefits.

(i) Benefits shall be payable as a fixed, one-time payment, made within 30 days of submission to the insurer, of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.

(ii) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, e.g., "cancer insurance," "heart disease insurance," the same dollar amounts shall be payable regardless of the particular subtype of the disease, e.g., lung or bone cancer, with one exception. In the case of clearly identifiable subtypes with significantly lower treatment costs, e.g., skin cancer, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.

(11) Catastrophic Coverage.
Catastrophic coverage is a policy of accident and health insurance that:

(a) provides benefits for medical expenses incurred by the insured to an aggregate maximum of not less than $1,000,000;

(b) contains no separate internal dollar limits;

(c) may be subject to a policy deductible which does not exceed the greater of 2% of the policy limit or the amount of other in-force accident and health insurance coverage for the same medical expenses; and

(d) contains no percentage participation or coinsurance clause for expenses which exceed the deductible.

(12) Limited Benefit Health Coverage.
Limited benefit health coverage is a policy of accident and health insurance, other than a policy covering only a specified disease or diseases, that provides benefits that are less than the [~~minimum~~]standards for benefits required under Subsections (1), (2), (3), (4), (5), (6), (8), (9), (10) and (11). These policies or contracts may be delivered or issued for delivery [~~in this state only~~]with the outline of coverage required by Section R590-126-8.

(13) The following policies are considered major medical expense coverage and shall follow the requirements of Subsections (5) and R590-126-8(5):

(a) basic hospital expense and hospital confinement indemnity; or

(b) basic medical-surgical and hospital confinement indemnity; or

(c) basic hospital expense, basic medical-surgical, and hospital confinement indemnity.

R590-126-8. Outline of Coverage Requirements.

(1) Basic Hospital Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(1). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE I

(COMPANY NAME)
BASIC HOSPITAL EXPENSE COVERAGE
THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS AND
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR
COMPREHENSIVE HEALTH INSURANCE COVERAGE
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Basic hospital coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

(c) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

daily hospital room and board;
miscellaneous hospital services; and
hospital out-patient services; and
other benefits, if any.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(2) Basic Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(2). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE II

(COMPANY NAME)
BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR
COMPREHENSIVE HEALTH INSURANCE COVERAGE
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses fees or unlimited medical-surgical expenses.

(c) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

surgical services;
anesthesia services;
in-hospital medical services; and
other benefits, if any.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(3) Basic Hospital/Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsections R590-126-7(1) and (2). The items included in the outline of coverage must appear in the sequence prescribed.

TABLE III

(COMPANY NAME)
BASIC HOSPITAL-MEDICAL-SURGICAL EXPENSE COVERAGE
THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR
COMPREHENSIVE HEALTH INSURANCE COVERAGE
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Basic hospital-medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

(c) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

daily hospital room and board;
miscellaneous hospital services;
hospital outpatient services;
surgical services;
anesthesia services;
in-hospital medical services; and
other benefits, if any.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(4) Hospital Confinement Indemnity Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(4). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE IV

(COMPANY NAME)
HOSPITAL CONFINEMENT INDEMNITY COVERAGE
THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT
INTENDED TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important feature of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Hospital confinement indemnity coverages designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

(c) (A brief specific description of the benefits in the following order:

daily benefit payable during hospital confinement; and
duration of benefit.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit, described in Section (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(f) (Any benefits provided in addition to the daily hospital benefit.)

(5) Major Medical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of R590-126-7(5). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE V

(COMPANY NAME)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY![)]

(b) Major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

daily hospital room and board;
miscellaneous hospital services;
surgical services;
anesthesia services;
in-hospital medical services;
out-of-hospital care;
maximum dollar amount for covered charges; and
other benefits, if any.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(6) Basic Medical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of R590-126-7(6). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VI

(COMPANY NAME)
BASIC MEDICAL EXPENSE COVERAGE
THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND
SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR
COMPREHENSIVE HEALTH INSURANCE COVERAGE
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Basic medical expense coverage is designed to provide, to persons insured, limited overage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

daily hospital room and board;
miscellaneous hospital services;
surgical services;
anesthesia services;
in-hospital medical services;
out-of-hospital care;
maximum dollar amount for covered charges; and
other benefits, if any.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(7) Disability Income Protection Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(7). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VII

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL EXPENSES
OUTLINE OF COVERAGE

(a) Read Your Policy (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Disability income protection coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(c) (A brief specific description of the benefits contained in this policy.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner

operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(8) Accident-Only Coverage.

An outline of coverage in the form prescribed below shall be issued in connection with policies meeting the standards of Subsection R590-126-7(8). The items included in the outline of coverage must appear in the sequence prescribed:

```
TABLE VIII
(COMPANY NAME)
ACCIDENT-ONLY COVERAGE
THIS (POLICY)(CERTIFICATE)  PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED
TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE
```

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Accident-only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(c) (A brief specific description of the benefits.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.)

(9) Specified Accident Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of R590-126-7(9). The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

```
TABLE IX
(COMPANY NAME)
SPECIFIED ACCIDENT COVERAGE
THIS (POLICY)  (CERTIFICATE)  PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE
```

(a) Read Your [~~(policy)(certificate)(Outline of Coverage)~~](Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Specified accident coverages designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(c) (A brief specific description of the benefits, including dollar amounts.)

(10) Specified Disease Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Subsection R590-126-7(10). The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

```
TABLE X
(COMPANY NAME)
SPECIFIED DISEASE COVERAGE
THIS (POLICY)  (CERTIFICATE)  PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE
```

(a) Specified disease coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

(b) Read Your ([~~p~~]Policy) ([~~c~~]Certificate)[~~(Outline of Coverage)~~] Carefully--This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(c) Specified disease coverages designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

(d) (A brief specific description of the benefits, including dollar amounts.)

(11) Catastrophic Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(11). The items included in the outline of coverage must appear in the sequence prescribed:

```
TABLE XI
(COMPANY NAME)
CATASTROPHIC COVERAGE
OUTLINE OF COVERAGE
```

(a) Read Your [~~Policy~~](Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY![~~)~~]

(b) Catastrophic coverage is designed to provide benefits for medical expenses incurred by the insured. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles with no separate internal dollar limits.

(c) (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:
daily hospital room and board;
miscellaneous hospital services;
surgical services;
anesthesia services;
in-hospital medical services;
out-of-hospital care; and
other benefits, if any.)

(d) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (c).)

(e) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

(12) Limited Benefit Health Coverage.
An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the [~~minimum~~]standards of Subsections (1), (2), (3), (4), (5), (6), (8), (9), (10) and (11). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE XII
(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

(c) (A brief specific description of the benefits, including amounts.)

(d) (A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Subsection (c).)

(e) (A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.)

(13) Dental Plans.
An outline of coverage, in the form prescribed below, shall be issued in connection with dental plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE XIII
(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL [~~MEDICAL~~]DENTAL EXPENSES
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) (A brief specific description of the benefits.)

(c) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Subsection (b).)

(d) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.)

(14) Vision Plans.
An outline of coverage in the form prescribed below shall be issued in connection with vision plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE XIV
(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL [~~MEDICAL~~]VISION EXPENSES
OUTLINE OF COVERAGE

(a) Read Your (Policy) (Certificate) Carefully--This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!

(b) (A brief specific description of the benefits.)

(c) (A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in Subsection (1)(b).)

(d) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.)

(15) An insurer shall deliver an outline of coverage to an applicant or enrollee [~~in~~]upon the sale of an accident and health insurance policy as required in this rule.

(16) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must 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."

(17) Outlines of coverage for hospital confinement indemnity, specified disease, or limited benefit policies which are to be delivered to persons eligible for Medicare by reason of age shall contain, the following language, which shall be printed on or attached to the first page of the outline of coverage:

[~~This~~]THIS IS NOT A MEDICARE SUPPLEMENT[~~ policy~~] POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(18) In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate,

an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(19) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in this rule.

R590-126-[~~10~~]9. [~~Requirements for~~]Replacement of Accident and Health Insurance Requirements.

(1) An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

(2) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection (3). The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in Subsection (4). In no event, however, will the notices be required in the solicitation of the following types of policies: accident-only and single-premium nonrenewable policies.

(3) The notice required by Subsection (2) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

TABLE XV
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concern your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

....
(Date)
....
(Applicant's Signature)

(4) The notice required by Subsection (2) for a direct response insurer shall be as follows:

TABLE XVI
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(To be included only if the application is attached to the policy). If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.

(COMPANY NAME)

R590-126-1[~~1~~]0. Separability.

If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected thereby.

R590-126-1[~~2~~]1. Existing Contracts.

Contracts issued prior to the effective date of this rule must be amended to comply with the revised provisions.

R590-126-1[~~3~~]2. Enforcement Date.

The commissioner will begin enforcing the revised provision of this rule 45 days from the rule's effective date.

KEY: health insurance
2003
Notice of Continuation February 1, 2002
31A-2-201
31A-2-202
31A-21-201
31A-22-605
31A-22-623
31A-22-626
31A-23-302
31A-26-301

Public Safety, Driver License
R708-2
Commercial Driver Training Schools

NOTICE OF CHANGE IN PROPOSED RULE
DAR File No.: 26287
Filed: 06/26/2003, 17:12

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Changes are made to the original proposed amendment because of the feedback received from the public hearing held with commercial school owners, instructors, and testers on June 6, 2003.

SUMMARY OF THE RULE OR CHANGE: The changes are: 1) defines what an "Instructor Demonstration" means; 2) includes computerized files as part of a permanent record book; 3) clarifies what "Testing Only Schools" means; 4) adds corporation and partnership language; 5) increases the surety bond minimum; 6) defines semester and quarter hours; 7) changes visual requirements for screening students; 8) allows, with division approval, testing in connection with an extended learning course at proctored testing facilities; 9) defines what credit will be accepted when students transfer from the Utah public school system; 10) changes requirements for markings on driver training vehicles; 11) deletes some of the school contract requirements; 12) defines when student record books must be updated; 13) clarifies where a school can locate in relation to facilities that issue vehicle registrations and driver licenses; and 14) makes other changes including revocations, probations, etc. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the June 1, 2003, issue of the Utah State Bulletin, on page 53. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 53-3-505

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: No changes from the original proposed amendment because these changes are for clarification.
❖ LOCAL GOVERNMENTS: No changes from the original proposed amendment because these changes are for clarification.
❖ OTHER PERSONS: No changes from the original proposed amendment because these changes are for clarification.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No changes from the original proposed amendment because these changes are for clarification.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: No changes from the original proposed amendment because these changes are for clarification.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SAFETY
DRIVER LICENSE
CALVIN L RAMPTON COMPLEX
4501 S 2700 W 3RD FL
SALT LAKE CITY UT 84119-5595, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Vinn Roos at the above address, by phone at 801-965-4456, by FAX at 801-964-4482, or by Internet E-mail at vroos@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Judy Hamaker Mann, Director

R708. Public Safety, Driver License.
R708-2. Commercial Driver Training Schools.
R708-2-1. Purpose.

Sections 53-3-501 through 509, requires the Driver License Division to administer the Commercial Driver Training Schools Act by licensing and regulating commercial driver training schools and instructors of such schools. This rule assists the division in doing that.

R708-2-2. Authority.

This rule is authorized by Section 53-3-505.

R708-2-3. Definitions.

(1) "Behind-the-wheel instruction" means instruction a student receives while driving a commercial driver training vehicle.

(2) "Branch office" means an approved location where the business of the driver training school is conducted other than the principal place of business.

(3) "Business plan" means a plan that [~~will~~]contains written acknowledgment of expectations, as outlined by this rule and a detailed explanation of how these expectations will be accomplished.

(4) "Classroom instruction" means that part of the driver training course which takes place in a classroom and which utilizes effective teaching methods such as lecture, discussion, and audio-visual aids.

(5) "Commercial driver training school" or "school" means a business enterprise conducted by an individual, association, partnership, or corporation for the education and training of persons, either practically or theoretically, or both, to drive motor vehicles, including motorcycles, and to prepare an applicant for an

examination given by the state for a license or learner permit, and charging a consideration or tuition for those services.

(6) "Commercial driver training vehicle" means a motor vehicle equipped with a second functioning foot brake and inside and outside mirrors which are positioned for use by the instructor for the purpose of observing rearward.

(7) "Commissioner" means the Commissioner of the Department of Public Safety.

(8) "Corporation" means a business incorporated under the laws of a state or other jurisdiction.

(9) "Department" means the Department of Public Safety.

(10) "Division" means the Driver License Division.

(11) "Driver training" means behind-the-wheel instruction, extended learning, observation time, and classroom instruction provided by a driver training school for the purpose of teaching students to safely operate motor vehicles.

(12) "Extended learning course" means a home-study course in driver education offered by a school and approved and operated under the direction of an institution of higher learning. The division must also approve the course.

(13) "Fraudulent practices" means any misrepresentation on the part of a licensee or any partner, officer, agent, or employee of a licensee tending to induce another to part with something of value or to surrender a legal right.

(14) "Higher education" means a university or college currently accredited by an appropriate accreditation agency recognized by the U.S. Dept. of Education and the Utah State Board of Regents.

(15) "Instructor" means any person, whether acting for himself as operator of a commercial driver training school or for any school for compensation, who teaches, conducts classes of, gives demonstrations to, or supervises practice of persons learning to drive motor vehicles, including motorcycles, or preparing to take an examination for a license or learner permit.

(16) "Instructor demonstration" means a demonstration of the operation of a motor vehicle performed by the instructor, which may be included as a part of the required six clock hours of observation time for a student.

[~~(16)~~](17) "Observation time" means the time a student is riding in the commercial driver training vehicle to observe the driver instructor, other student drivers, and other road users.

[~~(17)~~](18) "Operator" means any person who is certified as an instructor, has met requirements for operator status as outlined in this rule, is authorized or certified to operate or manage a driver training school, and who may supervise the work of any other instructor.

[~~(18)~~](19) "Partnership" means an association of two or more persons who co-own and operate a commercial driver training school or testing only school.

[~~(19)~~](20) "Permanent record book" means a permanently bound book with pages consecutively numbered, setting forth the name, address, date of birth, enrollment date, and completion date of every person receiving lessons, lectures, tutoring, instruction of any kind or any other services relating to instruction in the operation of motor vehicles. A computerized file that is printed and permanently bound at the end of the calender year will be accepted as a permanent record book upon approval by the division.

[~~(20)~~](21) "Probation" means action taken by the department which includes a period of close supervision as determined by the division.

[~~(21)~~](22) "Reinstatement" means the process for an instructor, operator, commercial driver training school or testing only school to re-license following revocation.

[~~(22)~~](23) "Revocation" means the removal of certification of an instructor license, operator license, commercial driver training school or testing only school for a period of six months.

[~~(23)~~](24) "Student record book" means a book or other record showing the name, date of birth for each student, and also the date, type, time, and duration of all lessons, lectures, tutoring, instructions or other services relating to instruction in the operation of motor vehicles. It will also contain the names of the instructors giving such lessons or instructions and identification of the vehicle in which any behind-the-wheel instruction is given.

[~~(24)~~](25) "Testing only school" means a school that has been designated by the division as a commercial testing only school, employs instructors who are certified in accordance with R708-37, and engages only in testing students for the purpose of obtaining a driver license. A testing only school may conduct behind-the-wheel and/or observation instruction upon approval by the division. A testing only school may not engage in education or training of persons, either practically or theoretically, or both, to drive motor vehicles, except when counseling the driver following a test in reference to errors made during the administration of the test or when conducting behind-the-wheel or observation instruction as approved by the division. A tester may not test an individual who has completed any behind-the-wheel or observation instruction through the school with which the tester is employed.

R708-2-4. Licensing Requirement for a Commercial Driver Training School.

(1) Every corporation, partnership or person who owns a commercial driver training school shall obtain a school license from the division. School license applications may be obtained from the Driver License Division at 4501 South 2700 West, Salt Lake City, Utah. Applicants are also responsible for obtaining any business licenses required by the municipality or county in which they are located. School and business licenses must be conspicuously displayed in the licensee's principal place of business and branch offices. Each school shall be inspected by a division representative before it can be licensed.

(2) A license is valid for the calendar year and expires on December 31 of the year issued. The annual fee for an original license is $80. The annual fee for a renewal license is $50. The annual fee for each branch license is $20. Fees shall be payable to the Department of Public Safety. If a license is revoked, or refused issuance or reinstatement, no part of the fee will be refunded.

(3) Licenses are not transferable.

(4) If a license is lost or destroyed, a duplicate will be issued upon payment of a fee of $5. A notarized affidavit setting forth the date the license was lost or destroyed and the circumstances of such loss or destruction must be provided.

(5) Whenever any school or branch office is discontinued, the school or branch office license must be surrendered to the division within five days. In such cases, the licensee shall state in writing the reason for such surrender.

(6) Any branch office or classroom facility in a location other than the school's principal place of business shall be separately licensed. A branch office shall meet the same requirements as the school's principal place of business and shall be similarly equipped and perform substantially the same services. Application for a branch office license shall be made on an application form provided

by the division. Branch offices shall be inspected by a division representative before they can be licensed.

(7) Each school [~~or branch office~~]must employ a licensed operator to operate the school and each branch office before it may become licensed. The current licensed operator must be identified on the application maintained by the division for each school or branch office. It is permissible for a single operator to operate multiple branch offices of the same school. If at any time the operator discontinues employment with the school, a new operator must be employed before continuation of operation of the school, including any branch offices for which the individual has been identified as the operator, may occur.[~~ The name of the school operator must be listed on the school license application.~~]

(a) It is not permissible for an individual to maintain employment with more than one commercial driver training school or testing only school at a time.

(8) Only one school may be operated from a branch office or a classroom facility. It is not permissible for two or more schools owned by separate individuals and owned under different school names to operate from the same facility or office space unless one school has been designated by the division as a testing only school. One commercial driver training school and one testing only school may be operated from the same school or branch office. A clear separation of the schools must be identified, and each school must comply with standards [~~sef~~]set forth in R708-2.

(9) Each school or classroom facility must be posted with signage that will identify the school by name as the school is listed on the school certification.

R708-2-5. Licensing Requirement for a Testing Only School.

(1) Every corporation, partnership or person who owns a testing only school shall obtain a school license from the division. School license applications may be obtained from the Driver License Division at 4501 South 2700 West, Salt Lake City, Utah. Applicants are also responsible for obtaining any business licenses required by the municipality or county in which they are located. School and business licenses must be conspicuously displayed in the licensee's principal place of business and branch offices. Each school shall be inspected by a division representative before it can be licensed.

(2) A license is valid for the calendar year and expires on December 31 of the year issued. The annual fee for an original license is $80. The annual fee for a renewal license is $50. The annual fee for each branch license is $20. Fees shall be payable to the Department of Public Safety. If a license is revoked, or refused issuance or reinstatement, no part of the fee will be refunded.

(3) Licenses are not transferable.

(4) If a license is lost or destroyed, a duplicate will be issued upon payment of a fee of $5. A notarized affidavit setting forth the date the license was lost or destroyed and the circumstances of such loss or destruction must be provided.

(5) Whenever any school or branch office is discontinued, the school or branch office license must be surrendered to the division within five days. In such cases, the licensee shall state in writing the reason for such surrender.

(6) Any branch office in a location other than the school's principal place of business shall be separately licensed. A branch office shall meet the same requirements as the school's principal place of business and shall be similarly equipped and perform substantially the same services. Application for a branch office license shall be made on an application form provided by the division. Branch offices shall be inspected by a division representative before they can be licensed.

(7) It is not permissible for an individual to maintain employment with more than one commercial driver training school or testing only school at a time.

(8) Only one school may be operated from a branch office. It is not permissible for two schools owned by separate individuals and owned under different school names to operate from the same facility or office space unless one school has been designated by the division as a testing only school. One commercial driver training school and one testing only school may be operated from the same school or branch office. A clear separation of the schools must be identified, and each school must comply with standards [~~sef~~]set forth in R708-2.

(9) Each school must be posted with signage that will identify the school by name as the school is listed on the school certification.

(10) It is not required that a testing only school maintain a classroom facility in the school or branch office location. It is required that the testing only school location or branch office have a designated area in which to maintain required files and records.

R708-2-6. Application for a Commercial Driver Training School License or a Testing Only School License.

(1) Application for an original or renewal commercial driver training school license or a testing only school license must be made on forms provided by the division, signed by the applicant, and notarized. In the case of a partnership, the application must be signed by all partners. In the case of a corporation, the application must be signed by an officer of the corporation. Applications must be submitted at least 30 days prior to licensing. An appointment should be made when the application is filed to have the school inspected by a division representative.

(2) Every application must be accompanied by the following supplementary documents:

(a) in the case of a corporation, a certified copy of a certificate of incorporation;

(b) samples of all forms and receipts to be used by the school;

(c) a schedule of fees for all services to be performed by the school;

(d) a fingerprint record for each applicant, partner or corporate officers. A Bureau of Criminal Identification check will be done by the division on all applicants, partners, and corporate officers. Fingerprints may be taken by any law enforcement agency. The division may require renewal applicants to submit new fingerprint records;

(e) a certificate of insurance for each vehicle used for driver training or testing purposes;

(f) a copy of all tests and criteria which the school requires in order for a student to satisfactorily complete the driver training course all of which are subject to approval of the division; including copies of translations[~~, which must be completed by a qualified translator~~]; and

(g) evidence that a surety bond has been obtained by the school. The amount of the surety bond will be determined by the division with the use of a formula that incorporates the number of students that the school is capable of instructing over a period of three months based on its facility, equipment, personnel, and the tuition that would be collected from each student, with a minimum requirement of [~~$5,000.00~~]$10,000.00 coverage and a maximum requirement of $60,000.00 coverage. If, at any time, there is a change in the number of instructors, the number of vehicles, or the

size of the classroom facility, the required surety bond amount will be reevaluated by the division and adjusted accordingly. Cancellation of the surety bond is grounds for revocation, probation, or refusal to issue or renew the school license. A school designated by the department as a testing only school will not be required to obtain a surety bond.

(3) The division may require that a credit check be performed for each applicant. Based on the results of the credit check, the division may deny certification.

R708-2-7. Application Requirements for a Commercial Driver Training School Instructor License.

(1) Every person who serves as an instructor in a commercial driver training school, including the owner, operator, partner or corporate officer of the licensee, substitute or part-time instructor, shall obtain an instructor's license from the division. Such license shall be valid only for the specific driver training school listed on the license.

(2) A license is valid for the calendar year and expires on December 31 of the year issued. The annual fee for an original license is $15. The annual fee for a renewal license is $10. Fees shall be payable to the Department of Public Safety. If a license is revoked or refused issuance, or refused renewed, no part of the fee will be refunded.

(3) Licenses are not transferable.

(4) If an instructor license is lost or destroyed, a duplicate will be issued upon [~~proof of loss or destruction and~~]payment of a fee of $3. A notarized affidavit setting forth the date the license was lost or destroyed and the circumstances of such loss or destruction must be provided.

R708-2-8. Application Requirements for a Commercial Driver Training School Operator License.

(1) Every person who serves as an operator of a commercial driver training school, including the owner, operator, partner or corporate officer of the licensee, substitute or part-time instructor, shall obtain an operator license from the division. Such license shall be valid only for the specific driver training school listed on the license.

(2) A school operator license is not valid unless accompanied by a valid instructor license.

(a) Requirements for licensure as a school operator include six college semester credit hours or eight college quarter credit hours in business related courses through an accredited college or university; or two years experience operating a business, or a combination thereof.

(b) Prior to licensure, a potential school operator must submit a business plan to the division for approval.

(c) Individuals who are functioning in the capacity of a commercial driver training school operator prior to January 1, 2003, will not be required to comply with section (a) of this section.

(3) An operator license is valid for the calendar year and expires on December 31 of the following year issued.

(4) Licenses are non-transferable.

(5) If an operator license is lost or destroyed, a duplicate will be issued upon request. A notarized affidavit setting forth the date the license was lost or destroyed and the circumstances of such loss or destruction must be provided.

R708-2-9. Additional Requirements for Commercial Driver Training School Instructors.

(1) In addition to obtaining a license, a commercial driver training school instructor must:

(a) have a valid Utah driver license;

(b) be at least twenty one years of age;

(c) have at least three years of driving experience in the United States, Canada, or a country with which the state of Utah has established a license reciprocity agreement;

(d) have a driving record free of conviction for a moving violation or chargeable accident resulting in suspension or revocation of the driver license for the two year period immediately prior to application and during employment and be checked to determine if there is an unsatisfactory driving record in any state;

(e) be in acceptable physical condition as required by Section 8 of this rule;

(f) complete specialized professional preparation in driver safety education consisting of not less than 21 quarter hours, or 14 semester hours of credit as approved by the division. Of the 21 quarter hours or 14 semester hours, one class must be in teaching methodology and another class must include basic driver training instruction or organization and administration of driver training instruction;

(g) pass a written test given by the division. The test may cover commercial driver training school rules, traffic laws, safe driving practices, motor vehicle operation, teaching methods and techniques, statutes pertaining to commercial driver training schools, business ethics, office procedures and record keeping, financial responsibility, no fault insurance, procedures involved in suspension or revocation of an individual's driving privilege, material contained in the "Utah Driver Handbook", and traffic safety education programs;

(h) pass a practical driving test;

(i) pass the same standard eye test that is given to applicants who apply for a Utah operator or commercial driver license; and

(j) submit a fingerprint record for a criminal history record check.

(2) Instructors shall be sponsored by a commercial driver training school which shall be responsible for controlling and supervising the actions of the instructors. No school may knowingly employ any person as an instructor or in any other capacity if such person has been convicted of a felony or any crime involving moral turpitude.

(3) The instructor's license must be in the possession of the instructor at all times while providing behind-the-wheel or classroom instruction.

R708-2-10. Application and Medical Requirements for a Commercial Driver Training School Instructor License.

(1) Application for an original or renewal instructor's license must be made on forms provided by the division, signed by the applicant in front of a division employee authorized to administer oaths. Applications must be submitted at least 30 days prior to licensing. The original and each yearly renewal application must be accompanied by a medical profile form provided by the division and completed by a health care professional as defined in Subsection 53-3-302(2).

(2) The medical profile form shall indicate any physical or mental impairments which may preclude service as a commercial driver training school instructor. The physical examinations must take place no more than three months prior to application.

(3) The commercial driver training school desiring to employ the applicant as an instructor must sign the application verifying that the applicant will be employed by the school.

(4) When deemed necessary by the division, an applicant seeking to renew an instructor's permit may be required to take a driving skills test.

R708-2-11. Re-certification.

All [~~H~~]holders of school licenses, operator licenses, and instructor licenses may at the discretion of the division be required to re-certify every three years. Re-certification may be obtained by submitting proof of completion of classes, seminars, and workshops approved by the division.

R708-2-12. Classroom and Behind-The-Wheel Instruction.

(1) Classroom instruction for students shall meet or exceed 18 clock hours and shall be conducted in not less than nine separate class sessions on nine separate days of two hours per class. Classroom curriculum may not be repeated in any of the nine sessions provided to a student. Not more than five of the classroom hours may be devoted to showing slides or films. Classroom instruction shall cover the following areas:

(a) attitudes and physical characteristics of drivers;

(b) driving laws with special emphasis on Utah law;

(c) driving in urban, suburban, and rural areas;

(d) driving on freeways;

(e) maintenance of the motor vehicle;

(f) affect of drugs and alcohol on driving;

(g) motorcycles, bicycles, trucks, and pedestrian's in traffic;

(h) driving skills;

(i) affect of the motor vehicle on modern life;

(j) Utah's motor vehicle laws regarding financial responsibility and no fault insurance, and a driver's responsibility when involved in an accident; and

(k) suspension or revocation of a driver license.

(2) Behind-the-wheel instruction shall include a minimum of six clock hours of instruction in a dual-control vehicle with a licensed instructor. Each student will be limited to a maximum of two hours of behind-the-wheel instruction per day. An instructor may not conduct more than 10 hours of behind-the-wheel instruction within a period of 24 hours and must have at least eight consecutive hours of off-duty time between each ten hour shift. The front seat of the vehicle shall be occupied by the instructor and no more than one student. Under no circumstances shall there be more than five individuals in the vehicle.

(a) Behind-the-wheel instruction shall include student practice in using vehicle controls to start, shift gears, make right and left turns, stop, backup, and park. This instruction shall begin under relatively simple conditions and progress until the student has acquired reasonable skill in operating the vehicle under varying traffic conditions.

(b) Students shall receive experience in driving on urban streets, open highways, [~~and~~]or freeways. Behind-the-wheel instruction shall include the experience of driving under variable conditions which may be used by the instructor at different times of the day and year. Special emphasis should be given to teaching students to show courtesy to other drivers and pedestrians.

(c) Students shall receive a minimum of six clock hours of observation time. This instruction [~~shall~~]may include instructor demonstrations and may not exceed two hours per day. Students observing from the rear seat, as well as the student driver, should benefit from time in the vehicle. The instructor's role is not merely to provide driving experience for the student behind-the-wheel, but to make the vehicle a practical classroom on wheels where all students may learn about the problems which face a driver and the appropriate solution to such problems.

(d) Behind-the-wheel instruction may not be conducted for a student unless the division has issued an instruction permit for the student and the instruction permit issued for the student is in the vehicle [~~and in the instructor's possession~~]at the time the instruction is conducted.

(3) All classroom and behind-the-wheel instruction will be conducted by an individual who is licensed as a commercial driver training school instructor as specified in this rule.

(a) It is a violation of this rule to conduct classroom or behind-the-wheel instruction or to allow another individual to conduct classroom or behind-the-wheel instruction without an instructors license.

(4) Instructors shall screen students for visual acuity and physical or emotional conditions which may compromise public safety before allowing students to participate in behind-the-wheel instruction. Screening may not be performed over the telephone. An employee of the school who is not certified as an instructor may not perform medical or visual screening unless approved by the division in writing.

(a) Students must have 20/40 visual acuity or better in [~~each~~]one eye and a visual field of 90 degrees[~~ in each eye~~]. Students with less than the required visual acuity and/or visual field [~~in each eye~~]shall be referred to a licensed medical practitioner for further consideration.

(b) Students must answer all questions on a health questionnaire approved by the Driver License Medical Advisory Board and sign a statement of affirmation of truth. Students indicating a physical or emotional condition on the questionnaire shall be referred to a licensed medical practitioner for further consideration. Health questionnaires shall be provided by the division.

(5) Commercial driver training schools shall provide each student a copy of the current Utah Driver Handbook. The handbook shall not be used as the sole text of the course, but as an essential aid when Utah traffic laws are studied. Handbooks may be obtained by the schools from the division.

R708-2-13. Monthly Reports.

(1) Each commercial driver training school shall submit a monthly report of the number of students completing both classroom and behind-the-wheel instruction.

(2) Monthly reports shall be submitted on forms supplied by the division and must be received by the division no later than the 15th day of each month.

(3) Failure to submit monthly reports within the prescribed time is grounds for the or revocation of the school's license.

(4) Monthly reports may be submitted electronically with division approval.

R708-2-14. Extended Learning Course.

(1) A commercial driver training school may offer an extended learning course of instruction as a substitute for the classroom

instruction set forth in Section 10 of this rule provided such course is approved by an institution of higher learning and the division.

(2) An extended learning course must be operated under the direction of an institution of higher learning. The institution of higher learning shall notify the division in writing when it has approved a school's extended learning course. The institution of higher learning will monitor any extended learning course approved by them to ensure the course is run as originally planned. They will notify the division of any substantive changes in the course as well as their approval of such changes. An institution of higher learning can approve the extended learning course of more than one school.

(3) An extended learning course shall consist at a minimum of a text, a workbook, and a 50 question competency test which addresses the subjects described in Section 10 of this rule.

(a) All materials, including texts, workbooks, and tests, used in the course must be submitted by the school to the division for approval.

(b) The average study time required to complete the workbook exercises must meet or exceed 30 clock hours.

(c) An extended learning student must complete all workbook exercises.

(d) An extended learning student must pass the 50 question written competency test at 80% or better. Testing shall occur under the following conditions:

(i) the test shall be taken at the school or at a proctored testing facility approved by the division;

[~~(ii) testing procedures shall be monitored by a licenced instructor;~~
] [~~(iii)~~](ii) the identity of the student will be verified by the licensed instructor prior to testing;

[~~(iv)~~](iii) the test shall be completed by the student without any outside help;

[~~(v)~~](iv) the school shall maintain at least three separate 50 question competency tests created from a test pool of at least 200 questions;

[~~(vi)~~](v) the extended learning student will be given a minimum of three opportunities to pass the test. After each failure the school will provide the student with additional instruction to assist the student to pass the next test;

[~~(vii)~~](vi) the original fees for the course must include the three opportunities to pass the test and any additional instruction that is required;

[~~(viii)~~](vii) an extended learning student must pass the test in order to complete driver training; and

[~~(ix)~~](viii) the school will maintain for three years records of all tests administered by the school. Test records shall include the results of all tests taken by every student.

R708-2-15. Instruction Permits.

(1) A commercial driver training school must obtain from the division an instruction permit for each student enrolled in the school. An instruction permit provides proof that the student is enrolled in a driver training course and is licensed to receive behind-the-wheel instruction with a licensed instructor. Instruction permits shall be retained by the instructor and shall be available in the vehicle at all times while the student is driving.

(a) It is the responsibility of the school to ensure that the instruction permit application contains the correct name, date of birth, and address of the student, by means of a birth certificate or other official form of identification.

(b) Application for an instruction permit must be typed or printed in ink. Duplicate instruction permits may not be issued unless the student's name and date of birth are the same as those on the original application.

(c) Instruction permits shall not be issued for persons under the age of 15 years and nine months.

(d) All unused instruction permits issued between January 1 and September 30 of each year shall be returned to the division prior to December 31 of that year. Unused permits issued during October, November, and December shall be submitted with the unused permits of the following year.

(2) Upon completion of the requirements of the driver training course, the commercial driver training school shall release to the student a form consisting of an instruction permit, a certificate of training which must be signed by the student, and a certificate of completion which must be signed by the instructor and the school owner.

(3) The student shall present the certificate of completion to the division when the student makes application for a driver license.

(4) Duplicate certificates of completion may be obtained for $5.

(5) Following notice of intent to take agency action, suspension of issuance of instruction permits to a school or instructor may occur whenever the division has reason to believe that a school or instructor is in non-compliance with this rule.

(6) After notice of intent to take agency action is sent to a school, and after allowing sufficient time for the school to have received the notice, the division will no longer issue instruction permits to the school.

(7) Suspension of issuance of instruction permits will remain in effect until such times as the school, operator or instructor is in compliance with requirements as stipulated in the notice of intent to take agency action and reinstatement of the school license, instructor license, and /or operator license has occurred. The subject of intended action may request a hearing regarding the agency's intent to take action. If a hearing is requested, suspension of issuance of instruction permits will remain in effect pending the outcome of the hearing.

(8) After a school has received notice from the division of intent for agency action to occur, it is a violation of this rule for the school to allow students to enroll in a driver training course at the school or to accept money from students for whom the school will be unable to obtain an instruction permit or for whom the school will be unable to provide a completion slip if the school license is revoked or refused renewal or reinstatement following a hearing as requested by the school.

(9) In the event that a school license is revoked or refused renewal, all incomplete instruction permits shall be returned to the division.

R708-2-16. Students Transferring from the Utah Public School System.

(1) Students transferring from the Utah public school system will not be given credit by the division for any previous partial driver education instruction unless authorized in writing by the State Office of Education.

(2) Students who have successfully completed the classroom portion of driver training in the public school system in the State of Utah or in another state, but who have not completed behind-the-wheel driving instruction and observation time, may receive credit for the classroom instruction if they provide an authorized letter or

certificate from the school which provided the training. The letter or certificate must be prepared on the school's letterhead, signed by a school representative, and state the number of classroom hours completed.

R708-2-17. Commercial Driver Training Vehicles.

(1) Commercial driver training vehicles used for behind-the-wheel instruction shall be properly registered, maintained in safe mechanical condition, and equipped with the following:

(a) functioning dual control brakes;

(b) outside and inside mirrors for both the driver and the instructor for the purpose of observing rearward;

(c) a separate seat belt for each occupant;

(d) functioning heaters and defrosters; and

(e) a functioning fire extinguisher, first aid kit, safety flares and/or reflectors.

(2) Students shall receive instruction in either standard shift or automatic transmission vehicles. The school shall have the option of choosing the type of transmission.

(3) If instruction is given in snow or on icy road surfaces tire chains or snow tires shall be used in compliance with local police or highway patrol recommendations.

(4) Vehicles must be capable of passing a state safety inspection at all times during their instructional use. Failure to maintain a vehicle in safe operating condition is grounds for the revocation of the license of the school operating the vehicle.

(5) Vehicles unable to meet safety standards shall be replaced by the school.

(6) It is the responsibility of the school to notify the division of any vehicle added to or deleted from their fleet. No vehicle may be used for driver training until it passes inspection by the division.

(7) Each vehicle used by a school for driver training shall be properly identified to safeguard against accidents. A vehicle is properly identified when the words "STUDENT DRIVER" are displayed on the front and rear and on both the left and right sides of the vehicle. The letters shall be at least three inches in height.

(8) Advertising or other markings on the vehicle for identifying or advertising the school shall [~~not exceed two inches in height~~]be approved by the division.

R708-2-18. Notification of Accident.

If any driver training vehicle is involved in an accident during the course of instruction, the school shall notify the division in writing within five working days of the date of the accident and submit to the division a copy of the investigating law enforcement officer's accident report as soon as it is available.

R708-2-19. Insurance.

(1) Each commercial driver training school or testing only school must file with the division evidence of the minimum required insurance with an insurance company authorized to do business in Utah. Schools shall maintain suitable insurance coverage on each vehicle used in the driver training program sufficient to protect the instructor, students, and the public. The minimum insurance coverage is that required by the Utah Insurance Code, in Title 31A, Chapter 22, Part 3.

(2) The insurance company supplying the policy shall furnish to the division a certificate of insurance and shall notify the division immediately upon cancellation of said insurance. Operation of a vehicle without the required minimum insurance coverage shall be grounds for revocation of the licensee's license.

R708-2-20. Contracts.

(1) A student shall not be given lessons, lectures, tutoring or any other service relating to instruction in driver training, unless a written contract approved by the division has been executed by the school and the student.

(a) The contract must be signed by both the student and a representative of the school who is employed by the school, is authorized to enter into a contract with the student on behalf of the school and who is listed as school representative on the school application. If the student is under 18 years of age, the contract must also be signed by a parent or legal guardian.

(2) A copy of the contract must be given to the student and the original retained by the school.

(3) A school shall not agree orally or in writing to give an unlimited number of lessons, to give instruction until the driver license is obtained, or to give free lessons, or a premium or discount if a driver license is not obtained.

(4) The term "no refund" or similar phrase is not permitted in contracts.

[~~(5) The contract must contain the following information:~~

~~(a) a disclaimer that specifies that if the school license is revoked or refused renewal the school will not be eligible to obtain an instruction permit for the student;~~

~~(b) a statement that if the school is unable to complete the instruction for a student, the school will reimburse all fees paid to the school by the student for instruction;~~

~~(c) a statement that if the school is unwilling or unable to reimburse the student, the student has the right to seek reimbursement for all fees paid to the school for instruction by either requesting reimbursement from the school directly, through the division in connection with the required surety bond, or by filing suit in court; and~~

~~(d) a statement that the division is not financially liable for reimbursement of fees for which a student is entitled in the event that a school is closed.~~

~~(6)~~](5) It is required that the student shall be provided with a receipt each time that money is paid by the student to the school. It is also required that the school shall maintain a copy of all receipts.

R708-2-21. Records.

(1) Every commercial driver training school shall maintain the following records:

(a) A permanent record book, defined as: a permanently bound book, with pages consecutively numbered, setting forth the name, address, date of birth, enrollment date, and completion date of every person receiving lessons, lectures, tutoring, instruction of any kind or any other services relating to instruction in the operation of motor vehicles. The permanent record book must be updated upon enrollment of each student. The division must approve the format of the permanent record book.

(b) A student record book, defined as: a book or other record showing the name and date of birth for each student; and the date, type, time of day, and duration of all lessons, lectures, tutoring, instructions or other services relating to instruction in the operation of motor vehicles. It will also contain the names of the instructors giving such lessons or instructions and identification of the vehicle in which any behind-the-wheel instruction is given. The student record book must be updated [~~on same day~~]within 24 hours of the time that instruction is conducted for each student. The division must approve the format of the student record book.

(c) Computerized files may be substituted for the permanently bound book and student record book if the format to be used has been approved by the division. It is a violation of this rule to maintain computerized files that have not been approved by the division.

(d) Each school [~~is expected to~~]shall maintain accurate, up to date records. Failure to do so is a violation of this rule.

(2) The division shall review the records of all schools at least annually and may observe the instruction given both in the classroom and behind the wheel. The division shall have the right to review the operation of the schools whenever the division deems it necessary to insure compliance with this rule.

(3) The loss, mutilation or destruction of any records which a school is required to maintain, must be immediately reported by the school to the division by affidavit stating:

(a) The date such records were lost, mutilated or destroyed; and

(b) The circumstances involving such loss, mutilation or destruction.

(4) All records must be retained by the schools for three years, with the exception of the permanently bound book or computerized file there of, which is to be kept permanently, during which time they shall be subject to inspection by the division during reasonable business hours. In the event that the school closes permanently, the permanent record book will be submitted by the school to the division.

(5) When deemed necessary by the division, the school records will be removed from the school location for the purpose of conducting an audit.

(a) When records are removed from the school location, a receipt will be provided to the school operator which will include the name of the school, location of the school, date of removal of records from the school location, information that specifies all records removed from the school location, the signature of the school operator, and the signature of a division representative.

(b) Upon return of the school records, the receipt will be updated to reflect the date that the records were returned to the school, the signature of the school operator, and the signature of the division designate returning the records.

(c) Records will be held by the division for the minimum amount of time necessary so that an audit can occur without creating an unnecessary hardship or inconvenience to the school.

(d) All records, including computerized records, must be provided to the division when requested for the purpose of an audit or review of the school's records. Failure to provide all records as requested by the division is a violation of this rule. In the event that a hearing occurs subsequent to an audit, records not provided by the school at the time of the audit may not be considered as evidence during the hearing.

R708-2-22. Advertising and School Location.

(1) Commercial driver training schools and testing only schools may not imply or expressly guarantee that a driver license is guaranteed or assured. The display of a sign such as "Driver License Secured Here" is forbidden.

(2) A Commercial driver training school or testing only school may display on its premises a sign reading, "This School is Licensed by the State of Utah".

(3) No Commercial driver training school or testing only school may solicit business directly or indirectly or display or distribute any advertising material within 1500 feet of a building in which vehicle registrations or driver licenses are issued to the public.

(4) In municipalities having a population of 50,000 or more, no license will be issued for a commercial driver training school or testing only school if the school's place of business is located within 1500 feet of a [~~building~~]facility in which vehicle registrations or driver licenses are issued to the public. If a school is established in a location prior to the origination of a facility located within 1500 feet of the school in which vehicle registrations or driver licenses are issued to the public, the school will be authorized to continue operation; however, the school's location may not be transferred to another corporation, partnership, or owner, under the same school name or a different school name.

(5) No commercial driver training school or testing only school may change its place of business or location without prior approval from the division.

(6) Each commercial driver training school shall provide classroom space, either in their own building or in any other building approved by the division. The classroom shall have seating for all students, access to sanitary facilities, and appropriate training aids, such as blackboards, charts, projectors, etc. Classroom facilities and buildings shall comply with federal, state, and local building, fire, safety and health codes.

R708-2-23. Change of Address and Officers.

(1) The commercial driver training school or testing only school shall immediately notify the division in writing if there is a change in the residence or business address of any individual owner, partner, officer or employee of the school.

(2) The commercial driver training school or testing only school shall immediately notify the division in writing of any change in officers or directors and shall provide the same information that would be required on an original application by the corporation.

(3) Failure to notify the division of a change of address, or of a change in the officers, directors or controlling stockholders of any corporation, or change in the members of a partnership, may be considered grounds for the revocation of the school license.

R708-2-24. Change in Ownership.

(1) In the event of any ownership change in the commercial driver training school or testing only school, the division must be notified immediately in writing by the new owner and a new application must be submitted. Such application shall be considered a renewal if one or more of the original licensees remain as part owner of the school. In the event the change in ownership is to any person or persons not named in the application for the last current license or renewal license of the school, such license shall be considered a new application.

(2) The division may permit continuance of the commercial driving training school or testing only school by the current licensee, pending processing of the application made by the person or persons to whom ownership of the school is to be transferred.

(3) Upon issuance of the new license, the prior license must be immediately surrendered to the division. Refund of any part of the license fee is not permitted.

R708-2-25. Grounds for Revocation, Probation or Refusal to Issue or Renew Instructor License, Oper[~~t~~]ator License, or School License.

(1) Following a hearing, the division may revoke, place on probation, or refuse to renew a license for either an instructor,

operator, commercial driver training school or a testing only school. The division may also refuse to issue a license for an instructor, operator, commercial driver training school or a testing only school. A license may be revoked, placed on probation or refused for renewal for any of the following reasons:

(a) failure to comply with any of the provisions of Title 53, Chapter 3, Part 5;

(b) failure to comply with any of the provisions of this rule;

(c) cancellation of surety bond as required in Section 6(2)(g) of this rule;

(d) providing false information in an application or form required by the division;

(e) commission of a violation of Section 7(1)(d) of this rule pertaining to moving violations or chargeable accident that results in a suspension or revocation of one's driver license;

(f) failure to permit the division or its representatives to inspect the school, classrooms, records, or vehicles used in the instruction of the school's students;

(g) conviction of any crime involving violence, dishonesty, deceit, indecency, degeneracy, drug or alcohol abuse, fraud, or moral turpitude;

(h) conviction of any fraudulent acts or practices by any partner, officer, agent or employee in relation to the business conducted under the license; or

(i) failure to appear for a hearing on any of the above charges; and

(j) violation of any of the provisions of this rule.

(2) Any proceeding to revoke, place on probation, or refuse to issue or renew an instructor license, operator license, commercial driver training school license or a testing only school license is hereby designated as an informal adjudicative proceeding under the Utah Administrative Procedures Act, Section 63-46b-4.

[~~(2)~~](3) Any licensee who has had a license revoked shall not be eligible to reapply for a license until six months have elapsed since the date of the revocation. The applicant will be required to complete an application for an original license and meet all applicable requirements for an original license as stated herein. In addition to the other fees provided for in section 4(2), the licensee shall be required to pay a $25.00 reinstatement fee for each license that was revoked to the division at the time of application for reinstatement.

(a) Upon receipt of a completed application for an instructor license, operator license, commercial driver training school license or a testing only school, and applicable documentation and fees, the division will conduct a review process as established by the division director in order to determine eligibility for reinstatement or re-licensure. Notice of a final decision will be made in writing by the division within twenty days of receipt of evidence that all applicable requirements have been met for reinstatement or re-licensure.

(b) In the event that a request for reinstatement is denied, the applicant will have an opportunity to request a hearing in writing within five days of receipt of the final decision made by the division.[

~~(3) Any proceeding to revoke, place on probation, or refuse to issue or renew an instructor license, operator license, commercial driver training school license or a testing only school license is hereby designated as an informal adjudicative proceeding under the Utah Administrative Procedures Act, Section 63-46b-4.~~]

(4) The following procedures will govern informal adjudicative proceedings:

(a) Action by the division to revoke, place on probation or refuse to issue or renew a license will be commenced by the division by the issuance of a notice of agency action. The notice of agency action will comply with the provisions of Section 63-46b-3.

(b) No response is required to the notice of agency action.

(c) An opportunity for a hearing will be granted on a revocation, probation or refusal to issue or renew a license if, within five days, the division receives in writing a request for a hearing.

(d) The licensee or applicant will receive written notice of the hearing at least ten days prior to the date of the hearing.

(e) No discovery, either compulsory or voluntary, will be permitted prior to the hearing except that all parties shall have access to information contained in the division's files, and to investigatory information and materials not restricted by law.

(f) The hearing shall be conducted by an individual, or panel, designated by the division.

(g) Within twenty days after the close of the hearing or after the failure of a party to appear for the hearing, the individual conducting the hearing shall issue a written decision which shall constitute final agency action. The written decision shall state the decision, the reason for the decision, notice of right to request reconsideration under Section 63-46b-13, notice of right of judicial review under Section 63-46b-15, and the time limits for filing an appeal to the appropriate district court.

(5) When a commercial driver training school license or a testing only school is under investigation by the division or when a commercial driver training school license or a testing only school license has been revoked, placed on probation or refused renewal, or reinstatement the school license may not be transferred to another party.

(6) If a commercial driver training school license is revoked, placed on probation or refused renewal, the existing incomplete instruction permits and or classroom, behind-the-wheel, and observation training hours may not be transferred to another school for completion.

(7) If a commercial driver training school license is revoked or refused renewal under the emergency provisions of UAPA, Section 63-46b-20, all remaining incomplete instruction permits will be confiscated from the school and the school will not be authorized to conduct business unless otherwise determined at a hearing.

(8) If an instructor license is revoked, placed on probation, or refused renewal under the emergency provisions of UAPA, Section 63-46b-20, and the school license is valid, the school may continue operation provided that there is an instructor employed by the school with a valid instructor license, and that to allow operation will not compromise public safety.

(9) If an operator license is revoked, placed on probation, or refused renewal under the emergency provisions of UAPA, Section 63-46b-20, and the school license is valid, the school may continue operation provided that there is an operator employed by the school with a valid operator license, and that to allow operation will not compromise public safety.

(10) An instructor license, operator license, commercial driver training school license or a testing only school may be placed on probation upon approval of the director of the division in the event that a violation of this section has occurred and it has been determined that the violation was not committed maliciously or with intent to defraud the department or the public. During a period of probation, provided that the terms of the probation agreement are adhered to by the subject, the instructor license, operator license, commercial driver training school license or a testing only school

license shall remain intact and the instructor, operator, or school will be allowed to continue operation.

KEY: driver education, schools, rules and procedures
2003
Notice of Continuation November 25, 2002
53-3-505

Public Safety, Driver License
R708-37
Certification of Licensed Instructors of Commercial Driver Training School to Administer Driving Skills Tests

NOTICE OF CHANGE IN PROPOSED RULE
DAR File No.: 26288
Filed: 06/26/2003, 16:48

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: This change in the original proposed amendment is being made due to public input.

SUMMARY OF THE RULE OR CHANGE: The visual requirements are changed to be consistent with the same visual requirements for getting a driver license. (DAR NOTE: This change in proposed rule has been filed to make additional changes to a proposed amendment that was published in the June 1, 2003, issue of the Utah State Bulletin, on page 62. Underlining in the rule below indicates text that has been added since the publication of the proposed rule mentioned above; strike-out indicates text that has been deleted. You must view the change in proposed rule and the proposed amendment together to understand all of the changes that will be enforceable should the agency make this rule effective.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 53-3-510

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: No changes from the original proposed amendment because this change is for consistency.

❖ LOCAL GOVERNMENTS: No changes from the original proposed amendment because this change is for consistency.

❖ OTHER PERSONS: No changes from the original proposed amendment because this change is for consistency.

COMPLIANCE COSTS FOR AFFECTED PERSONS: No changes from the original proposed amendment because this change is for consistency.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: No changes from the original proposed amendment because this change is for consistency.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SAFETY
DRIVER LICENSE
CALVIN L RAMPTON COMPLEX
4501 S 2700 W 3RD FL
SALT LAKE CITY UT 84119-5595, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Vinn Roos at the above address, by phone at 801-965-4456, by FAX at 801-964-4482, or by Internet E-mail at vroos@utah.gov

INTERESTED PERSONS MAY PRESENT THEIR VIEWS ON THIS RULE BY SUBMITTING WRITTEN COMMENTS TO THE ADDRESS ABOVE NO LATER THAN 5:00 PM on 08/14/2003.

THIS RULE MAY BECOME EFFECTIVE ON: 08/15/2003

AUTHORIZED BY: Judy Hamaker Mann, Director

R708. Public Safety, Driver License.
R708-37. Certification of Licensed Instructors of Commercial Driver Training Schools or Testing Only Schools to Administer Driving Skills Tests.
R708-37-1. Purpose.

The purpose of this rule is to establish standards and procedures to certify instructors of commercial driver training schools and testing only schools to administer driving skills tests.

R708-37-2. Authority.

This rule is authorized by Section 53-3-510.

R708-37-3. Definitions.

(1) "Agreement" means a written agreement between the state and a third-party tester agreeing to the conditions contained in this rule.

(2) "Cancellation" means action taken by the division that voids an instructor's testing certification.

(3) "Certification" means the process by which commercial driver training instructors are certified by the division to administer driving skills tests.

(4) "Commercial driver training school" or "school" means a business enterprise conducted by an individual, association, partnership, or corporation for the education and training of persons to drive motor vehicles, and to prepare applicants for examinations prerequisite to their obtaining driver licenses or learner permits.

(5) "Commercial driver training vehicle" means a motor vehicle equipped with a second functioning foot brake and inside and outside mirrors which are positioned for use by the instructor for the purpose of observing rearward.

(6) "Corporation" means a business incorporated under the laws of a state or other jurisdiction.

(7) "Division" means the Driver License Division of the Utah Department of Public Safety.

(8) "Instructor" means a person who is authorized to teach driver education in an approved commercial driver training school.

(9) "Partnership" means an association of two or more persons who co-own and operate a commercial driver training school or a testing only school.

(10) "Probation" means action taken by the department which includes a period of close supervision as determined by the division.

(11) "Suspension" means action taken by the division that temporarily voids an instructor's testing certification. The certification may be reinstated whenever the instructor follows a division-approved plan and complies with reinstatement procedures.

(12) "Test" means a driving skills test approved by the division.

(13) "Tester" means an instructor who is certified to administer driving skills tests.

R708-37-4. Application Procedures.

(1) An instructor shall become a certified tester by making application and by meeting the requirements of this rule. In order to become a certified tester, an individual must be certified as a commercial driver education instructor in accordance with R708-2-6,8 and 9. Application shall be made on a form furnished by the division and shall include the following information:

(a) the name of the instructor who is applying for tester certification;

(b) the name and address of the commercial driver training or testing only school where the instructor is employed; and

(c) the signature of the school owner indicating approval of the instructor for tester certification and consent to the use of school vehicles, facilities, etc. for the purpose of testing.

(2) The instructor must enter into a written agreement with the division. The agreement must contain provisions that:

(a) the tester cannot maintain employment with more than one commercial driver training school or testing only school at a time;

(b) allow the division to conduct random examinations, inspections, and audits without prior notice during normal business hours; and

(c) allow the division to conduct on-site inspections annually or when deemed necessary by the division.

(3) The division will offer training to instructors regarding minimum standards which must be met in the administration and scoring of tests.

(4) The division may authorize, train, and approve persons outside the division to provide the training. Instructors are responsible for any costs associated with training provided by approved organizations, agencies, or individuals.

(5) The division shall maintain a list of approved testers and shall assign testers identification numbers.

R708-37-5. Medical Screening.

(1) Prior to administering a driving skills test, the tester shall screen students for visual acuity, visual field and physical or emotional conditions which may compromise public safety. Screening may not be performed over the telephone. An employee of the tester who is not certified as an instructor or tester may not perform medical or visual screening unless approved in writing by the division.

(a) Students must have 20/40 or better visual acuity in [~~each~~]one eye and a visual field of 90 degrees[~~ in each eye~~]. Students with less than the required visual acuity and/or visual field [~~in each eye~~]shall be referred to a licensed medical practitioner for further consideration.

(b) Students must answer all questions on a health questionnaire approved by the Driver License Medical Advisory Board and sign a statement of affirmation of truth. Students indicating a physical or emotional condition on the questionnaire shall be referred to a licensed medical practitioner for further consideration. Health questionnaires shall be provided by the division and maintained for three years by the commercial driver training school or testing only school as a part of the school's records.

(c) The driver will not be required to submit to a medical screening if one of the following is provided to the tester:

(i) a verification of medical fitness approval form as completed by a commercial driver education instructor; or

(ii) a driver receipt issued by the division that indicates that the medical screening has taken place in the division.

R708-37-6. Tests.

(1) When testing students for driver licenses, instructors certified as testers shall administer tests developed in accordance with these rules which meet or exceed minimum division testing standards.

(2) Tests shall be conducted:

(a) on test routes approved by the division;

(b) by certified testers who are also certified instructors;

(c) in vehicles provided by commercial driver training schools or testing only schools which have been inspected and approved for use in driver training by the division or in a personal vehicle provided by the applicant. Each school shall notify the division of any vehicle added to or deleted from their fleet. No vehicle owned by a commercial driver training school or testing only school may be used for testing until it passes an inspection by the division;

(d) using division approved content, forms, and scoring procedures;

(e) only for students who have completed a course of driver education or who have had a previous driver license;

(f) with only the student and the tester occupying the vehicle. The tester shall be seated next to the student. No other passengers or observers shall occupy the vehicle during the test, except upon approval and written consent by the division; and

(g) only for students who have in their possession a temporary driving permit, a learner permit, an instruction permit issued by the division; or a valid driver license issued by a jurisdiction other than the State of Utah.

(h) only for students who have in their possession adequate verification of their identity.

(3) a tester may not make any changes to a testing route without prior written approval by the division.

(4) a tester shall not employ an employee of the division as a tester.

R708-37-7. Test Requirements.

(1) A tester may not administer a skills test to a student who:

(a) completed the driver training course at the same commercial driver training school or testing only school in which the tester is employed as an instructor; or

(b) completed the driver training course at a commercial driver training school that is owned completely or partially by an individual or individuals who possess any ownership in the school in which the tester is employed as an instructor.

(2) A student who fails the skills test given by a tester may:
(a) apply to the same tester for additional testing;
(b) apply to a different tester for additional testing; or
(c) complete the skills test at a division office.
(3) The written test shall be administered by the division.

R708-37-8. Notification of Accident.

If any vehicle is involved in an accident during the driving skills test the tester shall notify the division of the accident in a written report on a form supplied by the division within five working days of the date of the accident. If damages are $1,000 or more, the accident must also be reported to the local law enforcement agency. A copy of the officer's report shall also be submitted to the division when available.

R708-37-9. Evidence of Test Completion.

(1) The tester shall furnish a certificate of test completion to the student in a sealed envelope with the tester's signature signed over the seal. The certificate shall be a form approved by the division and shall contain the results of tests taken, the signature and certification number of the tester who administered the tests, and the dates the tests were completed. The test results are valid for a period of one year from the test completion date.

(2) The tester shall provide the student with a receipt each time money is paid by the student to the tester. The tester shall maintain a copy of all receipts.

(3) A student, under this rule, must submit a certificate of completion of a driver education course and a certificate of successful test completion, issued by a tester, to the division and make an application in order to obtain a Class D Driver License.

(4) The commercial driver training school or testing only school shall maintain records of all tests administered for a period of three years. Records shall be maintained in separate files for each tester for auditing purposes. The records shall be subject to inspection by the division during business hours.

R708-37-10. Monthly Reports.

(1) Each third-party tester shall submit to the division a monthly report containing the number of tests administered each month.

(2) Monthly reports shall be submitted on forms supplied by the division and must be received by the division no later than the 10th day of each month following the month in which the testing occurred.

(3) Failure to submit monthly reports within the prescribed time is grounds for suspension or cancellation of the third-party tester's certification.

(4) Monthly reports may be submitted electronically with division approval.

R708-37-11. Refusal to Certify, Grounds for Cancellation, Suspension, or Probation of a Tester's Certification.

(1) The division may refuse to certify tester applicants who do not meet the standards for training or who submit an application that contains false or incomplete information.

(2) The tester certification shall remain effective as long as the tester retains the status of instructor for a commercial driver training school or testing only school or until the tester certification is canceled or suspended by the division. A commercial driver training school or testing only school may initiate suspension or cancellation of the testing certification held by one of their instructors by providing the division with acceptable written justification.

(3) The tester certification shall be canceled or suspended upon cancellation, revocation, denial of issuance of renewal of the tester's instructor certification. Grounds for cancellation or suspension of the tester certification shall include all items listed in R708-2-25.

(4) Certification may be canceled or suspended for non-compliance with these rules.

(5) Certification may be canceled or suspended for failure to participate in any in-service training required by the division.

(6) Certification may be canceled or suspended when a third-party tester's personal driver license has been denied, suspended, revoked, canceled, or disqualified. The tester shall be required to notify the division in writing within five working days of any action taken against the tester's driving privilege.

(7) When the division determines it is necessary to cancel, suspend, or place on probation a tester's certification, it shall determine an appropriate course of action from the following options:

(a) probation, with terms that must be met and adhered to by the tester;

(b) suspension, pending a remedial plan leading to reinstatement; or

(c) cancellation.

(8) Action by the division to cancel, suspend, place on probation or refuse to issue a tester certification is designated as an informal adjudicative proceeding under the Utah Administrative Procedures Act, Section 63-46b-4.

(9) The following procedures will govern informal adjudicative proceedings:

(a) action by the division to cancel, revoke, place on probation or refuse to issue a certification will be commenced by the division by the issuance of a notice of agency action. The notice of agency action will comply with the provisions of Section 63-46b-3;

(b) no response is required to the notice of agency action;

(c) an opportunity for a hearing will be granted on a cancellation, revocation, probation or refusal to issue a certification if, within five days, the division receives a request for a hearing;

(d) the tester will receive written notice of the hearing at least ten days prior to the date of the hearing;

(e) no discovery, either compulsory or voluntary, will be permitted prior to the hearing except that all parties shall have access to information contained in the division's files, and to investigatory information and materials not restricted by law;

(f) the hearing shall be conducted by an individual, or panel designated by the division; and

(g) within twenty days after the close of the hearing or after the failure of a party to appear for the hearing, the individual conducting the hearing shall issue a written decision which shall constitute final agency action. The written decision shall state the decision, the reason for the decision, notice of right to request reconsideration under Section 63-46b-13, notice of right to judicial review under Section 63-46b-15, and the time limits for filing an appeal to the appropriate district court.

(10) Reinstatement following cancellation of certification shall consist of completing an approved training plan and making application for a new certification. Instructors and testers must have a driving record free of suspensions or revocations of their driving privilege resulting from moving violations, chargeable accidents, and drug or alcohol related offenses, in all states, for a two year period immediately prior to application and during employment.

(11) Certification shall be canceled when testers are no longer employed as instructors in commercial driver training schools or testing only schools. Testers who discontinue employment as instructors with a commercial driver training schools or testing only school and subsequently return to instruct and test under the sponsorship of a different commercial driver training schools or testing only school must make a new application with the division for a new instructor certification and tester certification. If the period of cancellation of testing certification exceeds six months the applicant shall complete a course of approved training.

R708-37-12. Advertising.

(1) No advertisement shall indicate in any way that a commercial driver training schools or testing only school or a tester can issue or guarantee the issuance of a driver license, or imply that the testing program, except for reporting test scores, can in any way influence the division in the issuance of a Class D driver license; or imply that preferential or advantageous treatment can be obtained from the division through participation in their testing program.

(2) No tester, employee, or agent of a commercial driver training schools or testing only school shall be permitted to advertise or solicit business or cause business to be solicited in its behalf, or display or distribute any advertising material within 1500 feet of a building in which vehicle registrations or driver licenses are issued to the public.

KEY: driver training, skills tests
2003
53-3-510

End of the Notices of Changes in Proposed Rules Section

NOTICES OF
120-DAY (EMERGENCY) RULES

An agency may file a 120-DAY (EMERGENCY) RULE when it finds that the regular rulemaking procedures would:

(a) cause an imminent peril to the public health, safety, or welfare;
(b) cause an imminent budget reduction because of budget restraints or federal requirements; or
(c) place the agency in violation of federal or state law (*Utah Code* Subsection 63-46a-7(1) (2001)).

As with a PROPOSED RULE, a 120-DAY RULE is preceded by a RULE ANALYSIS. This analysis provides summary information about the 120-DAY RULE including the name of a contact person, justification for filing a 120-DAY RULE, anticipated cost impact of the rule, and legal cross-references. A row of dots in the text (· · · · ·) indicates that unaffected text was removed to conserve space.

A 120-DAY RULE is effective at the moment the Division of Administrative Rules receives the filing, or on a later date designated by the agency. A 120-DAY RULE is effective for 120 days or until it is superseded by a permanent rule.

Because 120-DAY RULES are effective immediately, the law does not require a public comment period. However, when an agency files a 120-DAY RULE, it usually files a PROPOSED RULE at the same time, to make the requirements permanent. Comment may be made on the proposed rule. Emergency or 120-DAY RULES are governed by *Utah Code* Section 63-46a-7 (2001); and *Utah Administrative Code* Section R15-4-8.

Human Services, Services for People with Disabilities
R539-1-5
Graduated Fee Schedule

NOTICE OF 120-DAY (EMERGENCY) RULE
DAR FILE NO.: 26440
FILED: 07/01/2003, 16:53

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: Pursuant to H.B. 308 the Division of Services for People with Disabilities establishes a graduated fee schedule. (DAR NOTE: H.B. 308 is found at UT L 2003 Ch 246, and was effective May 6, 2003.)

SUMMARY OF THE RULE OR CHANGE: The established graduated fee schedule is used to assess and collect fees from Non-Waiver Persons. These are Persons who do not meet the Medicaid financial eligibility requirements listed in the Developmental Disabilities/ Mental Retardation Waiver, the Traumatic Brain Injury Waiver or the Physical Disabilities Waiver. Family size and gross income shall be used to determine the fee. This rule does not apply to Persons who qualify for Medicaid waiver funding but who choose to have funding reduced to the state match per R539-1-2 rather than participate in the Medicaid Waiver. (DAR NOTE: A corresponding proposed amendment is under DAR No. 26439 in this issue.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Section 62a-5-105

ANTICIPATED COST OR SAVINGS TO:
❖ THE STATE BUDGET: There will be administrative costs to implement the new section that will be absorbed in the current budget. This cost will include time to train staff to implement the new schedule. These are new requirements that are being enacted in the rule, so we are unsure of the actual costs.
❖ LOCAL GOVERNMENTS: No local government funding is used in any of these activities, therefore, it is expected that there is no cost to local governments
❖ OTHER PERSONS: Eligible Persons shall be assessed an annual fee according to the schedule established in the Division's fee schedule. The fee is based on the formula (assets + income) / by the total number of family members. Available income below 300% of the poverty level will not be assessed a fee. Non-Waiver Persons with available income between 300% and 399% of poverty will be assessed a 1% fee, those with available income between 400% and 499% of poverty will be assessed a 2% fee and those with available income over 500% of poverty will be assessed a 3% fee. No Person shall be assessed more than 3% of available income. It is estimated that about 30-35 people will have assets or income over 300% of poverty. These individuals will need to pay a fee.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Cost will be to those persons who qualify to pay a fee (see explanation under "Other person").

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: The changes in this rule have no fiscal impact on the providers.

EMERGENCY RULE REASON AND JUSTIFICATION: REGULAR RULEMAKING PROCEDURES WOULD place the agency in violation of federal or state law.

Legislative intent language stated that this Rule would be effective July 1,2003.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

HUMAN SERVICES
SERVICES FOR PEOPLE WITH DISABILITIES
Room 411
120 N 200 W
SALT LAKE CITY UT 84103-1500, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Meredith Mannebach at the above address, by phone at 801-538-4197, by FAX at 801-538-4279, or by Internet E-mail at mmannebach@utah.gov

THIS RULE IS EFFECTIVE ON: 07/01/2003

AUTHORIZED BY: Robin Arnold-Williams, Executive Director

R539. Human Services, Services for People with Disabilities.
R539-1. Eligibility.
R539-1-5. Graduated Fee Schedule.

(1) Pursuant to Utah Code 62a-5-105 the Division establishes a graduated fee schedule for use in assessing fees to individuals. The graduated fee schedule shall be applied to Persons who do not meet the Medicaid financial eligibility requirements listed in the Developmental Disabilities/ Mental Retardation Waiver, the Traumatic Brain Injury Waiver or the Physical Disabilities Waiver. Family size and gross income shall be used to determine the fee. This rule does not apply to Persons who qualify for Medicaid waiver funding but who choose to have funding reduced to the state match per R539-1-2 rather than participate in the Medicaid Waiver.

(a) Non-Waiver Persons who do not meet Waiver level of care must apply for a Medicaid Card within 30 days of the effective date of this rule. Non-Waiver Persons who meet Waiver level of care must apply for determination of financial eligibility using Form 927 within 30 days of the effective date of this rule. Non-Waiver Persons shall provide the support coordinator with the determination letter within 10 days of the receipt of such documentation. Non-Waiver Persons who fail to comply with these requirements shall have funding reduced to the state match rate.

(b) Non-Waiver Persons must report all cash assets (stocks, bonds, certified deposits, savings, checking and trust amounts), annual income and number of family members living together using Division Form 2-1G. The Person / family shall submit a new form at the time of the annual planning meeting, if there has been a change in income or assets. The Person / family shall return Form 2-1G to the support coordinator prior to delivery of new services. Persons / families currently receiving services will have 60 days to return a completed and signed Form 2-1G. Persons / families who complete the Division fee Determination Form shall be assessed a fee no more than 3% of their income. If the form is not received within 60 days, the Person will have funding reduced to the state match rate.

(c) Cash assets, income and number of family members will be used to calculate available income (using the formula: {assets + income} / by the total number of family members = available income). Available income will be used to determine the fee percent (0 percent to 3 percent). The annual fee amount will be calculated by multiplying available income by the fee percent. Non-Waiver persons below 300 percent of the poverty level will not be assessed a fee. Persons with available income between 300 percent and 399 percent of poverty will be assessed a 1 percent fee, those with available income between 400 percent and 499 percent of poverty will be assessed a 2 percent fee and those with available income over 500 percent of poverty will be assessed a 3 percent fee.

(d) No fee shall be assessed for a Non-Waiver person who receives funding for less than 31 percent of the assessed need. A multiplier shall be applied to the fee of Non-Waiver Persons receiving at least 31 percent but less than 100% percent of the assessed need.

(e) If the Person is assessed a fee the Person shall pay the Division of Services for People with Disabilities or designee 1/12th of the annual fee by the end of each month.

(f) Only one fee will be assessed per family, regardless of the number of children in the family receiving services. Non-waiver persons under the age of 18 shall be assessed a fee based upon parent income. Non-waiver persons over the age of 18 shall be assessed a fee based upon individual income and assets.

KEY: disabled persons[*], social services
July 1, 2003
Notice of Continuation December 18, 2002
62A-5-103
62A-5-105

Labor Commission, Industrial Accidents

R612-2-22

Medical Records

NOTICE OF 120-DAY (EMERGENCY) RULE

DAR FILE NO.: 26405
FILED: 06/20/2003, 15:16

RULE ANALYSIS

PURPOSE OF THE RULE OR REASON FOR THE CHANGE: The purpose of this rule change is to provider medical providers with direction on what records need to be released, to whom, and under what conditions when dealing with workers' compensation injury or occupational disease claims in light of the federal Health Insurance Portability and Accountability Act (HIPAA).

SUMMARY OF THE RULE OR CHANGE: The proposed change in this section establishes that the Utah Workers' Compensation Program is exempt from HIPAA; and sets forth what records should be released and to whom in workers' compensation cases. The subsections have also been rearranged so that understanding is clearer. (DAR NOTE: A corresponding amendment is under DAR No. 26406 in this issue.)

STATE STATUTORY OR CONSTITUTIONAL AUTHORIZATION FOR THIS RULE: Sections 34A-2-101 et seq., 34A-3-101 et seq., and 34A-1-104

ANTICIPATED COST OR SAVINGS TO:

❖ THE STATE BUDGET: This proposal will impose no additional costs to the state budget. By simplifying standards for information release, the proposed change may reduce the state's compliance costs in a small indefinite amount.

❖ LOCAL GOVERNMENTS: This proposal will impose no additional costs to local government budgets. By simplifying standards for information release, the proposed change may reduce local government's compliance costs in a small indefinite amount.

❖ OTHER PERSONS: This proposal will impose no additional costs to other persons. By simplifying standards for information release, the proposed change may reduce other persons' compliance costs in a small indefinite amount.

COMPLIANCE COSTS FOR AFFECTED PERSONS: Because Utah's workers' compensation program is exempt from HIPAA, there should be no cost to persons affected by this rule. There may be a small savings attributable to simplified compliance.

COMMENTS BY THE DEPARTMENT HEAD ON THE FISCAL IMPACT THE RULE MAY HAVE ON BUSINESSES: Any fiscal impact on businesses affected by this rule should be positive. The rule will reduce business costs in obtaining and disseminating medical information for workers' compensation purposes.

EMERGENCY RULE REASON AND JUSTIFICATION: REGULAR RULEMAKING PROCEDURES WOULD cause an imminent peril to the public health, safety, or welfare.

Due to HIPAA, parties to workers' compensation claims are unable to obtain medical records to make a determination on the claims. State workers' compensation programs are exempt from HIPAA.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

LABOR COMMISSION
INDUSTRIAL ACCIDENTS
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:

Joyce Sewell at the above address, by phone at 801-530-6988, by FAX at 801-530-6804, or by Internet E-mail at jsewell@utah.gov

THIS RULE IS EFFECTIVE ON: 06/20/2003

AUTHORIZED BY: R Lee Ellertson, Commissioner

R612. Labor Commission, Industrial Accidents.
R612-2. Workers' Compensation Rules-Health Care Providers.
R612-2-22. Medical Records.

A. Pursuant to 45 CFR, 164.512(1), release of medical records for use in Utah's workers' compensation system is exempt from the privacy regulations established by the federal Health Insurance Portability and Accountability Act (HIPAA). The following rules, instead of HIPAA standards, govern release of medical records for workers' compensation purposes:

B. A medical provider shall release the following medical records pertaining to treatment of an injured worker to the persons or entities listed in subsection C of this rule. The medical records shall be released regardless of whether the injured worker has authorized release of such medical records.

1. Medical records or documentation to substantiate a bill submitted for payment to an insurance carrier, third party administrator, self-insured employer, or the Labor Commission, as required by Commission rules.

2. The "Physician Initial Report of Injury/Illness" and any other forms required by Labor Commission rules.

3. Medical records related to a claim for benefits made by an injured worker for a work related injury or illness,

4. Any other medical records requested by the Labor Commission to adjudicate or settle a workers' compensation claim.

5. Upon written request, medical records of past medical treatment, including prescription drug records. These records of past medical treatment are required by the workers' compensation system to resolve issues of causation, compensability or treatment of the workers' compensation claim.

C[~~B~~]. The following[~~Those~~] persons or entities [~~who~~]are entitled to [~~copies of~~]the medical records [~~involving an industrial case are~~]described in subsection B. of this rule:

1. The injured [~~employee~~]worker or his/her dependents,

2[~~3~~]. The employer's [~~workers' compensation~~]insurance carrier, third party administrator, or an agent of the insurance carrier or third party administrator. An agent of the insurance carrier or third party administrator includes but is not limited to a case manager or a reviewing physician,

3. A self-insured employer who is duly authorized by the Labor Commission to self-administer its workers' compensation claims,

4. The Uninsured Employers' Fund,

5. The Employers' Reinsurance Fund,

6. The Labor Commission,[~~ and~~]

7. Any attorney representing any of the above in an industrial injury or occupational disease claim[~~.~~], and

8[~~2~~]. The employer of the injured worker[~~,~~]. However, except as provided in subsection C.3 of this rule, an employer's right to receive medical records is limited to information necessary to determine the injured worker's ability to return to work.

[~~C. No other person or entity is entitled to medical records unless ordered by a Court or provided with a notarized release executed by the injured worker.~~]D. On request, an injured worker seeking workers' compensation benefits shall provide the person or entities identified in subsection C.1 through 7 with the names and addresses of previous medical providers for up to the past 15 years. Labor Commission form 307 "Medical Treatment Provider List"

shall be used for this purpose and will notify the injured worker that all medical records of the medical providers listed on the form may be provided to the requesting party without the injured worker's authorization or release.

E[A]. When any medical practitioner provides copies of medical records[to the parties of an industrial case], other than the records required when submitting a bill for payment, the following charges are presumed reasonable:

1. A search fee of $15 payable in advance of the search,

2. Copies at $0.50 per page including copies of microfilm payable after the records have been prepared, and

3. Actual costs of postage payable after the records have been prepared. Actual costs of postage are deemed to be the cost of regular mail unless the requesting party has requested the delivery of the records by special mail or method.

F[D]. The Commission will [operate in the]release [of]its records to the parties/entities [as]specified under C above with a signed and notarized release unless the information is classified as controlled under the Government Records Access and Management Act (GRAMA).[unless the information is classified as confidential under the Government Records Access and Management Act (GRAMA).]

G[E]. No fee shall be charged when the RBRVS requires specific documentation for a procedure or when [physicians and surgeons]medical providers are required to report by statute or rule.

H[F]. An injured worker may obtain one of each of the following records related to the industrial injury or occupational disease, at no cost, when the injured worker or his/her dependents have a signed form by the division to substantiate his/her industrial injury/illness claim:

1. History and physical,

2. Operative reports of surgeries,

3. Hospital [D]discharge summary,[and]

4. Emergency room records,

5. Radiological reports,

6. Specialized testing results, and

7. Physician SOAP notes, progress notes, or specialized reports.

(a) Alternatively, a summary of the patient's record may be made available to the claimant at the discretion of the physician.[

8. And such other records as may be requested by the Commission in order to make a determination of liability.]

KEY: workers' compensation, fees, medical practitioner
June 20, 2003
Notice of Continuation June 15, 1998
34A-2-101 et seq.
34A-3-101 et seq.
34A-1-104

End of the Notices of 120-Day (Emergency) Rules Section

FIVE-YEAR NOTICES OF REVIEW AND STATEMENTS OF CONTINUATION

Within five years of an administrative rule's original enactment or last five-year review, the responsible agency is required to review the rule. This review is designed to remove obsolete rules from the *Utah Administrative Code*.

Upon reviewing a rule, an agency may: repeal the rule by filing a PROPOSED RULE; continue the rule as it is by filing a NOTICE OF REVIEW AND STATEMENT OF CONTINUATION (NOTICE); or amend the rule by filing a PROPOSED RULE and by filing a NOTICE. By filing a NOTICE, the agency indicates that the rule is still necessary.

NOTICES are not followed by the rule text. The rule text that is being continued may be found in the most recent edition of the *Utah Administrative Code*. The rule text may also be inspected at the agency or the Division of Administrative Rules. NOTICES are effective when filed. NOTICES are governed by *Utah Code* Section 63-46a-9 (1998).

Career Service Review Board, Administration

R137-2

Government Records Access and Management Act

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26397
FILED: 06/18/2003, 16:10

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 63-2-204 of the Government Records Access and Management Act allows a governmental entity to make rules specifying where and to whom requests for access to records shall be directed. Section 63-2-203 allows entities to charge reasonable fees to cover actual costs of duplicating a record; therefore the rule allows for these charges and waivers of these charges if necessary. The rule also delineates a way for records to be amended and for a denial of access to be appealed.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No written comments have been received concerning this process from the public or State agencies over the past five years.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Some documents maintained by the division are public, but many are private and protected, so the division must have a rule in place to allow those who need access and have a legal right to access may obtain those documents; and there is also a need to be able to deny access to those records that are protected and not legally available. This rule covers those requirements and should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

CAREER SERVICE REVIEW BOARD
ADMINISTRATION
Room 1120 STATE OFFICE BLDG
450 N MAIN ST
SALT LAKE CITY UT 84114-1201, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Claudia Jones at the above address, by phone at 801-538-3048, by FAX at 801-538-3139, or by Internet E-mail at cjones@utah.gov

AUTHORIZED BY: Robert W. Thompson, Administrator

EFFECTIVE: 06/18/2003

Environmental Quality, Air Quality

R307-203

Emission Standards: Sulfur Content of Fuels

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26398
FILED: 06/19/2003, 13:08

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Rule R307-203 establishes the maximum amount of sulfur that may be contained in coal and oil burned in industrial processes and residential heating, thus holding down the emissions of sulfur dioxide from these processes. Subsection 19-2-104(1)(a) authorizes the Air Quality Board to make rules "...regarding the control, abatement, and prevention of air pollution from all sources and the establishment of the maximum quantity of air

contaminants that may be emitted by any air contaminant source."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: Without this rule, users could burn coal or oil with higher sulfur content, thus emitting more sulfur dioxide into the atmosphere. Sulfur dioxide is harmful to human health so this rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
AIR QUALITY
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jan Miller at the above address, by phone at 801-536-4042, by FAX at 801-536-4099, or by Internet E-mail at janmiller@utah.gov

AUTHORIZED BY: M. Cheryl Heying, Planning Branch Manager

EFFECTIVE: 06/19/2003

Environmental Quality, Air Quality
R307-206
Emission Standards: Abrasive Blasting

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26400
FILED: 06/19/2003, 13:51

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Rule R307-206 sets forth performance standards and maximum concentration of contaminants allowed in the air for operations that clean or prepare a surface by forcefully propelling a stream of abrasive material against the surface. Subsection 19-2-104(1)(a) allows the Air Quality Board to make rules "...regarding the control, abatement, and prevention of air pollution from all sources and the establishment of the maximum quantity of air contaminants that may be emitted by any air contaminant source."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received in the last five years.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule protects the health of neighbors when abrasive blasting operations are underway and should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
AIR QUALITY
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jan Miller at the above address, by phone at 801-536-4042, by FAX at 801-536-4099, or by Internet E-mail at janmiller@utah.gov

AUTHORIZED BY: M. Cheryl Heying, Planning Branch Manager

EFFECTIVE: 06/19/2003

Environmental Quality, Air Quality
R307-222
Emission Standards: Existing Incinerators for Hospital, Medical, Infectious Waste

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26399
FILED: 06/19/2003, 13:50

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Rule R307-222 regulates emissions from incinerators that burn hospital, medical, and infectious waste. Subsection 19-2-104(1)(a) allows the Air Quality Board to make rules "...regarding the control, abatement, and prevention of air pollution from all sources and the establishment of the maximum quantity of air contaminants that may be emitted by any air contaminant source."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received in the last five years.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS

IN OPPOSITION TO THE RULE, IF ANY: Incinerators emit small quantities of a variety of hazardous air pollutants, and some are located in populated areas. It is important that their emissions be as low as possible and this rule details those standards and should be continued. In addition, the rule is required by 40 CFR Part 60, Subpart Ce and the Clean Air Act, 42 U.S.C. 7411(d).

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
AIR QUALITY
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jan Miller at the above address, by phone at 801-536-4042, by FAX at 801-536-4099, or by Internet E-mail at janmiller@utah.gov

AUTHORIZED BY: M. Cheryl Heying, Planning Branch Manager

EFFECTIVE: 06/19/2003

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Environmental Quality, Air Quality
R307-302
Davis, Salt Lake, Utah Counties: Residential Fireplaces and Stoves

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26402
FILED: 06/19/2003, 14:14

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Rule R307-302 identifies no-burn periods for residential woodburning stoves and fireplaces in areas that sometimes exceed the health standards for fine particulate and carbon monoxide. Subsection 19-2-104(1)(a) allows the Air Quality Board to make rules "...regarding the control, abatement, and prevention of air pollution from all sources and the establishment of the maximum quantity of air contaminants that may be emitted by any air contaminant source."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The provisions to regulate residential woodburning are part of the requirements to reduce particulates and carbon monoxide that are included in Utah's state implementation plans for PM10 and carbon monoxide. The provisions in this rule are needed to reduce pollution during winter temperature inversions when pollutants build up in the air so the rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
AIR QUALITY
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jan Miller at the above address, by phone at 801-536-4042, by FAX at 801-536-4099, or by Internet E-mail at janmiller@utah.gov

AUTHORIZED BY: M. Cheryl Heying, Planning Branch Manager

EFFECTIVE: 06/19/2003

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Environmental Quality, Air Quality
R307-305
Davis, Salt Lake and Utah Counties and Ogden City, and Nonattainment Areas for PM10: Particulates

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26403
FILED: 06/19/2003, 15:10

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Rule R307-305 sets visible emission limits, testing methods and schedules, and compliance schedules for sources of air pollution that are regulated under Utah's PM10 state implementation plan to protect public health. Subsection 19-2-104(1)(a) allows the Air Quality Board to make rules "...regarding the control, abatement, and prevention of air pollution from all sources and the establishment of the maximum quantity of air contaminants that may be emitted by any air contaminant source."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received in the last five years.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS

IN OPPOSITION TO THE RULE, IF ANY: Emission limits and testing of emissions helps to ensure that industrial facilities are operating properly and emitting the least possible pollution to protect human health which this rule outlines and should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
AIR QUALITY
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jan Miller at the above address, by phone at 801-536-4042, by FAX at 801-536-4099, or by Internet E-mail at janmiller@utah.gov

AUTHORIZED BY: Rick Allis, Director

EFFECTIVE: 06/19/2003

Environmental Quality, Air Quality
R307-307
Davis, Salt Lake, and Utah Counties: Road Salting and Sanding

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26404
FILED: 06/19/2003, 15:35

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Rule R307-307 sets limits on the particulate matter that may be included in salt used on roads. The limits are needed to reduce the particulate matter that is harmful to human health, and are one of the measures included in Utah's state implementation plan for PM10. Subsection 19-2-104(1)(a) allows the Air Quality Board to make rules "...regarding the control, abatement, and prevention of air pollution from all sources and the establishment of the maximum quantity of air contaminants that may be emitted by any air contaminant source."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received in the past five years.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The limits in this rule are needed to reduce particulate matter that is harmful to human health, and are one of the measures included in Utah's state implementation plan for PM10 and should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
ENVIRONMENTAL QUALITY
AIR QUALITY
150 N 1950 W
SALT LAKE CITY UT 84116-3085, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Jan Miller at the above address, by phone at 801-536-4042, by FAX at 801-536-4099, or by Internet E-mail at janmiller@utah.gov

AUTHORIZED BY: M. Cheryl Heying, Planning Branch Manager

EFFECTIVE: 06/19/2003

Public Service Commission, Administration
R746-110
Uncontested Matters to be Adjudicated Informally

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26420
FILED: 06/25/2003, 14:37

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 54-4-1 gives the Public Service Commission (PSC) general jurisdiction to regulate every public utility in Utah and to supervise all of the business of every such public utility in Utah, and to do all things necessary or convenient in the exercise of that power and jurisdiction. Section 63-46b-5 requires the PSC to enact rules designating one or more categories of adjudicative proceedings as informal adjudicative proceedings, and to, by rule, prescribe procedures for informal adjudicative proceedings.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: No comments have been received since the last five-year review.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule should be continued so the PSC can continue to comply with Sections 54-4-1 and 63-46b-5.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SERVICE COMMISSION
ADMINISTRATION
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Sandy Mooy or Barbara Stroud at the above address, by phone at 801-530-6708 or 801-530-6714, by FAX at 801-530-6796 or 801-530-6796, or by Internet E-mail at smooy@utah.gov or bstroud@utah.gov

AUTHORIZED BY: Barbara Stroud, Paralegal

EFFECTIVE: 06/25/2003

Public Service Commission, Administration

R746-210

Utility Service Rules Applicable Only to Electric Utilities

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26419
FILED: 06/25/2003, 13:56

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Sections 113 and 115 PURPA 16 USCA standards for Master Metered Multiple Tenancy Dwellings make it necessary for the Public Service Commission (PSC) to set the standards and exemptions in this rule.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: On February 25, 2002, PacifiCorp (formerly UP&L) filed a Petition for Rule Amendment to establish a specific kilowatt hour (kWh) threshold to define "near minimum bill requirements of the tariff" as used in Subsection R746-210-2(A.2) and to add language to require disclosure to the utility of applicant's basis for the load projection to help prevent misuse of the exemption with unsupported projections. PacifiCorp proposed 250 kWh per unit. The PSC filed a Notice of Proposed Rule Amendment to make those changes on April 15, 2002. No comments were received during the comment period and the amendment was made effective on June 20, 2002.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The standards in this rule, for master metered multiple tenancy dwellings, continue to be relevant and necessary to the Commission's duty to supervise and regulate electric utility companies in Utah so the rule should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SERVICE COMMISSION
ADMINISTRATION
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Barbara Stroud at the above address, by phone at 801-530-6714, by FAX at 801-530-6796, or by Internet E-mail at bstroud@utah.gov

AUTHORIZED BY: Barbara Stroud, Paralegal

EFFECTIVE: 06/25/2003

Public Service Commission, Administration

R746-240

Telecommunication Service Rules

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26421
FILED: 06/25/2003, 17:13

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 54-4-1 authorizes the Public Service Commission (PSC) to regulate every public utility in Utah and supervise the business of those public utilities necessary to accomplish that regulation and supervision. Section 54-4-7 requires that the PSC provide rules to ensure that utility service and equipment is just, safe, proper, and adequate. Subsection 54-4-18(10) states that, "the commission may promulgate rules: (a) necessary to implement this section; (b) consistent with any rules promulgated by the Federal Communications Commission; and (c) in a nondiscriminatory and competitively neutral manner." Subsection 54-4-37(23) states, "The commission is granted authority to: (a) enforce this section; and (b) implement rules to carry out the requirements of the section."

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: On June 22, 2000, the Division of Public Utilities filed a petition with the PSC for an

amendment to this rule. The Division proposed changes consistent with current FCC requirements and provided for expedited information exchange to help resolve complaints and make the Informal Complaint Section consistent with other PSC rules for utilities other than telecommunications. The PSC filed an amendment proposing those changes on July 18, 2000. The PSC also received comments from Qwest, AT&T, and TCG. Qwest stated in their comments that the amendment would impose impractical requirements on the complainant, the division, or the telecommunications corporation. AT&T's comments stated that AT&T believed the timelines set forth in the proposed amendments were unreasonable, punitive, and would increase customer confusion. The Division filed a response to the comments of Qwest and AT&T on October 27, 2000, with proposed revisions incorporating many suggestions made by Qwest and AT&T. Qwest filed more comments answering the Division's response. The PSC reviewed all comments and on November 30, 2000, filed a Notice of Proposed Rule which was made effective on February 14, 2001.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule remains necessary to provide guidelines for telecommunication service and resolution of customer complaints and should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:

PUBLIC SERVICE COMMISSION
ADMINISTRATION
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Sandy Mooy or Barbara Stroud at the above address, by phone at 801-530-6708 or 801-530-6714, by FAX at 801-530-6796 or 801-530-6796, or by Internet E-mail at smooy@utah.gov or bstroud@utah.gov

AUTHORIZED BY: Barbara Stroud, Paralegal

EFFECTIVE: 06/25/2003

Public Service Commission, Administration

R746-340

Service Quality for Telecommunications Corporations

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION
DAR FILE NO.: 26418
FILED: 06/25/2003, 13:51

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Section 54-4-1 gives the Public Service Commission (PSC) general jurisdiction to regulate every public utility in Utah and to supervise all of the business of every such public utility in Utah, and to do all things necessary or convenient in the exercise of that power and jurisdiction. Section 54-4-14 authorizes the Commission to make rules that require every public utility to construct, maintain, and operate its line, plant, system, equipment, apparatus, tracks and premises that promote and safeguard the health and safety of its employees, customers and the public, and the installation, use, maintenance and operation of appropriate safety or other devices or appliances and to establish standards of construction and equipment, and to require the performance of any other acts which the health or safety of its employees, customers or the public. Section 54-4-23 authorizes the PSC to establish a system of accounts to be kept by public utilities subject to its jurisdiction and to determine the manner in which such accounts shall be kept. It may also, in its discretion, prescribe the forms of accounts, records, and memoranda to be kept by such public utilities and any forms, records, and memoranda which in the judgment of the commission may be necessary to comply with the provisions of this section.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: On July 11, 2000, a Petition for Modification and Addition to Rule was filed by the Division of Public Utilities (the Division). The proposed additions to the rule were made pursuant to Subsection 54-8b-3.3(6)(a), enacted by the Utah Legislature at its 2000 General Session, which mandated that the PSC "adopt rules by September 30, 2000, governing service quality standards to end users for all tariffed public telecommunications services." On August 1, 2000, the PSC filed a Notice of Proposed Rule Change which included amendments to Sections R746-340-1 through R746-340-6 and the addition of new Sections R746-340-7 through R746-340-10. On August 11, 2000, Qwest filed an Initial Recommendation Regarding Proposed Rule Amendments, and on August 30, 2000, a Request for Hearing Regarding Proposed Rule Amendments. On September 14, 2000, AT&T and TCG Utah filed comments and Utah Rural Telecom Association also filed comments. On September 14, 2000, Qwest also filed supplemental comments regarding the proposed rule amendments. The Division filed comments in response to Qwest's August comments. On October 2, 2000, the PSC filed a Notice of 120-Day Emergency Rule because continued efforts were needed to adequately consider the comments submitted and proposed additional changes in light of the comments received. Qwest agreed to incur the costs of service quality standards as part of the public benefit offered in support of the approval of its merger with US West. The emergency rule attempted to incorporate the service standards agreed to in the merger approval, hence compliance costs did not directly arise from the emergency rule, but from the companies' merger offering. The emergency rule was submitted as the pending rulemaking

process did not permit the PSC to resolve disputed proposals, formulate a final retail service quality rule, and make it effective on the date required by statute. The process would extend beyond a statutorily imposed deadline by which the PSC was required to have service quality rules in effect. The Division filed Comments Regarding Proposed Rule Amendments on December 22, 2000. On December 28, 2000, AT&T and TCG also filed comments. Utah Rural Telecom Association's comments were filed on January 2, 2001. Qwest also filed additional comments on January 2, 2001. The PSC held a Technical Conference on January 17, 2001, to discuss comments to the proposed rule. On January 23, 2001, a draft proposed rule was sent to participating parties stating that it would be submitted for publication and that comments would be due by January 29, 2001. On January 29, 2001, comments were filed by: Qwest, the Division, and Utah Rural Telecom Association. Beehive Telephone Company filed comments on January 30, 2001. The PSC file a Notice of Proposed Rule or Change on January 31, 2001, with proposed amendments made to the rule as a result of comments received. On March 19, 2001, Qwest filed comments on the revised proposed Rule R746-340. The proposed rule was made effective on March 27, 2001.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: This rule continues to be necessary to ensure that adequate and satisfactory service will be rendered to the public by telecommunications utilities under the jurisdiction of the Commission and should be continued.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
PUBLIC SERVICE COMMISSION
ADMINISTRATION
HEBER M WELLS BLDG
160 E 300 S
SALT LAKE CITY UT 84111-2316, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Barbara Stroud at the above address, by phone at 801-530-6714, by FAX at 801-530-6796, or by Internet E-mail at bstroud@utah.gov

AUTHORIZED BY: Barbara Stroud, Paralegal

EFFECTIVE: 06/25/2003

Regents (Board Of), Administration

R765-605

Utah Centennial Opportunity Program for Education

FIVE YEAR NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

DAR FILE NO.: 26432
FILED: 06/30/2003, 14:57

NOTICE OF REVIEW AND STATEMENT OF CONTINUATION

CONCISE EXPLANATION OF THE PARTICULAR STATUTORY PROVISIONS UNDER WHICH THE RULE IS ENACTED AND HOW THESE PROVISIONS AUTHORIZE OR REQUIRE THE RULE: Title 53B, Chapter 8a, provides for the administration and operation of the Utah Centennial Opportunity Program for Education by rule.

SUMMARY OF WRITTEN COMMENTS RECEIVED DURING AND SINCE THE LAST FIVE YEAR REVIEW OF THE RULE FROM INTERESTED PERSONS SUPPORTING OR OPPOSING THE RULE: There were no written comments received during the past five-year period.

REASONED JUSTIFICATION FOR CONTINUATION OF THE RULE, INCLUDING REASONS WHY THE AGENCY DISAGREES WITH COMMENTS IN OPPOSITION TO THE RULE, IF ANY: The continuance of this program is necessary to assist students attending institutions of higher education in Utah in meeting the cost of such education by providing grant funds to eligible students.

THE FULL TEXT OF THIS RULE MAY BE INSPECTED, DURING REGULAR BUSINESS HOURS, AT:
REGENTS (BOARD OF)
ADMINISTRATION
BOARD OF REGENTS BUILDING, THE GATEWAY
60 SOUTH 400 WEST
SALT LAKE CITY UT 84101-1284, or
at the Division of Administrative Rules.

DIRECT QUESTIONS REGARDING THIS RULE TO:
Ronell Crossley at the above address, by phone at 801-321-7291, by FAX at 801-321-7299, or by Internet E-mail at rcrossley@utahsbr.edu

AUTHORIZED BY: Chalmers Gail Norris, Associate Commissioner for Student Financial Aid

EFFECTIVE: 06/30/2003

NOTICES OF FIVE-YEAR REVIEW EXTENSIONS

Rulewriting agencies are required by law to review each of their administrative rules within five years of the date of the rule's original enactment or the date of last review (*Utah Code* Section 63-46a-9 (1996)). If the agency finds that it will not meet the deadline for review of the rule (the five-year anniversary date), it may file an extension with the Division of Administrative Rules. The extension permits the agency to file the review up to 120 days beyond the anniversary date.

Agencies have filed extensions for the rules listed below. The "Extended Due Date" is 120 days after the anniversary date. The five-year review extension is governed by *Utah Code* Subsection 63-46a-9(4) and (5) (1996).

Workforce Services

Administration

No. 26416 (filed 06/25/2003 at 11:36 a.m.): R982-401. JTPA Fiscal Procedures.
Enacted or Last Five-Year Review: 06/29/98 (No. 21251, 5YR, filed 06/29/98 at 7:07 a.m., published 07/15/98)
Extended Due Date: 10/27/2003

No. 26417 (filed 06/25/2003 at 11:40 a.m.): R982-501. JTPA Procurement/Property Management Procedures.
Enacted or Last Five-Year Review: 06/29/98 (No. 21252, 5YR, filed 06/29/98 at 7:07 a.m., published 07/15/98)
Extended Due Date: 10/27/2003

End of the Notices of Five-Year Review Extensions Section

NOTICES OF RULE EFFECTIVE DATES

These are the effective dates of PROPOSED RULES or CHANGES IN PROPOSED RULES published in earlier editions of the *Utah State Bulletin*. These effective dates are at least 31 days and not more than 120 days after the date the following rules were published.

Abbreviations
AMD = Amendment
CPR = Change in Proposed Rule
NEW = New Rule
R&R = Repeal and Reenact
REP = Repeal

Administrative Services
Finance
No. 26204 (AMD): R25-7. Travel-Related Reimbursements for State Employees.
Published: May 15, 2003
Effective: July 1, 2003

Commerce
Administration
No. 26199 (AMD): R151-14. New Automobile Franchise Act Rule.
Published: May 15, 2003
Effective: June 17, 2003

No. 26198 (AMD): R151-35. Powersport Vehicle Franchise Act Rule.
Published: May 15, 2003
Effective: June 17, 2003

Occupational and Professional Licensing
No. 26192 (AMD): R156-38. Residence Lien Restriction and Lien Recovery Fund Rules.
Published: May 15, 2003
Effective: June 17, 2003

No. 26152 (AMD): R156-56-707. Statewide Amendments to the IPC.
Published: May 1, 2003
Effective: July 1, 2003

No. 26154 (AMD): R156-56. Utah Uniform Building Standard Act Rules.
Published: May 1, 2003
Effective: July 1, 2003

Education
Administration
No. 26190 (AMD): R277-108. Annual Assurance of Compliance by School Districts.
Published: May 15, 2003
Effective: June 17, 2003

No. 26189 (NEW): R277-484. Data Standards, Deadlines and Procedures.
Published: May 15, 2003
Effective: June 17, 2003

Environmental Quality
Air Quality
No. 25825 (CPR): R307-214-2. Part 63 Sources.
Published: May 15, 2003
Effective: June 17, 2003

Health
Health Care Financing, Coverage and Reimbursement Policy
No. 26202 (AMD): R414-304. Income and Budgeting.
Published: May 15, 2003
Effective: July 1, 2003

Human Resource Management
Administration
No. 26207 (AMD): R477-1. Definitions.
Published: May 15, 2003
Effective: July 1, 2003

No. 26208 (AMD): R477-2. Administration.
Published: May 15, 2003
Effective: July 1, 2003

No. 26217 (AMD): R477-4. Filling Positions.
Published: May 15, 2003
Effective: July 1, 2003

No. 26219 (AMD): R477-5. Employee Status and Probation.
Published: May 15, 2003
Effective: July 1, 2003

No. 26220 (AMD): R477-6. Compensation.
Published: May 15, 2003
Effective: July 1, 2003

No. 26221 (AMD): R477-7. Leave.
Published: May 15, 2003
Effective: July 1, 2003

No. 26222 (AMD): R477-8. Working Conditions.
Published: May 15, 2003
Effective: July 1, 2003

No. 26224 (AMD): R477-10. Employee Development.
Published: May 15, 2003
Effective: July 1, 2003

No. 26225 (AMD): R477-11. Discipline.
Published: May 15, 2003
Effective: July 1, 2003

No. 26227 (AMD): R477-12. Separations.
Published: May 15, 2003
Effective: July 1, 2003

No. 26229 (AMD): R477-14. Substance Abuse and Drug-Free Workplace.
Published: May 15, 2003
Effective: July 1, 2003

Human Services

No. 26196 (NEW): R495-881. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Implementation.
Published: May 15, 2003
Effective: June 24, 2003

Aging and Adult Services

No. 26046 (CPR): R510-106. Minimum Percentages of Older Americans Act, Title III: Grants for State and Community Programs on Aging Part B: Supportive Services and Senior Centers Funds That an Area Agency on Aging Must Spend on Access, In-home and Legal Assistance.
Published: May 15, 2003
Effective: June 30, 2003

Insurance

Administration

No. 26159 (AMD): R590-192. Unfair Health and Disability Claims Settlement Practices Rule.
Published: May 1, 2003
Effective: June 24, 2003

No. 26194 (NEW): R590-222. Viatical Settlements.
Published: May 15, 2003
Effective: June 24, 2003

Natural Resources

Oil, Gas and Mining; Oil and Gas

No. 25788 (CPR): R649-3-1. Bonding.
Published: May 15, 2003
Effective: July 1, 2003

Wildlife Resources

No. 26241 (AMD): R657-5. Taking Big Game.
Published: May 15, 2003
Effective: June 17, 2003

Public Safety

Highway Patrol

No. 26119 (NEW): R714-159. Vehicle Safety Inspection Apprenticeship Program Guidelines.
Published: April 15, 2003
Effective: June 26, 2003

No. 26121 (R&R): R714-220. Standards for Motorcycle Protective Headgear.
Published: April 15, 2003
Effective: June 26, 2003

Peace Officer Standards and Training

No. 26179 (AMD): R728-409-3. Cause to Evaluate Certification for the Refusal, Suspension, or Revocation of Peace Officer Certification or Authority.
Published: May 15, 2003
Effective: June 26, 2003

Public Service Commission

Administration

No. 26197 (AMD): R746-347-5. Customer Survey for New or Expanded EAS.
Published: May 15, 2003
Effective: June 30, 2003

Regents (Board Of)

No. 26156 (NEW): R765-606. Utah Leveraging Educational Assistance Partnership Program.
Published: May 1, 2003
Effective: June 30, 2003

No. 26155 (REP): R765-660. Utah State Student Incentive Grant Program.
Published: May 1, 2003
Effective: June 30, 2003

Workforce Services

Employment Development

No. 26232 (AMD): R986-100. Employment Support Programs.
Published: May 15, 2003
Effective: July 1, 2003

No. 26210 (AMD): R986-200. Family Employment Program.
Published: May 15, 2003
Effective: July 1, 2003

No. 26216 (AMD): R986-400. General Assistance and Working Toward Employment.
Published: May 15, 2003
Effective: July 1, 2003

No. 26226 (AMD): R986-700. Child Care Assistance.
Published: May 15, 2003
Effective: July 1, 2003

No. 26211 (AMD): R986-900-902. Options and Waivers.
Published: May 15, 2003
Effective: July 1, 2003

RULES INDEX
BY AGENCY (CODE NUMBER)
AND
BY KEYWORD (SUBJECT)

The *Rules Index* is a cumulative index that reflects all effective changes to Utah's administrative rules. The current *Index* lists changes made effective from January 2, 2003, including notices of effective date received through July 1, 2003, the effective dates of which are no later than July 15, 2003. The *Rules Index* is published in the *Utah State Bulletin* and in the annual *Index of Changes*. Nonsubstantive changes, while not published in the *Bulletin*, do become part of the *Utah Administrative Code (Code)* and are included in this *Index*, as well as 120-Day (Emergency) rules that do not become part of the *Code*. The rules are indexed by Agency (Code Number) and Keyword (Subject).

DAR NOTE: The index may contain inaccurate page number references. Also the index is incomplete in the sense that index entries for Changes in Proposed Rules (CPRs) are not preceded by entries for their parent Proposed Rules. These difficulties with the index are related to a new software package used by the Division to create the Bulletin and related publications; we hope to have them resolved as soon as possible. Bulletin issue information and effective date information presented in the index are, to the best of our knowledge, complete and accurate. If you have any questions regarding the index and the information it contains, please contact Nancy Lancaster (801 538-3218), Mike Broschinsky (801 538-3003), or Kenneth A. Hansen (801 538-3777).

A copy of the *Rules Index* is available for public inspection at the Division of Administrative Rules (4120 State Office Building, Salt Lake City, UT), or may be viewed online at the Division's web site (http://www.rules.utah.gov/).

RULES INDEX - BY AGENCY (CODE NUMBER)

ABBREVIATIONS

AMD = Amendment
CPR = Change in proposed rule
EMR = Emergency rule (120 day)
NEW = New rule
5YR = Five-Year Review
EXD = Expired
NSC = Nonsubstantive rule change
REP = Repeal
R&R = Repeal and reenact
* = Text too long to print in *Bulletin*, or repealed text not printed in *Bulletin*

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
Administrative Services					
Facilities Construction and Management					
R23-3	Authorization of Programs for Capital Development Projects	25639	R&R	01/02/2003	2002-23/3
R23-3	Planning and Programming for Capital Projects	25989	AMD	03/24/2003	2003-4/4
R23-4	Contract Performance Review Committee and Suspension/Debarment From Consideration for Award of State Contracts	25964	5YR	01/15/2003	2003-3/62
R23-4	Contract Performance Review Committee and Suspension/Debarment From Consideration for Award of State Contracts	25783	AMD	02/04/2003	2003-1/3
R23-5	Contingency Funds	25955	5YR	01/15/2003	2003-3/62
R23-6	Value Engineering and Life Cycle Costing of State-Owned Facilities Rules and Regulations	25956	5YR	01/15/2003	2003-3/63
R23-7	Utah State Building Board Policy Statement Master Planning	25770	REP	02/04/2003	2003-1/5

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
R23-7	Utah State Building Board Policy Statement Master Planning (5YR EXTENSION)	25984	NSC	02/04/2003	Not Printed
R23-8	Planning Fund Use	25640	REP	01/02/2003	2002-23/5
R23-9	Building Board State/Local Cooperation Policy	25957	5YR	01/15/2003	2003-3/63
R23-9	Building Board State/Local Cooperation Policy	25988	R&R	03/24/2003	2003-4/5
R23-10	Naming of State Buildings	25962	5YR	01/15/2003	2003-3/64
R23-10	Naming of State Buildings	25784	AMD	02/04/2003	2003-1/5
R23-11	Facilities Allocation and Sale Procedures	25771	REP	02/04/2003	2003-1/7
R23-11	Facilities Allocation and Sales Procedures (5YR EXTENSION)	25986	NSC	02/04/2003	Not Printed
R23-13	State of Utah Parking Rules for Facilities Managed by the Division of Facilities Construction and Management	26117	5YR	03/25/2003	2003-8/44
R23-14	Management of Roofs on State Buildings	26115	NEW	05/16/2003	2003-8/7
R23-21	Division of Facilities Construction and Management Lease Procedures	25959	5YR	01/15/2003	2003-3/64
R23-24	Capital Projects Utilizing Non-appropriated Funds	25960	5YR	01/15/2003	2003-3/65
Finance					
R25-6	Relocation Reimbursement	26206	5YR	05/01/2003	2003-10/146
R25-7	Travel-Related Reimbursements for State Employees	26203	5YR	05/01/2003	2003-10/146
R25-7	Travel-Related Reimbursements for State Employees	26204	AMD	07/01/2003	2003-10/4
Fleet Operations					
R27-3	Vehicle Use Standards	25879	AMD	05/15/2003	2003-2/5
Purchasing and General Services					
R33-2-102	Authority to Make Small Purchases	26136	AMD	05/27/2003	2003-8/8
R33-3	Source Selection and Contract Formation	26138	AMD	05/27/2003	2003-8/9
R33-5	Construction and Architect - Engineer Selection	26139	AMD	05/27/2003	2003-8/15
Agriculture and Food					
Marketing and Conservation					
R65-2	Utah Cherry Marketing Order	26383	5YR	06/13/2003	2003-13/62
R65-5	Utah Red Tart and Sour Cherry Marketing Order	26386	5YR	06/13/2003	2003-13/62
R65-7	Horse Racing	26083	AMD	06/09/2003	2003-7/5
Plant Industry					
R68-5	Grain Inspection	26385	5YR	06/13/2003	2003-13/63
R68-9	Utah Noxious Weed Act	26387	5YR	06/13/2003	2003-13/63
R68-14	Quarantine Pertaining to Gypsy Moth - Lymantria Dispar	26388	5YR	06/13/2003	2003-13/64
R68-16	Quarantine Pertaining to Pine Shoot Beetle, Tomicus piniperda	26389	5YR	06/13/2003	2003-13/64
R68-17	Quarantine Pertaining to Necrotic Strain of the Potato Virus Y	26390	5YR	06/13/2003	2003-13/65
Alcoholic Beverage Control					
Administration					
R81-1-17	Advertising	25886	AMD	02/26/2003	2003-2/5
R81-5-5	Advertising	25887	AMD	02/26/2003	2003-2/8
R81-7-3	Guidelines for Issuing Permits for Outdoor or Large-Scale Public Events	25650	AMD	01/24/2003	2002-24/6

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
Career Service Review Board					
Administration					
R137-2	Government Records Access and Management Act	26397	5YR	06/18/2003	2003-14/95
Commerce					
Administration					
R151-14	New Automobile Franchise Act Rules	25624	AMD	01/02/2003	2002-23/6
R151-14	New Automobile Franchise Act Rule	26199	AMD	06/17/2003	2003-10/9
R151-33	Pete Suazo Utah Athletic Commission Act Rule	25649	AMD	01/15/2003	2002-24/7
R151-35	Powersport Vehicle Franchise Act Rule	25724	NEW	01/15/2003	2002-24/9
R151-35	Powersport Vehicle Franchise Act Rule	26198	AMD	06/17/2003	2003-10/10
R151-46b	Department of Commerce Administrative Procedures Act Rules	25822	AMD	02/18/2003	2003-1/8
Corporations and Commercial Code					
R154-2	Utah Uniform Commercial Code, Revised Article 9 Rules	25549	AMD	03/14/2003	2002-22/7
R154-10	Utah Digital Signatures Rules	25553	AMD	03/14/2003	2002-22/9
Occupational and Professional Licensing					
R156-3a	Architect Licensing Act Rules	26174	AMD	06/03/2003	2003-9/3
R156-22	Professional Engineers and Professional Land Surveyors Licensing Act Rules	25922	5YR	01/13/2003	2003-3/65
R156-22	Professional Engineers and Professional Land Surveyors Licensing Act Rules	25763	AMD	04/03/2003	2003-1/10
R156-22	Professional Engineers and Professional Land Surveyors Licensing Act Rules	25763	CPR	04/03/2003	2003-5/27
R156-28	Veterinary Practice Act Rules	26150	AMD	06/03/2003	2003-9/3
R156-31b	Nurse Practice Act Rules	26319	5YR	06/02/2003	2003-12/70
R156-38	Residence Lien Restriction and Lien Recovery Fund Rules	26192	AMD	06/17/2003	2003-10/12
R156-46a	Hearing Instrument Specialist Licensing Act Rules	25987	AMD	03/18/2003	2003-4/7
R156-47b-202	Massage Therapy Education Peer Committee	26126	AMD	05/19/2003	2003-8/17
R156-47b-302a	Qualifications for Licensure as a Massage Therapist - Massage School Curriculum Standards - Equivalent Education and Training	25651	AMD	01/16/2003	2002-24/10
R156-53	Landscape Architects Licensing Act Rules	26320	5YR	06/02/2003	2003-12/70
R156-55a	Utah Construction Trades Licensing Act Rules	26175	AMD	06/03/2003	2003-9/6
R156-56	Utah Uniform Building Standard Act Rules	26154	AMD	07/01/2003	2003-9/7
R156-56-707	Statewide Amendments to the IPC	26152	AMD	07/01/2003	2003-9/57
R156-59	Professional Employer Organization Act Rules	25920	5YR	01/09/2003	2003-3/66
R156-59	Professional Employer Organization Act Rules	26116	REP	05/19/2003	2003-8/18
R156-60a	Social Worker Licensing Act Rules	25629	AMD	01/02/2003	2002-23/8
R156-68	Utah Osteopathic Medical Practice Act Rules	26321	5YR	06/02/2003	2003-12/71
Real Estate					
R162-6-1	Improper Practices.	26025	AMD	06/05/2003	2003-5/2
R162-8-9	Disclosure Requirements	25663	AMD	01/16/2003	2002-24/11
R162-9	Continuing Education	26118	AMD	05/21/2003	2003-8/19
R162-105	Scope of Authority	26024	AMD	04/23/2003	2003-5/4
R162-106	Professional Conduct	26060	AMD	04/23/2003	2003-6/3
R162-107	Unprofessional Conduct	25981	5YR	01/21/2003	2003-4/52

CODE REFERENCE	TITLE	FILE NUMBER	ACTION	EFFECTIVE DATE	BULLETIN ISSUE/PAGE
Community and Economic Development					
Community Development, History					
R212-1	Adjudicative Proceedings	25630	AMD	01/06/2003	2002-23/10
R212-1	Adjudicative Proceedings	25570	AMD	01/06/2003	2002-22/10
R212-4	Archaeological Permits	25787	AMD	03/11/2003	2003-1/13
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ABBREVIATIONS

AMD = Amendment	NSC = Nonsubstantive rule change
CPR = Change in proposed rule	REP = Repeal
EMR = Emergency rule (120 day)	R&R = Repeal and reenact
NEW = New rule	* = Text too long to print in *Bulletin*, or repealed text not printed in *Bulletin*
5YR = Five-Year Review	
EXD = Expired	

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	25979	R527-39	5YR	01/17/2003	2003-4/57
	26061	R527-39	AMD	04/21/2003	2003-6/8
	26075	R527-56	5YR	03/10/2003	2003-7/90
	25869	R527-201	AMD	03/05/2003	2003-2/34
	26076	R527-305	5YR	03/10/2003	2003-7/91
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Human Services, Child and Family Services	26258	R512-100	EMR	05/06/2003	2003-11/76
	26256	R512-200	EMR	05/06/2003	2003-11/78
	26255	R512-201	EMR	05/06/2003	2003-11/80
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	26257	R512-305	EMR	05/06/2003	2003-11/91
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Education, Administration	26190	R277-108	AMD	06/17/2003	2003-10/22
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Public Safety, Criminal Investigations and Technical Services, Criminal Identification	25999	R722-300	5YR	01/28/2003	2003-4/59
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	25937	R277-709	5YR	01/14/2003	2003-3/70
	25938	R277-718	5YR	01/14/2003	2003-3/71
	25939	R277-730	5YR	01/14/2003	2003-3/72
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	25704	R765-171	REP	03/31/2003	2002-24/55
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	26259	R510-100-2	EMR	05/15/2003	2003-11/74
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	25819	R865-9I-29	AMD	03/11/2003	2003-1/43
	26078	R865-9I-39	AMD	06/10/2003	2003-7/61
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Education, Administration	26091	R277-751	5YR	03/12/2003	2003-7/75
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	26074	R313-19-100	AMD	05/09/2003	2003-7/10
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Public Service Commission, Administration	25578	R746-347	NEW	03/10/2003	2002-22/44
	26197	R746-347-5	AMD	06/30/2003	2003-10/116
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	26199	R151-14	AMD	06/17/2003	2003-10/9
	25724	R151-35	NEW	01/15/2003	2002-24/9
	26198	R151-35	AMD	06/17/2003	2003-10/10
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	26165	R657-5-70	AMD	06/03/2003	2003-9/103
	25721	R657-17	AMD	01/15/2003	2002-24/46
	25890	R657-23	AMD	02/16/2003	2003-2/41
	25892	R657-33	AMD	02/16/2003	2003-2/43
	26056	R657-33-6	AMD	04/15/2003	2003-6/15
	26274	R657-34	5YR	05/14/2003	2003-11/95
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	25827	R986-400-404	AMD	02/06/2003	2003-1/43
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Natural Resources, Parks and Recreation	26041	R651-102-4	NSC	03/01/2003	Not Printed
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Commerce, Administration	25822	R151-46b	AMD	02/18/2003	2003-1/8
	26225	R477-11	AMD	07/01/2003	2003-10/97

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	26138	R33-3	AMD	05/27/2003	2003-8/9
	26139	R33-5	AMD	05/27/2003	2003-8/15
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	26057	R315-2-2	NSC	03/01/2003	Not Printed
	25915	R315-3	NSC	03/01/2003	Not Printed
	25912	R315-4	NSC	03/01/2003	Not Printed
	25913	R315-7	NSC	03/01/2003	Not Printed
	25911	R315-8	NSC	03/01/2003	Not Printed
	26058	R315-8-15	NSC	03/01/2003	Not Printed
	25914	R315-12	NSC	03/01/2003	Not Printed
	25918	R315-14	NSC	03/01/2003	Not Printed
	26064	R315-15	5YR	03/03/2003	2003-7/76
	25916	R315-16	NSC	03/01/2003	Not Printed
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	26079	R428-13	5YR	03/10/2003	2003-7/89
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Health, Health Systems Improvement, Licensing	25868	R432-3	AMD	03/13/2003	2003-2/29
	25452	R432-5	AMD	01/15/2003	2002-21/92
	25791	R432-13	AMD	03/13/2003	2003-1/32
	25792	R432-14	AMD	03/13/2003	2003-1/34
	26038	R432-16	5YR	02/12/2003	2003-5/39

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Insurance, Administration	25093	R590-215	NEW	01/09/2003	2002-15/65
	25093	R590-215	CPR	01/09/2003	2002-23/100
	25919	R590-215	NSC	03/01/2003	Not Printed
	26133	R590-215	AMD	05/20/2003	2003-8/34
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Health, Center for Health Data, Health Care Statistics	26080	R428-11	5YR	03/10/2003	2003-7/88
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Health, Center for Health Data, Health Care Statistics	26079	R428-13	5YR	03/10/2003	2003-7/89
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	26432	R765-605	5YR	06/30/2003	2003-14/102
	26134	R765-660	5YR	04/01/2003	2003-8/44
	25713	R765-660	NSC	04/01/2003	Not Printed
	26085	R765-685	AMD	05/20/2003	2003-7/55
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	26162	R380-250	NEW	06/09/2003	2003-9/72
	26160	R495-881	EMR	04/14/2003	2003-9/132
	26196	R495-881	NEW	06/24/2003	2003-10/104
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Insurance, Administration	25870	R590-76	AMD	02/26/2003	2003-2/35
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Agriculture and Food, Marketing and Conservation	26083	R65-7	AMD	06/09/2003	2003-7/5
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	25948	R414-5	EMR	01/15/2003	2003-3/52
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Health, Center for Health Data, Health Care Statistics	26080	R428-11	5YR	03/10/2003	2003-7/88
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Human Services, Administration, Administrative Services, Licensing	25652	R501-1	AMD	01/30/2003	2002-24/15
	26071	R501-2	AMD	05/06/2003	2003-7/20
	25707	R501-8	AMD	01/17/2003	2002-24/19
	25978	R501-8	NSC	03/01/2003	Not Printed
	25660	R501-11	AMD	01/30/2003	2002-24/25
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	25703	R501-16	NSC	02/26/2003	Not Printed
	26055	R501-16	5YR	02/26/2003	2003-6/17
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Tax Commission, Auditing	25829	R865-9I-26	AMD	03/11/2003	2003-1/40
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Environmental Quality, Water Quality	25636	R317-1	AMD	01/30/2003	2002-23/17
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Environmental Quality, Air Quality	26399	R307-222	5YR	06/19/2003	2003-14/96
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Pardons (Board Of), Administration	26120	R671-201	AMD	05/16/2003	2003-8/39
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	25394	R671-308	AMD	02/12/2003	2002-20/110
	25398	R671-311	AMD	02/12/2003	2002-20/112
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Administrative Services, Facilities Construction and Management	25957	R23-9	5YR	01/15/2003	2003-3/63
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Agriculture and Food, Plant Industry	26385	R68-5	5YR	06/13/2003	2003-13/63
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	25958	R590-219	CPR	06/13/2003	2003-9/127
	25958	R590-219	NEW	06/13/2003	2003-3/23
	26194	R590-222	NEW	06/24/2003	2003-10/105
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	26182	R590-94	5YR	04/17/2003	2003-10/148
	26159	R590-192	AMD	06/24/2003	2003-9/84
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Insurance, Administration	26158	R590-223	NEW	06/13/2003	2003-9/89
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Environmental Quality, Drinking Water	26172	R309-700	AMD	07/01/2003	2003-9/66
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Education, Applied Technology Education (Board for), Rehabilitation	25646	R280-203	AMD	01/03/2003	2002-23/16
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Public Safety, Fire Marshal	26003	R710-9	AMD	03/18/2003	2003-4/38
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	26150	R156-28	AMD	06/03/2003	2003-9/3
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	26320	R156-53	5YR	06/02/2003	2003-12/70
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	26154	R156-56	AMD	07/01/2003	2003-9/7
	26152	R156-56-707	AMD	07/01/2003	2003-9/57
	25920	R156-59	5YR	01/09/2003	2003-3/66
	26116	R156-59	REP	05/19/2003	2003-8/18
	25629	R156-60a	AMD	01/02/2003	2002-23/8
	26321	R156-68	5YR	06/02/2003	2003-12/71
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	25707	R501-8	AMD	01/17/2003	2002-24/19
	25978	R501-8	NSC	03/01/2003	Not Printed
	25660	R501-11	AMD	01/30/2003	2002-24/25
	25644	R501-12	AMD	01/30/2003	2002-23/82
	25703	R501-16	NSC	02/26/2003	Not Printed
	26055	R501-16	5YR	02/26/2003	2003-6/17
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	25948	R414-5	EMR	01/15/2003	2003-3/52
	25967	R414-5	NEW	05/13/2003	2003-3/8
	25969	R414-6	EMR	01/15/2003	2003-3/53
	25974	R414-6	NEW	05/13/2003	2003-3/9
	26010	R414-10	EMR	02/01/2003	2003-4/45
	26036	R414-10	EMR	02/11/2003	2003-5/33
	26008	R414-10	AMD	04/07/2003	2003-4/11
	25192	R414-13	NSC	01/03/2003	Not Printed
	25907	R414-13	5YR	01/03/2003	2003-3/74
	25968	R414-21	EMR	01/15/2003	2003-3/54
	25973	R414-21	AMD	04/07/2003	2003-3/10
	25982	R414-27	5YR	01/21/2003	2003-4/52
	26318	R414-51	5YR	05/30/2003	2003-12/71
	25970	R414-52	EMR	01/15/2003	2003-3/57
	25976	R414-52	AMD	04/09/2003	2003-3/14
	26347	R414-52	5YR	06/06/2003	2003-13/71
	25971	R414-53	EMR	01/15/2003	2003-3/59
	25972	R414-53	AMD	04/07/2003	2003-3/15
	26346	R414-53	5YR	06/06/2003	2003-13/71
	26011	R414-60	EMR	02/01/2003	2003-4/50
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	25898	R414-63	AMD	04/07/2003	2003-2/12
	26004	R414-301	5YR	01/31/2003	2003-4/53
	26018	R414-305	5YR	01/31/2003	2003-4/55
	25897	R414-504	AMD	02/17/2003	2003-2/21
	26051	R414-504	AMD	06/09/2003	2003-6/4
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Education, Administration	25647	R277-611	NEW	01/03/2003	2002-23/12
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minority education					
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Public Service Commission, Administration	26142	R746-331	5YR	04/02/2003	2003-9/136
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	26128	R651-410	AMD	05/19/2003	2003-8/38
oil and gas law					
Natural Resources, Oil, Gas and Mining; Oil and Gas	25788	R649-3-1	AMD	07/01/2003	2003-1/35
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	25398	R671-311	AMD	02/12/2003	2002-20/112
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	26160	R495-881	EMR	04/14/2003	2003-9/132
	26196	R495-881	NEW	06/24/2003	2003-10/104
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	25640	R23-8	REP	01/02/2003	2002-23/5
	25957	R23-9	5YR	01/15/2003	2003-3/63
	25962	R23-10	5YR	01/15/2003	2003-3/64
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	26143	R746-332	5YR	04/02/2003	2003-9/136
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	26094	R315-303	5YR	03/14/2003	2003-7/78
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	26044	R884-24P-60	AMD	04/23/2003	2003-5/15
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	26188	R277-508	5YR	04/25/2003	2003-10/147
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	26145	R746-342	5YR	04/02/2003	2003-9/137
	25578	R746-347	NEW	03/10/2003	2002-22/44
	26197	R746-347-5	AMD	06/30/2003	2003-10/116
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transportation safety					
Transportation, Operations, Traffic and Safety	26295	R920-50-11	EMR	05/16/2003	2003-12/68
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Tax Commission, Auditing	25826	R865-9I-28	AMD	03/11/2003	2003-1/42
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Public Safety, Criminal Investigations and Technical Services, Criminal Identification	25998	R722-320	5YR	01/28/2003	2003-4/60
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	26307	R994-208	5YR	05/23/2003	2003-12/79
	26135	R994-303-104	AMD	06/05/2003	2003-8/42
	26355	R994-306	5YR	06/11/2003	2003-13/72
	26358	R994-307	5YR	06/11/2003	2003-13/73
	25946	R994-406-311	AMD	03/04/2003	2003-3/46
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	26356	R994-508	5YR	06/11/2003	2003-13/74
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Environmental Quality, Radiation Control	25785	R313-12-3	AMD	03/14/2003	2003-1/22
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Human Services, Mental Health, State Hospital	26302	R525-4	5YR	05/20/2003	2003-12/73
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	26097	R315-307	5YR	03/14/2003	2003-7/80
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	26100	R315-309	5YR	03/14/2003	2003-7/81
	26099	R315-310	5YR	03/14/2003	2003-7/82
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Environmental Quality, Water Quality	25203	R317-4-3	AMD	01/10/2003	2002-18/43
	25635	R317-4-3	AMD	01/30/2003	2002-23/21
	25637	R317-11	AMD	01/30/2003	2002-23/80
wastewater					
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	26142	R746-331	5YR	04/02/2003	2003-9/136
	26143	R746-332	5YR	04/02/2003	2003-9/136
water pollution					
Environmental Quality, Water Quality	25636	R317-1	AMD	01/30/2003	2002-23/17
	25634	R317-8	AMD	01/30/2003	2002-23/33
	25633	R317-9	NEW	02/05/2003	2002-23/74
	25638	R317-10	AMD	01/30/2003	2002-23/78
water quality					
Environmental Quality, Water Quality	25632	R317-6-6	AMD	01/30/2003	2002-23/25
	25631	R317-7-13	AMD	01/30/2003	2002-23/32
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Natural Resources, Water Rights	26195	R655-5	5YR	04/29/2003	2003-10/149
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Agriculture and Food, Plant Industry	26387	R68-9	5YR	06/13/2003	2003-13/63
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Human Services, Recovery Services	25977	R527-3	AMD	03/19/2003	2003-4/26
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Natural Resources, Wildlife Resources	26167	R657-3	5YR	04/15/2003	2003-9/135
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	25720	R657-5	AMD	01/15/2003	2002-24/29
	26241	R657-5	AMD	06/17/2003	2003-10/111
	26165	R657-5-70	AMD	06/03/2003	2003-9/103
	25721	R657-17	AMD	01/15/2003	2002-24/46
	25890	R657-23	AMD	02/16/2003	2003-2/41
	26169	R657-26-8	AMD	06/03/2003	2003-9/104
	25892	R657-33	AMD	02/16/2003	2003-2/43
	26056	R657-33-6	AMD	04/15/2003	2003-6/15
	26274	R657-34	5YR	05/14/2003	2003-11/95
	26275	R657-37	5YR	05/14/2003	2003-11/96
	25722	R657-38	AMD	01/15/2003	2002-24/48
	25723	R657-42	AMD	01/15/2003	2002-24/52
	26278	R657-42	5YR	05/14/2003	2003-11/97
	25894	R657-44	R&R	02/16/2003	2003-2/46
	26168	R657-53	NEW	06/03/2003	2003-9/107
wildlife conservation					
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Labor Commission, Industrial Accidents	26315	R612-2	5YR	05/28/2003	2003-12/75
	26405	R612-2-22	EMR	06/20/2003	2003-14/92
	26316	R612-3	5YR	05/28/2003	2003-12/76
	26317	R612-5	5YR	05/28/2003	2003-12/76
	26314	R612-7	5YR	05/28/2003	2003-12/77
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Workforce Services, Employment Development	26216	R986-400	AMD	07/01/2003	2003-10/127
	25827	R986-400-404	AMD	02/06/2003	2003-1/43
x-ray					
Environmental Quality, Radiation Control	25786	R313-28	AMD	03/14/2003	2003-1/27
youth					
Human Services, Administration, Administrative Services, Licensing	25707	R501-8	AMD	01/17/2003	2002-24/19
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	25703	R501-16	NSC	02/26/2003	Not Printed
	26055	R501-16	5YR	02/26/2003	2003-6/17
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Administrative Services, Facilities Construction and Management	25957	R23-9	5YR	01/15/2003	2003-3/63
	25988	R23-9	R&R	03/24/2003	2003-4/5
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