R21. Administrative Services, Debt Collection.
R21-1. Transfer of Collection Responsibility of State Agencies.
R21-1-1. Purpose.

The purpose of this rule is to establish the procedures by which agencies shall bill and make initial collection efforts according to a coordinated schedule, the method to be used by agencies to transfer their delinquent accounts receivable to the Office or its designee for additional collection action, write-off of receivables, and the procedures and allocation of costs of collection established pursuant to Subsections 63A-3-502(4)(g), 63A-3-502(6)(b), Section 15-1-4,Utah Code, and by the Legislature in applicable laws.

R21-1-2. Authority.

This rule is established pursuant to Subsections 63A-3-502(3)(m), 63A-3-502(7)(f), 63A-3-502(4)(g), 63A-3-502(6)(b), Section 15-1-4, Utah Code and the Office intent language and fees authorized by the Legislature in applicable laws. Subsection 63A-3-502(3)(m) authorizes the Office to establish procedures for writing off accounts receivable for accounting and collection purposes. Subsection 63A-3-502(7)(f) authorizes the Office to require state agencies to bill and make initial collection efforts of its receivables up to the time the accounts must be transferred. Subsection 63A-3-502(7)(a) authorizes the Office to require state agencies to transfer collection responsibility to the Office or its designee according to time limits specified by the Office. Subsection 63A-3-502(4)(g) authorizes Office to establish a fee to cover the administrative costs of collection, a late penalty fee and an interest charge by following the procedures and requirements of Section 63J-1-504. Subsection 63A-3-502(6)(b) prohibits the Office from assessing the interest charge established by the Office under Subsection 63A-3-502(4)(g) on an account receivable subject to the postjudgment interest rate established by Section 15-1-4. Section 15-1-4 requires civil and criminal judgments of the district court and justice court to bear interest at the federal postjudgment interest rate and sets forth the procedures to be followed. The annual Appropriation Act authorizes the fees charged by the Office to collect accounts and provides legislative intent language allowing the costs of collection to be collected from the debtor.

R21-1-3. Definitions.

In addition to terms defined in Section 63A-3-501, the following terms are defined below as follows:

(1) "Delinquent" means any account receivable for which the state has not received payment in full by the payment demand date.

(2) "Designee" means a Private Sector Collector or State Agency that the Office of State Debt Collection has contracted with to provide accounts receivable collection services.

(3) "Payment demand date" is the date by which the agency requires payment for the account receivable that an entity has incurred.

(4) "Skipped" means that the entity formerly transacting business with the state is not known at the address or telephone number previously used nor is any new address or telephone number known of the entity.

(5) "Event" is the day the goods are purchased, services completed, fines, fees, and assessments are due, etc.

(6) "Trust" means a receivable that is owed to a victim of a crime.

R21-1-4. Agency Billing and Collection Responsibility.

Pursuant to Subsection 63A-3-502(3)(b), (d), and (f) as provided by Subsection 63G-3-201, state agencies shall document and track agency receivables on the state's Advanced Receivable Subsystem unless the state agency has received an exemption from the Office of State Debt Collection. If a state agency receives such an exemption, the state agency shall track their receivables on the agency system and provide the Office with quarterly receivable reports pursuant to 63A-3-502(7)(g). The receivable reports are due to Office no later than 45 days after the end of the quarter.

State agency customers shall be billed within 10 days from the event creating the receivable or the next billing cycle, if reoccurring. The payment demand date shall be no later than 30 days from the event date unless the state agency can demonstrate the 30 day demand date is not appropriate for the agency's business processes. State agencies shall contact customers for payment by phone or written notice when payment is not received within 10 days after the payment demand date.

The Office has published guidelines for billing receivables and collecting delinquent accounts. These guidelines are included in the document entitled "Statewide Guidelines for Accounting, Reporting and Collecting Accounts Receivable". This document is available at the Office of State Debt Collection, Room 4130 State Office Building, Salt Lake City, Utah, during regular working hours, for review.

R21-1-5. Transfer of Collection Responsibility.

Each state agency with delinquent accounts shall comply with the provisions of Section 63A-3-502, et seq. unless prohibited by current state or federal statute or regulation. A state agency or user of the Office of State Debt Collection services shall transfer collection responsibility to the Office, or its designee, when the account receivable is not paid within 90 days of the event or is delinquent 61 days. A state agency can negotiate a different receivable transfer date with the Office by demonstrating how the state benefits from the negotiated transfer date. Office recommendations related to the transfer of collection responsibility can be found in the Office publication "Statewide Guidelines for Accounting, Reporting and Collecting Accounts Receivable".

R21-1-6. Format for Transfer of Accounts Receivable Data.

State agencies shall transfer delinquent accounts to the Office or its designee electronically through the state's Advanced Receivable Subsystem. State agencies exempted from using the state's Advanced Receivable Subsystem shall work with the Office to generate an electronic placement file for placing accounts.

R21-1-7. Costs of Collection.

Pursuant to Subsections 63A-3-502(4) (g), Section 15-1-4, Utah Code, and by the legislature in applicable laws, the Office shall charge penalty, interest, and administrative costs of collection and shall collect these costs in addition to the receivable balance from the debtor. The fee calculation and payment priority shall be applied according to the following methodology.

(a) Pursuant to 63A-3-502(4)(g)(i), the costs of collection shall be charged on all accounts referred for collection and the cost shall be calculated based on the dollars collected times the rate authorized by the legislature. The cost of collection shall be paid first from each payment.

(b) The Penalty shall be calculated as a percent of the receivable balance referred for collection. A percent of each payment shall be applied to the outstanding penalty until the penalty is paid in full. The penalty payment shall be calculated based on the authorized penalty percent set annually by the legislature, times the received payment amount. The calculated penalty amount shall be paid after the costs of collection are determined and paid.

(c) Two types of interest shall be charged on accounts referred to the Office. Postjudgment interest as established by

Section 15-1-4, Utah Code, applies to receivables with judgments established by the courts with a sentencing date subsequent to May 5, 1999. Postjudgment interest accrues on the unpaid judgment balance of the receivable. Postjudgment interest that accrues on a trust or the trust portion of a receivable, shall be paid subsequent to the state's outstanding receivable. All other state receivables referred to the Office are charged an interest charge pursuant to 63A-3-502 (4) (g)(iii)(B), Utah Code. This interest is referred to as OSDC interest. OSDC accrued interest shall be paid from each payment after the payment of the costs of collection and the penalty except on trust receivables or receivables including a trust account.

(d) Each payment received on trust receivables shall be applied to the following items in the priority listed until the payment is fully disbursed: 1st - cost of collection, 2nd - penalty, 3rd - the trust receivable balance, and 4th - the accrued postjudgment interest.

(e) Each payment received on receivables that include trust(s) and state receivable balances shall be applied to the following items in the priority listed until the payment is fully disbursed: 1st - cost of collection, 2nd - penalty, 3rd - the trust(s) receivable balance until paid in full, 4th - accrued post-judgment or OSDC interest on the state receivable balance, 5th - the state receivable balance, and 6th - the accrued trust post-judgment interest.

(f) Each payment received on receivables owed only to the state shall be applied to the following items in the priority listed until the payment is fully disbursed: 1st - cost of collection, 2nd penalty payment, 3rd - accrued post-judgment or OSDC interest, and 4th - the receivable balance.

(g) Trust Payments sent to victims of crimes that are returned to the Office because of bad addresses, shall be reversed from the trust account and applied to amounts owed the state on the account. After the state debt is liquidated, payments shall be applied to the trust and if the victim still cannot be located, the payments shall be retained by the division of Finance for the appropriate time and then sent to Unclaimed Property and thereafter to Crime Victims Reparation.

R21-1-8. Write Off of Accounts Receivable.

State agencies shall follow the statewide Accounting Policies and Procedures outlined in FIACCT 06-01.14 and 06-02.04, available from the state Division of Finance.

R21-1-9. Original Signature Required on Certain Office of State Debt Collection (OSDC) Documents.

An Original Signature is Required by the Office of State Debt Collection (OSDC) on the following documents:

(1) Victim Settlement Agreement

(2) OSDC Debt Repayment Contract Agreement

(3) Wage Assignments to pay debts

(4) Authority for the automatic transfer of funds (EFT) to pay debts

(5) Authority for the automatic Credit/Debit Card charge to pay debts

KEY: accounts receivable, collection transfer

September 7, 2012 **63A-3-502(3)(m)**

Notice of Continuation June 28, 2012 **63A-3-502(4)(g)**

63A-3-502(6)(a)

63A-3-502(6)(b)

63A-3-502(7)(f)

15-1-4

R30. Administrative Services, Inspector General of Medicaid Services (Office of).
R30-1. Office of Inspector General of Medicaid Services.
R30-1-1. Introduction and Authority.

(1) This rule generally characterizes the scope of the Office of Inspector General of Medicaid Services in Utah, and defines all of the provisions necessary to administer the Office.

(2) The rule is authorized under Utah Code Annotated Section 63A-13-602 pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

R30-1-2. Definitions.

(1) The terms used in this rule are defined in Section 63A-13-102.

(2) Policy is defined as the Utah State Plan, Medicaid Administrative rule, provider manuals and their attachments, and the Medicaid Information Bulletins.

R30-1-3. The Office of Inspector General.

(1) The Office of Inspector General shall inspect and monitor the Utah Medicaid Program pursuant to Section 63A-13-202.

(2) The Office of Inspector General has entered into a Memorandum of Understanding (MOU) with the Department of Health outlining the delegation of duties from the Department to the Office and as required by federal and state statutes.

R30-1-4. Office Duties.

(1) The Office of the Inspector General shall perform the following duties:

(a) The Office shall receive reports of suspected fraud, waste, or abuse in the state Medicaid program through phone, website, mail, or other electronic means open to the public:

(i) Establish a 24-hour, toll free hotline monitored by staff, or voicemail as appropriate.

(ii) Establish a separate identifiable email to report fraud, waste or abuse of Medicaid funds.

(b) The Office shall investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program by post payment review of claims paid under fee-for service, managed care, capitation, waiver, contracts or other payment methods where funds are expended by the Department of Health for Medicaid related services or programs.

(c) The Office shall establish an MOU with the Medicaid Fraud Control Unit to identify and recover improperly or fraudulently expended Medicaid funds.

(d) The Office shall determine appropriate methodology for identifying risk associated with the Department of Health and its programs under Medicaid funding.

(2) The Office shall regularly report to the Department regarding all identified cases of fraud, waste or abuse. The Office will report how the Department can reduce cost or improve performance through changes in policies or claims payment systems. The Office will operate the program integrity function and audit function to the extent possible and as described under a MOU with the Department

(3) The Office shall establish a means for providers to return payments to the Office. The Office will return all collected overpayments to the appropriate department.

(4) The Office shall afford any person or entity due process and administrative hearing rights through Subsection R414-1-5(16).

R30-1-5. Incorporations by Reference.

(1) All rules, regulations, and laws below are incorporated by reference.

R30-1-6. Medicaid Fraud (Criminal).

(1) The Office establishes and maintains methods, criteria, and procedures that meet all federal and state requirements for prevention of program fraud and abuse.

(2) The Office will enter into an MOU with The Medicaid Fraud Control Unit (MFCU) and the Department to ensure appropriate measures are established to reduce and prevent fraud and abuse in the Medicaid program.

(3) The Office shall report any instances of suspected Provider criminal fraud or misconduct to the MFCU within reasonable time.

(a) A hold shall be placed on the funds in accordance with 42 CFR 455.23.

(i) The Office shall notify the provider of the suspension within five (5) days; notice shall be given to the provider in accordance with Section R30-1-11a.

(ii) Law Enforcement may request in writing to delay notification of the provider in accordance with 42 CFR 455.23.

(4) The Office shall report instances of suspected recipient criminal fraud or misconduct in accordance with Subsection 63A-13-202(1)(k) to the appropriate law enforcement agency within a reasonable time.

R30-1-7a. Auditing of the State and Local Entities: Audit Responsibilities.

(1) Audit is defined as an independent, objective review of a process and associated controls to determine the effectiveness, efficiency and or compliance of that program or process. Audits will be conducted under the regular supervision of the Inspector General.

(a) The specific definition of Audit, defined above, shall only apply to audits executed within the scope of Section R30-1-7a.

(2) The audit reports pertaining to the functioning of the Department will then be released to the Governor, Speaker of the House, President of the Senate, Executive Director of the Department that is audited.

(3) Audits will primarily be determined through a risk assessment approved by the Office.

(4) Audit activities of the Office will remain free of influence from any Department, Division, private or contracted entities.

(5) The Office audit group will follow the Generally Accepted Government Auditing Standards (GAGAS) Federal OIG Quality Standards by the Council of Inspectors General on Integrity and Efficiency (CIGIE) as it relates to audit standards, inspections and review standards.

(6) The auditors will immediately notify the Inspector General of any serious deficiency or the suspicion of significant fraud during its review.

(7) Pursuant to Section 63A-13-301 the Office will have unrestricted access to all records of state executive branch entities, all local government entities, and all providers relating directly or indirectly to the state Medicaid program.

R30-1-7b. Auditing of the State and Local Entities: Audit Plan.

(1) An audit plan will be prepared by the Office at least annually and shall:

(a) Identify the audits to be performed based on audit risk assessment reviewed annually;

(b) Identify resources to be devoted to audits in plan;

(c) Ensure that audits evaluate the efficiency and effectiveness of tax payer dollars in the Medicaid program;

(d) Determine adequacy of Medicaid's controls over federal and state compliance.

(2) The OIG audit function shall:

(a) Issue regular audit reports on the effectiveness and efficiency of the defined audits within the Medicaid program in Utah;

(b) Ensure that such audits are conducted within

professional standards such as those defined by the Generally Accepted Governmental Auditing Standards (GAGAS), GIGIE QSI, or the Association of Inspector Generals;

(c) Report annually to the Governor's office on or before October 1, and to the Utah Legislature before November 30 as stated in Section 63A-13-502.

R30-1-8a. Auditing of Medical Providers.

(1) The Office may conduct performance and financial audits of entities described in Subsection 63A-13-202(2).

(2) Ensure that such audits are conducted within professional standards such as those defined by the Generally Accepted Governmental Auditing Standards (GAGAS), Federal Office of Inspector General, or the Association of Inspector Generals.

(3) The Office may conduct audits based upon risk assessments, random samples, and referrals from any credible source.

(4) The audit findings shall be reported to the audited entity within 30 days of the closing of the audit. The Office shall send a written report with the findings and recommendations.

(5) Each audit shall consider impact to the provider community when making recommendations to the Department and applying a remedy if necessary.

R30-1-8b. Access to Records and Employees.

(1) In order to fulfill the duties described in Section 63A-13-202, the Office shall have unrestricted access to all records of state executive branch entities, all local government entities, and all providers relating, directly or indirectly, as stated in 63A-13-301. Access to employees that the inspector general determines may assist in the fulfilling of the duties of the Office shall be granted as stated in Section 63A-13-302.

(2) The Office shall request access to records or documents through a written request. The responding agency or entity must respond to the request within 30 days.

(a) The written request shall be sent in accordance with R30-1-11-2.

R30-1-9. Subpoena Power.

(1) The Office shall have the power to issue a subpoena to obtain records or interview a person that the Office has the right to access as stated in 63A-13-401.

(2) The form of Subpoena shall meet the requirements of Utah Rule of Civil Procedure 45.

R30-1-10a. Post-Payment Review: Utilization Reviews and Medicaid Reviews of Services Provided Under the Utah Medicaid Program.

(1) The Office shall conduct hospital utilization reviews as outlined in the Department's Superior System Waiver in effect at the time service was rendered.

(2) The Office may request records that support provider claims for payment under programs funded through the Department.

(3) The medical records requests shall comply with Section R30-1-11b.

(4) The Office shall review the records in accordance with Department rules and policies in effect at the time the service was rendered.

(i) The Office shall enforce policies in accordance with Subsections 63A-13-202(3)(a) - (b).

R30-1-10b. Post-Payment Review: Thirty Day Re-Admissions.

(1) The Office shall conduct reviews of hospital re-admissions within 30 days. The reviews shall be conducted in accordance with the Department's Superior System Waiver in effect at the time service was rendered.

(2) The Office may request records to evaluate the re-admissions.

(3) The medical records requests shall comply with Section R30-1-11b.

(4) If after review of the re-admission and the claim or encounter does not comply with the Department's policy the Office shall appropriately enforce the Department's policy and or rule.

R30-1-10c. Post-Payment Review: Medicaid Program Integrity (MPI).

(1) The Office shall conduct post-payment review of claims submitted by providers to Medicaid.

(2) The Office shall investigate of any referral that contains allegations of fraud, waste and abuse in accordance with 42 CFR 455.

(3) The Office shall conduct post-payment review of the claims for fraud, waste and abuse.

(4) The Office may request medical records to evaluate the claims.

(5) The medical records requests shall comply with Section R30-1-11b.

(6) If after review, the claim submitted does not comply with the Department Health policy, the Office shall appropriately enforce Department Health policy and or rule.

(7) The Office shall enforce policies in accordance with Subsections 63A-13-202(3)(a) - (b).

R30-1-10d. Post-Payment Review: Site Visits.

(1) The Office of Inspector General shall conduct site visits in a minimally intrusive manner. The Office shall perform the following prior to a site visit:

(a) The Office shall notify the provider of a site visit in writing, seven (7) calendar days before the inspection. The notice requirement shall comply with Section R30-1-11a.

(b) The Office shall make reasonable efforts to coordinate and afford the provider an opportunity to make an appointment and arrange visits at a time best suited for the provider.

(c) The Office shall attempt to minimize interference with patient care.

(2) If there is a credible allegation of fraud, the requirements of Section R30-1-12(1) are not required.

(3) This rule does not limit the Office from conducting new Provider Enrollment site visits under 42 CFR 455.432.

(a) Provider Enrollment visits shall be conducted in a minimally intrusive manner, during normal business hours.

(b) No notice is required for Provider Enrollment site visits, if it is a verification visit.

R30-1-10e. Post-Payment Review: Training.

(1) The Office of Inspector General shall provide training to the provider community at no cost.

(2) The training may include the following:

(a) Common methods to prevent fraud, waste and abuse.

(b) Current trends on how fraud, waste and abuse are occurring.

(c) How to report fraud, waste, and abuse.

(d) Office programs and audit policies, procedures, and compliance.

(e) Any other topic necessary to carry out the duties of the Office.

(3) The Office may conduct quarterly webinars on topics that pertain to Medicaid.

(4) The Office may consult with the Department to prepare curriculum and training material.

(5) Any provider may request training by contacting the Office.

R30-1-10f. Post-Payment Review: Policy Reviews.

(1) The Office shall conduct policy reviews of the Medicaid Provider Manuals and the Medicaid information bulletins (MIBs). These reviews shall be conducted as follows:

(a) The Office shall review the policies for internal inconsistencies and report those to the Department.

(b) The Office shall complete the review within 45 days from receiving the proposed policy from the Department.

(c) The Office shall advise and make recommendations on the policy if there is a policy that would create waste or abuse in the Medicaid program.

(d) Recommendations may be submitted to the Department for review.

(e) This procedure shall occur prior to the publishing of the MIB and policies.

R30-1-11a. Provider Communication: Notices of Recovery.

(1) The Office shall notify providers of overpayments and recover improperly paid claims through the following:

(a) Any suspected recoupment or take back against future funds less than $5,000 shall be communicated to the provider via first class mail including a verification certificate attached to verify delivery.

(b) Any suspected recoupment or take back against future funds greater than $5,000 shall be communicated to the provider through certified mail or similar guaranteed delivery mechanism.

(c) Administrative hearing notice requirements will also comply with (a) and (b) above.

(d) Notices of suspension of payments and placement of holds will also comply with (a) and (b) above.

(d) In addition to the methods set forth in this rule, a party may be served as permitted by the Utah Rules of Civil Procedure.

(2) The Office shall send the notice of recovery to the mailing address that is on file with the Department of Health. The Provider may, request in writing, that the Office use the billing address or the service location address on file with the Department of Health. The written request to the Office shall specify the address to be used, the address identified by the Provider must be on file with the Department of Health, the OIG shall not send correspondence to an address not on file with the Department of Health.

R30-1-11b. Provider Communication: Records Requests.

(1) The Office may request records that support provider claims for payment under programs funded through the Department of Health. These requests shall be in writing and identify the records to be reviewed.

(2) The requests shall be sent first class mail with proper United States Postal Service postage attached; to the mailing address on file with the Department of Health.

(i) If a request is returned undeliverable the Office shall send the notification of an invalid address to the Department of Health.

(ii) The Office shall file a certificate of service that certifies the request was sent that contain the following requirements:

(a) The date of mailing.

(b) The name of the sender.

(c) The signature, electronic or otherwise, of the sender that verifies the document was properly mailed.

(d) Address that the records request was sent to.

(e) Written responses to requests shall be returned within 30 days of the date of the written request. Responses must include the complete record of all services and supporting services for which reimbursement is claimed.

(f) However, if there is no response within the 30 day period, the Office shall close the record and shall evaluate the payment based on the records that the Office has in its file.

(3) The Office shall send the requests for records to the mailing address that is on file with the Department of Health. The Provider may, requests in writing, that the Office use the billing address or the service location address on file with the Department of Health. The written request to the Office shall specify the address to be used, the address identified by the Provider must be on file with the Department of Health, the OIG shall not send correspondence to an address not on file with the Department of Health.

(4) The Office shall limit requests for medical records to 36 months prior to the date of the inception of the investigation in accordance with Section 63A-13-204.

R30-1-12. Placement of Hold.

(1) The Office shall notify the provider of any hold on payment through written correspondence with in five (5) days. The correspondence shall be communicated to the provider in a manner consistent with Section R30-1-11a.

(2) The correspondence shall contain the following:

(a) Name and address of provider.

(b) Notification of suspension.

(c) General reason for suspension.

(d) Explanation of due process rights.

(3) Providers may request a state fair hearing through Subsection R414-1-5(16) Office of Inspector General Administrative Hearings Procedures Manual.

R30-1-13. Human Resources.

(1) The Office incorporates by reference the DHRM rules under Title R477 applicable to the type and category of the employees in the Office.

(2) The Office incorporated by reference the OIG Human Resources Manual and Policies.

R30-1-14. General Rule Format.

(1) The following format is used generally throughout the rules of the Office. Section headings as indicated and the following general definitions are for guidance only. The section headings are not part of the rule content itself. In certain instances, this format may not be appropriate and will not be implemented due to the nature of the subject matter of a specific rule.

(2) Introduction and Authority. A concise statement as to what Medicaid service is covered by the rule, and a listing of specific federal statutes and regulations and state statutes that authorize or require the rule.

(3) Definitions. Definitions that have special meaning to the particular rule.

(4) Other Sections. As necessary under the particular rule, additional sections may be indicated. Other sections include regulatory language that does not fit into sections (1) through (4).

KEY: Office of the Inspector General, Medicaid fraud, Medicaid waste, Medicaid abuse
June 21, 2013 63A-13-101 to 602
Notice of Continuation April 21, 2017

R58. Agriculture and Food, Animal Industry.
R58-11. Slaughter of Livestock and Poultry.
R58-11-1. Authority.

Promulgated under authority of Section 4-32-8.

R58-11-2. Definitions.

(1) "Adulterated" means as defined in Section 4-32-3(1).

(2) "Bill of Sale for Hides" means a hide release or some other formal means of transferring the title of hides.

(3) "Business" means an individual or organization receiving remuneration for services.

(4) "Commissioner" means the Commissioner of Agriculture or his representative.

(5) "Custom Slaughter-Release Permit" means a permit that will serve as a brand inspection certificate and will allow animal owners to have their animals farm custom slaughtered.

(6) "Department" means the Utah Department of Agriculture and Food.

(7) "Detain or Embargo" means the holding of a food or food product for legal verification of adulteration, misbranding or proof of ownership.

(8) "Emergency Slaughter" means for the purpose of this chapter that Emergency Slaughter is no longer allowed for non-ambulatory injured cattle. Non-ambulatory disabled cattle that cannot rise from a recumbent position or cannot walk, including, but not limited to, those with broken appendages, severed tendons or ligaments, nerve paralysis, fractured vertebral column or metabolic conditions, are not allowed to be slaughtered for food.

(9) "Farm Custom Slaughtering" means the slaughtering, skinning and preparing of livestock and poultry by humane means for the purpose of human consumption which is done at a place other than a licensed slaughtering house by a person who is not the owner of the animal.

(10) "Food" means a product intended for human consumption.

(11) "Immediate Family" means persons living together in a single dwelling unit and/or their sons and daughters.

(12) "License" means a license issued by the Utah Department of Agriculture and Food to allow farm custom slaughtering.

(13) "Licensee" means a person who possesses a valid farm custom slaughtering license.

(14) "Misbranded" means as defined in Section 4-32-3(27).

(15) "Owner" means a person holding legal title to the animal.

(16) "Sanitary Standards, Practices",

(a) Sanitary operating conditions: All food-contact surfaces and non-food-contact surfaces of an exempt facility are cleaned and sanitized as frequently as necessary to prevent the creation of insanitary conditions and the adulteration of product. Cleaning compounds, sanitizing agents, processing aids, and other chemicals used by an exempt facility are safe and effective under the conditions of use. Such chemicals are used, handled, and stored in a manner that will not adulterate product or create insanitary conditions. Documentation substantiating the safety of a chemical's use in a food processing environment are available to inspection program employees for review. Product is protected from adulteration during processing, handling, storage, loading, and unloading and during transportation from exempt establishments.

(b) Grounds and pest control: The grounds of exempt operation are maintained to prevent conditions that could lead to insanitary conditions or adulteration of product. Plant operators have in place a pest management program to prevent the harborage and breeding of pests on the grounds and within the facilities. The operator's pest control operation is capable of preventing product adulteration. Management makes every effort to prevent entry of rodents, insects, or animals into areas where products are handled, processed, or stored. Openings (doors and windows) leading to the outside or to areas holding inedible product have effective closures and completely fill the openings. Areas inside and outside the facility are maintained to prevent harborage of rodents and insects. The pest control substances used are safe and effective under the conditions of use and are not applied or stored in a manner that will result in the adulteration of product or the creation of insanitary conditions.

(c) Sewage and waste disposal: Sewage and waste disposal systems properly remove sewage and waste materials--feces, feathers, trash, garbage, and paper--from the facility. Sewage is disposed of into a sewage system separate from all other drainage lines or disposed of through other means sufficient to prevent backup of sewage into areas where product is processed, handled, or stored. When the sewage disposal system is a private system requiring approval by a State or local health authority, upon request, the management must furnish to the inspector a letter of approval from that authority.

(d) Water supply and water, ice, and solution reuse: A supply of running water that complies with the National Primary Drinking Water regulations (40 CFR part 141) at a suitable temperature and under pressure as needed, is provided in all areas where required (for processing product; for cleaning rooms and equipment, utensils, and packaging materials; for employee sanitary facilities, etc.). If a facility uses a municipal water supply, it must make available to the inspector, upon request, a water report, issued under the authority of the State or local health agency, certifying or attesting to the potability of the water supply. If a facility uses a private well for its water supply, it must make available to the inspector, upon request, documentation certifying the potability of the water supply that has been renewed at least semi-annually.

(e) Facilities: Maintenance of facilities during slaughtering and processing is accomplished in a manner to ensure the production of wholesome, unadulterated product.

(f) Dressing rooms, lavatories, and toilets: Dressing rooms, toilet rooms, and urinals are sufficient in number ample in size, conveniently located, and maintained in a sanitary condition and in good repair at all times to ensure cleanliness of all persons handling any product. Dressing rooms, lavatories, and toilets are separate from the rooms and compartments in which products are processed, stored, or handled.

(g) Inedible Material Control: The operator handles and maintains inedible material in a manner that prevents the diversion of inedible animal products into human food channels and prevents the adulteration of human food.

(17) Commerce: Means the exchange transportation of poultry product between states, U.S. territories (Guam, Virgin Islands of the United States, and American Samoa), and the District of Columbia.

R58-11-3. Registration and License Issuance.

(1) Farm Custom Slaughtering License.

(a) Any person or person desiring to do farm custom slaughtering shall apply to the Department. Such application for a license will be made on a department form for a Farm Custom Slaughter License. The form shall show the name, address and telephone number of the owner, the name, address and telephone number of the operator if it is different than the owner, a brief description of the vehicle and the license number. Licenses will be valid for the calendar year (January 1 to December 31). Each licensee will be required to re-apply for a license every calendar year. Change of ownership or change of vehicle license will require a new application to be filed with the Department.

(b) Registration will not be recognized as complete until the applicant has demonstrated his ability to slaughter and has

completed and signed the registration form.

(c) A fee must be paid prior to license issuance.

R58-11-4. Equipment and Sanitation Requirements.

(1) Unit of vehicle and equipment used for farm custom slaughtering:

(a) The unit or vehicle used for farm custom slaughtering shall be so constructed as to permit maintenance in a clean, sanitary manner.

(b) A tripod or rail capable of lifting a carcass to a height which enables the carcass to clear the ground for bleeding and evisceration must be incorporated into the unit or vehicle. Hooks, gambles, or racks used to hoist and eviscerate animals shall be of easily cleanable metal construction.

(c) Knives, scabbards, saws, etc. shall be of rust resistant metal or other impervious easily cleanable material.

(i) A clean dust proof container shall be used to transport and store all instruments and utensils used in slaughtering animals.

(d) A water tank shall be an integral part of the unit or vehicle. It shall be of approved construction with a minimum capacity of 40 gallons. Water systems must be maintained in a sanitary manner and only potable water shall be used.

(e) A tank (for sanitizing) large enough to allow complete emersion of tools used for slaughtering must be filled during slaughter operations with potable water and maintained at a temperature of at least 180 degrees Fahrenheit. In lieu of 180 degrees Fahrenheit water, chemical sterilization may be used with an approved chemical agent after equipment has been thoroughly cleaned. Chloramine, hypochloride, and quaternary ammonium compounds or other approved chemical compounds may be used for this purpose and a concentration must be maintained at sufficient levels to disinfect utensils. Hot water, cleaning agents, and disinfectant shall be available at all times if chemicals are used in lieu of 180 degrees Fahrenheit water.

(f) Cleaning agents and paper towels shall be available so hands and equipment may be cleaned as needed.

(g) Aprons, frocks and other outer clothing worn by persons who handle meat must be clean and of material that is easily cleanable.

(h) All inedible products and offal will be denatured with either an approved denaturing agent or by use of pounch material as a natural denaturing agent.

(i) When a licensee transports uninspected meat to an establishment for processing, he shall:

(i) do so in a manner whereby product will not be adulterated or misbranded, and/or mislabeled; and

(ii) transport the meat in such a way that it is properly protected; and

(iii) deliver carcasses in such a way that they shall be placed under refrigeration within one hour of time of slaughter (40 degrees F).

(j) Sanitation.

(i) Unit or Vehicle.

(A) The unit or vehicle must be thoroughly cleaned after each daily use.

(B) All food-contact and non-food contact surfaces of utensils and equipment must be cleaned and sanitized as necessary to prevent the creation of insanitary conditions and the adulteration of carcasses and parts.

(C) Carcasses must be protected from adulteration during processing, handling, storage, loading, unloading and during transportation to processing establishments.

(ii) Equipment.

(A) All knives, scabbards, saws and all other food contact surfaces shall be cleaned and sanitized prior to slaughter and as needed to prevent adulteration.

(B) Equipment must be cleaned and sanitized after each slaughter and immediately before each slaughter.

(iii) Inedibles.

(A) Inedibles shall be placed in designated containers and be properly denatured, and the inedible containers must be clearly marked (Inedible Not For Human Consumption in letters not less than 4 inches in height).

(B) Containers for inedibles shall be kept clean and properly separated from edible carcasses to prevent adulteration.

(iv) Personal Cleanliness.

(A) Adequate care shall be taken to prevent contamination of the carcasses from fecal material, ingesta, milk, perspiration, hair, cosmetics, medications and similar substances.

(B) Outer clothing worn by permittee shall, while handling exposed carcasses, be clean.

(C) No licensee with a communicable disease or who is a disease carrier or is infected with boils, infected wounds, sores or an acute respiratory infection shall participate in livestock slaughtering.

(D) Hand wash facilities shall be used as needed to maintain good personal hygiene.

R58-11-5. Slaughtering Procedures of Livestock.

(1) Slaughter Area

(a) Slaughtering shall not take place under adverse conditions (such as blowing dirt, dust or in mud).

(b) If a slaughter area is used for repeated kills, the area should be maintained to prevent blood from collecting, running off on to adjacent property, or contaminating water sources.

(c) Hides, viscera, blood, pounch material, and all tissues must be removed and disposed at a rendering facility, landfill, composting or by burial as allowed by law.

(2) Humane Slaughter - Animals shall be rendered insensible to pain by a single blow, or gun shot or electrical shock or other means that is instantaneous and effective before being shackled, hoisted, thrown, cast or cut.

(3) Hoisting and Bleeding - Animals shall be hoisted and bled as soon after stunning as possible to utilize post-stunning heart action and to obtain complete bleeding. Carcasses shall be moved away from the bleeding area for skinning and butchering.

(4) Skinning - Carcass and head skin must be handled without neck tissue contamination. This may be done by leaving the ears on the hide and tying the head skin. Feet must be removed before carcass is otherwise cut. Except for skinning and starting skinning procedures, skin should be cut from inside outward to prevent carcass contamination with cut hair. Hair side of hide should be carefully rolled or reflected away from carcass during skinning. When carcass is moved from skinning bed, caution should be taken to prevent exposed parts from coming in contact with adulterating surfaces.

(5) Evisceration - Before evisceration, rectum shall be tied to include bladder neck and to prevent urine and fecal leakage. Care should also be taken while opening abdominal cavities to prevent carcass and/or viscera contamination.

(6) Carcass washing - Hair, dirt and other accidental contamination should be trimmed prior to washing. Washing should proceed from the carcass top downward to move away any possible contaminants from clean areas.

R58-11-6. Identification and Records.

(1) Livestock Identification - Pursuant to requirements of Section 4-24-13, it shall be unlawful for any license holder to slaughter livestock which do not have a Brand Inspection Certificate or Farm Custom Slaughter Tag filled out at time of slaughter.

(a) Animal owners must have a Brand Inspection Certificate for livestock intended to be farm custom slaughtered, issued by a Department Brand Inspector prior to slaughter, paying the legal brand inspection fee and beef promotion fee. This will be accomplished by the animal owner contacting a Department Brand Inspector and obtaining a Brand Inspection

Certificate (Custom Slaughter-Release Permit).

(b) Animal owners must also obtain farm custom slaughter identification tags from a Department Brand Inspector for a fee of $1 each. These tags will be required on beef, pork, and sheep.

(2) Records.

(a) The Custom Slaughter-Release Permit or Farm Custom Slaughter Tag will record the following information:

(i) An affidavit with a statement that shall read "I hereby certify ownership of this animal to be slaughtered by (name). I fully understand that having my animal farm custom slaughtered means my animal will not receive meat inspection and is for my use, the use of my immediate family, non-paying guests, or full-time employees. The carcass will be stamped "NOT FOR SALE" and will not be sold." This statement must be signed by the owner or designee.

(ii) In addition to this affidavit, the following information will be recorded:

(A) date;

(B) owner's name, address and telephone number;

(C) animal description including brands and marks;

(D) Farm Custom Slaughter tag number.

(b) The Farm Custom Slaughter tag must record the following information:

(i) date;

(ii) owner's name, address and telephone number;

(iii) location of slaughter;

(iv) name of licensee;

(v) licensee permit number; and

(vi) carcass destination.

(c) Prior to slaughter the licensee shall:

(i) Prepare the Farm Custom Slaughter tag with complete and accurate information;

(A) One tag shall stay in the license holder's file for at least one year.

(B) One tag plus a copy of the Farm Custom Slaughter-Release Permit shall be sent into the Department by the 10th of each month for the preceding month's slaughter by the licensee.

(C) After slaughter, all carcasses must be stamped "NOT FOR SALE" on each quarter with letters at least 3/8" in height; further, a Farm Custom Slaughter "NOT FOR SALE" tag must be affixed to each quarter of beef and each half of pork and sheep.

(D) Hide Purchase - Licensee receiving hides for slaughtering services must obtain a copy of the Custom Slaughter-Release Permit to record transfer of ownership as required by Section 4-24-18.

R58-11-7. Poultry Slaughter.

(1) Personal Use Exemption.

(a) A person who raises poultry may slaughter and or process the poultry if:

(i) slaughtering or processing poultry is not prohibited by local ordinance;

(ii) the poultry product derived from the slaughtered poultry is consumed exclusively by the person or the person's immediate family, regular employees of the person, or nonpaying guests;

(iii) the slaughtering and processing of the poultry is performed only by the owner or an employee;

(iv) the poultry is healthy when slaughtered;

(v) the exempt poultry is not sold or donated for use as human food; and

(vi) the immediate containers bear the statement, "NOT FOR SALE".

(2) Farm Custom Slaughter/Processing

(a) A person may slaughter and or process poultry belonging to another person if:

(i) the person holds a valid farm custom slaughter license issued by the department;

(ii) slaughtering or processing poultry is not prohibited by local ordinance;

(iii) the licensee does not engage in the business of buying or selling poultry products capable for use as human food;

(iv) the poultry is healthy when slaughtered;

(v) the slaughtering and or processing is conducted in accordance with sanitary standards, practices, and procedures that produce poultry products that are sound, clean, and fit for human food;

(vi) the unit or vehicle used for farm custom slaughtering shall be so constructed as to permit maintenance in a clean and sanitary manner;

(A) the immediate containers bear the following information:

(B) the owner's name and address;

(C) the licensee's name and address, and;

(D) the statement, "NOT FOR SALE".

(3) Producer/Grower 1,000 Bird Limit Exemption

(a) A poultry grower may slaughter no more that 1,000 birds of his or her own raising in a calendar year for distribution as human food if;

(i) the person holds a valid poultry exemption license issued by the department;

(ii) slaughtering or processing poultry is not prohibited by local ordinance;

(iii) the poultry grower does not engage in buying or selling poultry products other than those produced from poultry raised on his or her own farm (includes rented or leased property);

(iv) the slaughtering and or processing are conducted under sanitary standards, practices and procedures according to United State Department of Agriculture (USDA) Food Safety Inspection Service (FSIS) regulations and guidance material capable of producing poultry products that are sound, clean, and fit for human food (not adulterated);

(v) the producer keeps slaughter records and records covering the sales of poultry products to customers for the current calendar year,

(vi) The poultry products do not move in commerce. Distribution directly to household consumers, retail establishments, restaurants, hotels, and boarding houses for use in their dining rooms or in the preparation of meals sold directly to consumers within the jurisdiction where it is prepared; and

(vii) the immediate containers bear the following information:

(A) name of product;

(B) ingredients statement (if applicable);

(C) net weights statement;

(D) name and address of processor;

(E) Safe food handling statement;

(F) date of package and/or Lot number, and;

(G) the statement "Exempt R58-11-7(C)".

(4) Producer/Grower 20,000 Bird Limit Exemption

(a) A poultry grower may slaughter no more than 20,000 healthy birds of his or her own raising in a calendar year for distribution as human food if;

(i) the person holds a valid poultry exemption license issued by the department;

(ii) slaughtering or processing poultry is not prohibited by local ordinance;

(iii) the poultry grower does not engage in buying or selling poultry products other than those produced from poultry raised on his or her own farm (includes rented or leased property);

(iv) the slaughtering and or processing is conducted in a fixed establishment and in accordance with sanitary standards, practices, and procedures that produce poultry products that are sound, clean, and fit for human food;

(v) the producer keeps slaughter records and records covering the sales of poultry products to customers for the current calendar year,

(vi) The poultry products do not move in commerce. Distribution is directly to household consumers, retail establishments, restaurants, hotels, and boarding houses for use in their dining rooms or in the preparation of meals sold directly to consumers within the jurisdiction where it is prepared; and

(vii) the immediate containers bear the following information:

(A) name of product;

(B) ingredients statement (if applicable);

(C) net weights statement;

(D) name and address of processor;

(E) Safe food handling statement;

(F) date of package and/or Lot number, and;

(G) the statement "Exempt R58-11-7(4)".

(5) Producer/Grower or Other Person Exemption

(a) The term "Producer/Grower or Other Person" in this section means a single entity, which may be:

(i) A poultry grower who slaughters and processes poultry that he or she raised for sale directly to household consumers, restaurants, hotels, and boarding houses to be used in those homes and dining rooms for the preparation of meals served or sold directly to customers.

(ii) A person who purchases live poultry from a grower and then slaughters these poultry and processes such poultry for sale directly to household consumers, restaurants, hotels, and boarding houses to be served in those homes or dining rooms for the preparation of meals sold directly to customers.

(b) A business may slaughter and process poultry under this exemption if;

(i) the person holds a valid poultry exemption license issued by the department;

(ii) slaughtering or processing poultry is not prohibited by local ordinance;

(iii) the producer/grower or other person slaughters for processing and sale directly to household consumers, restaurants, hotels, and boarding houses for use in dining rooms or in the preparation of meals sold directly to customers;

(iv) the producer/grower or other person slaughters no more than 20,000 birds in a calendar year that the producer/grower or other person raised or purchased;

(v) the producer/grower or other person does not engage in the business of buying or selling poultry or poultry products prepared under an other exemptions in the same calendar year he or she claims the Producer/Grower or Other Person Exemption;

(vi) The poultry products do not move in commerce. Distribution is directly to household consumers, restaurants, hotels, and boarding houses for use in their dining rooms or in the preparation of meals sold directly to consumers within the jurisdiction where it is prepared; and

(vii) the slaughtering and or processing is conducted in a fixed establishment and in accordance with sanitary standards, practices, and procedures that produce poultry products that are sound, clean, and fit for human food;

(viii) the producer keeps slaughter records and records covering the sales of poultry products to customers for the current calendar year, and;

(ix) the immediate containers bear the following information:

(A) name of product;

(B) ingredients statement (if applicable);

(C) net weights statement;

(D) name and address of processor;

(E) safe food handling statement;

(F) date of package and/or Lot number, and;

(G) the statement "Exempt R58-11-7(5)".

(c) A business preparing poultry product under the Producer/Grower or Other Person Exemption may not slaughter or process poultry owned by another person.

(d) A business preparing poultry products under the Producer/Grower or Other Person Exemption may not sell poultry products to a retail store or other producer/grower.

(6) Small Enterprise Exemption

(a) A business that qualifies for the Small Enterprise Exemption may be:

(i) A producer/grower who raises, slaughters, and dresses poultry for use as human food whose processing of dressed exempt poultry is limited to cutting up;

(A) A business that purchases live poultry that it slaughters and whose processing of the slaughtered poultry is limited to the cutting up; or

(B) A business that purchases dressed poultry, which it distributes as carcasses and whose processing is limited to the cutting up of inspected or exempted poultry products, for distribution for use as human food.

(ii) A business may slaughter, dress, and cut up poultry for distribution as human food if;

(A) the person holds a valid poultry exemption license issued by the department;

(B) slaughtering or processing poultry is not prohibited by local ordinance;

(C) the processing of federal or state inspected or exempt poultry product is limited to the cutting up of carcasses or the business slaughters and dresses or cuts up no more than 20,000 birds in a calendar year;

(D) the slaughtering and or processing is conducted in a fixed establishment and in accordance with sanitary standards, practices, and procedures that produce poultry products that are sound, clean, and fit for human food;

(E) the facility used to slaughter or process poultry is not used to slaughter or process another person's poultry;

(F) the immediate containers bear the following information:

(I) name of product;

(II) ingredients statement (if applicable);

(III) net weights statement;

(IV) name and address of processor;

(V) safe food handling statement;

(VI) date of package and/or Lot number, and;

(VII) the statement "Exempt R58-11-7(6)"

(iii) A business may not cut up and distribute poultry products produced under the Small Enterprise Exemption to a business operating under the following exemptions:

(A) Producer/Grower or PGOP Exemption,

(B) Retail Dealer, or

(C) Retail Store.

R58-11-8. Producer/Growers Sharing a Fixed Facility.

(1) Each producer/grower must comply with all the laws and regulations governing such establishments as set forth in Utah Meat and Poultry and Poultry Products Inspection and Licensing Act, this rule, the United State Department of Agriculture (USDA) Poultry Exemptions and federal regulations that apply.

(2) The poultry producer/ grower shall hold a valid Custom Exempt Meat Establishment License (2202) issued by the department

(a) the individual who hold the 2202 license shall be present when slaughter and processing operation are being performed.

(3) The department shall be notified five business days prior to slaughtering and processing. The individual shall provide the department with the following information pertaining to the slaughtering and processing of birds:

(a) the date;

(b) the time; and
(c) the location.
(4) The producer/grower shall:
(a) conduct a pre-operational inspection on all food-contact surfaces;
(b) document the findings of the pre-operational inspection and corrective actions as described in 9 CFR 416.12(a) and 416.15 prior to the commencement of operations;
(c) maintain records for at least one year and have them available for inspection upon request by department officials;
(d) fully label product in accordance with this rule before leaving the facility;
(e) maintain the product temperature at 40 degrees F or less during transport;
(f) keep a written recall plan as described in 9 CFR 418 and have it available upon request by department officials;
(5) Producer/growers shall not process on the same day as any other producer/grower.

R58-11-9. Enforcement Procedures.
(1) Livestock and Poultry Slaughtering License:
(a) It shall be unlawful for any person to slaughter or assist in slaughtering livestock and poultry as a business outside of a licensed slaughterhouse unless he holds a valid Farm Custom Slaughtering License issued to him by the Department.
(b) Only persons who comply with the Utah Meat and Poultry Products Inspection and Licensing Act and Rules pursuant thereto, and the Utah Livestock Brand and Anti-Theft Act shall be entitled to receive and retain a license.
(c) License may be renewed annually and shall expire on the 31st of December of each year.
(2) Suspension of license - license may be suspended whenever:
(a) The Department has reason to believe that an eminent public health hazard exists;
(b) Insanitary conditions are such that carcasses would be rendered adulterated and or contaminated.
(c) The license holder has interfered with the Department in the performance of its duties;
(d) The licensee violates the Utah Meat and Poultry Products Inspection and Licensing Act or the Utah Livestock Brand and Anti-Theft Act or rules pursuant to these acts.
(3) The department may, in accordance with the 9 CFR Part 500 suspend or terminate any exemption with respect to any person whenever the department finds that such action will aid in effectuating the purposes of the Act. Failure to comply with the conditions of the exemption including but not limited to failure to process poultry and poultry products under clean and sanitary condition s may result in termination of an exemption, in addition to other Penalties consistent with 9 CFR 318.13
(4) Warning letter - In instances where a violation may have occurred a warning letter may be sent to the licensee which specifies the violations and affords the holder a reasonable opportunity to correct them.
(5) Hearings - Whenever a licensee has been given notice by the Department that suspected violations may have occurred or when a license is suspended he may have an opportunity for a hearing to state his views before the Department.
(6) Reinstatement of Suspended Permit - Any person whose license has been suspended may make application for the purpose of reinstatement of the license. The Department may then re-evaluate the applicant and conditions; if the applicant has demonstrated to the Department that he will comply with the rules, the license may be reinstated.
(7) Detainment or Embargo - Any meat found in a food establishment which does not have the proper identification or any uninspected meat slaughtered by a licensee which does not meet the requirements of these rules may be detained or embargoed.
(8) Condemnation - Meat which is determined to be unfit for human consumption may be denatured or destroyed.

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R70. Agriculture and Food, Regulatory Services.
R70-101. Bedding, Upholstered Furniture and Quilted Clothing.
R70-101-1. Authority and Purpose.

Pursuant to Section 4-10-3, this rule establishes the standards, practices and procedures for the manufacture, repair, sale, and distribution of bedding, upholstered furniture, quilted clothing products, and filling materials.

R70-101-2. Definitions.

1) "Clean" means free from stains, dirt, trash, filth, pulp, sludge, oil, grease, fat, skin, epidermis, excreta, vermin, insects, insect eggs, insect carcasses, contamination, hazardous materials, residual or objectionable substances or odors.

2) "Department" means the Utah Department of Agriculture and Food.

3) "Law Label or Label" means a tag attached to a product that provides information about the product to the consumer.

4) "Manufacture" means the making, processing, or preparing of new or secondhand bedding, upholstered furniture, quilted clothing, or filling material.

5) "Manufacturer" means a person who makes or has employees make any bedding, upholstered furniture, quilted clothing, filling material, or any part thereof.

6) "Non-resident" means a person licensed under these rules who does not have premises in the State of Utah.

7) "Person" means an individual, partnership, association, firm, auctioneer, trust, limited liability company, or corporation, and agents, and employees of them.

8) "Premises" means all places where bedding, upholstered furniture, quilted clothing, or filling material is sold, offered for sale, exposed for sale, stored, renovated or manufactured and the delivery vehicles used in their transportation.

9) "Supply dealer" means a person who manufactures, processes, or sells at wholesale any felt, batting, pads, or other filling, loose in bags, in bales or in containers, concealed or not concealed, intended for use in bedding, upholstered furniture, or quilted clothing.

10) "Second Hand Law Tag or Tag" means a tag attached to a product or filling material that has previously been used.

11) "Sterilization Permit Number" means the number issued by a state to be used on filling materials or on the label for bedding, upholstered furniture, or quilted clothing to identify the sterilizing facility, person, or company.

12) "Sterilize" means a process used to make wool, feathers, down, shoddy, or hair free from bacteria or other living microorganisms.

13) "Sterilizer" means a person who sterilizes wool, feathers, down, shoddy, or hair.

14) "Uniform Registry Number or URN" means the number issued by a state to be used on the law label of bedding, furniture, or filling materials to identify the manufacturing facility, person, or company.

R70-101-3. Application of Rule.

1) This rule shall apply to all persons engaged in the business of manufacturing, retailing, wholesaling, processing, repairing, sterilizing, and selling items of bedding, upholstered furniture, quilted clothing and filling materials, regardless of their point of origin.

R70-101-4. Licensing Requirements for Manufacturers, Repairers, and Wholesalers.

1) Any person, who advertises, solicits, or contracts to manufacture or repair bedding, upholstered furniture, quilted clothing, or filling materials shall secure a license from the department.

a) This license must be obtained before such products are offered for sale in Utah.

2) Any person seeking a license shall provide the following to the department:

a) a complete registration application form,

b) a sample of the identification label that will be used, and

c) a sample tag

i) wholesale bedding, upholstered furniture dealers, upholstery supply dealer, and quilted clothing manufacturers are exempted from providing a sample tag to the department.

3) A licensing fee will be assessed annually. This fee shall be paid before January 1 or a late fee will be assessed. All fees are listed in the department's fee schedule approved by the legislature.

R70-101-5. Sterilization Permit Requirements for Sterilizers.

1) Any person, who advertises, solicits, or contracts as a sterilizer shall secure a sterilization permit from the department.

a) This permit must be obtained before such products are offered for sale in Utah.

2) Any person seeking a sterilization permit shall provide to the department a sterilization permit application completed by a department authorized third party inspector.

3) A permit fee will be assessed annually. This fee shall be paid before January 1 or a late fee will be assessed. All fees are listed in the department's fee schedule approved by the legislature.

4) Inspections for sterilization permits shall be conducted every three years

a) Copies of the inspection reports shall be submitted to the department with the renewal form for that year.

R70-101-6. Revocation of License or Permit.

1) The department shall have the authority to suspend or revoke a license or permit for any violation of these provisions.

2) A suspension or revocation shall be in accordance with section 4-1-5.

R70-101-7. Sanitation Requirements.

1) The premises, delivery equipment, machinery, appliances, and devices shall at all times be kept free from refuse, dirt, contamination, or insects.

2) No person shall use in the making, repairing, or renovating of bedding, upholstered furniture, or quilted clothing any filling material that:

a) contains any bugs, vermin or filth,

b) is not clean, or

c) contains burlap or other material that has been used for baling.

3) Bedding, quilted clothing, and filling materials shall be stored four inches off the floor.

4) New and used products shall be stored separately.

R70-101-8. Sterilization Requirements for New Fill Material.

1) All wool, feathers, down, shoddy, and hair shall be cleaned and sterilized before being used as new filling material.

2) Methods for Sterilization

a. Pressure Steam: The material shall be subjected to treatment by steam at 15 PSI (.104 mPA) for 30 minutes or 20 PSI (.0138 mPA) for 20 minutes.

i. The gauge for registering steam pressure must be visible from outside of the room or chamber.

b. Streaming Steam: Two applications of streaming steam maintained for a period of one hour each, applied at intervals of not less than six nor more than 24 hours, may be used.

i. Valved outlets shall be provided near the bottom and the top of the room or chamber when streaming steam is employed.

c. Heat: a temperature of 235 degrees F held for a period

of 2 hours, within a closed container is considered satisfactory for proper sterilization.

d. Other methods as may be approved by the department upon petition.

R70-101-9. Manufacturing, Wholesale, Sterilizers, and Supply Dealer Labeling Requirements for Quilted Clothing.

1) The department adopts by reference the Rules and Regulations under the Textile Fiber Products Identification Act, Fur Products Labeling Act, and Wool Products Labeling Act found in 16 CFR parts 300, 301, and 303.

2) Articles of plumage-filled clothing shall meet the following label requirements:

a) Any label stating the contents of Down, Goose Down, or Duck Down shall also state the minimum percentage of Down, Goose Down, or Duck Down that is contained in the article. The down label is a qualified general label and shall include in parentheses the minimum percentage of down in the product which must be 75% or greater.

b) Down and Waterfowl Feathers: may be used to designate any plumage product containing between 50% (minimum) and 74% down and plumules. The percentage of both must be stated on the sewn-in label and hang tags,

c) Waterfowl Feathers and Down: may be used to designate any plumage product containing between 5% (minimum) and 49% down and plumules. The percentage of both must be stated on the sewn-in label and hang tags.

d) Waterfowl Feathers: may be used to designate any plumage product containing less than 5% down and plumules.

e) Quill Feathers are not permitted unless disclosed.

f) Other Plumage Products which do not meet the requirements for any of the above listed categories must be labeled accurately with each component listed separately in order of predominance.

3) The sterilization permit number (PER. NO.) shall be listed on the textile label

a) manufacturers of quilted clothing shall have five years compliance period, starting January 1, 2017, for the inclusion of the sterilization permit number on the textile label.

4) The form of identification used on labels and tags shall be the same as those supplied to the department with the registration application.

R70-101-10. Filling Material.

1) All terms and definitions of filling materials shall be those terms which have been submitted and approved by International Association of Bedding Law Officials (IABFLO), except as otherwise required by this rule.

2) All plumage materials shall follow the standards as set forth in the "USA-2000 Labeling Standards- Down and Feather Products" and ASTM D-4522.

3) All other filling materials shall be clean.

4) "Imperfect, irregular foam" means any foam products which show major imperfections or that fall below the foam manufacturer's usual standards or specifications and must be stated on the tag as "imperfect" or "irregular" along with the generic name of the foam.

5) "Imperfect, irregular fibers" shall mean fibers that have imperfections or that fall below the fiber manufacturer's usual standards or specifications and must be stated on the tag as "imperfect" or irregular" along with the generic name of the fiber.

6) The terms "Prime", "Super", "Northern" and similar terms shall not be used unless the fill can be proved to be of superior quality and meet the terms of the qualifying statement.

R70-101-11. Generic Names, Grades, Descriptive Terms, and Definitions of Filling Material.

1) Filling material shall be described on the label and on the tag using the:

a) true generic name,

b) grade,

c) description terms, or

d) definitions of the filling material which have been approved by the department.

2) When more than one kind of filling material is used in a mixture, the percentage by weight shall be listed in order of predominance.

a) Federal fiber tolerance standards are applicable, except as pertains to plumage products.

b) Blends may be described in accordance with section 10 of this rule.

3) When different filling materials are used in various parts of the garment, the areas of the garment shall be named, followed by the name of the filling material used in that area.

R70-101-12. Manufacturer Identification and Law Label Requirements For Bedding and Upholstered Furniture.

1) The form of identification used on labels and tags shall be the same as those supplied to the department with the registration application.

2) For articles of bedding and upholstered furniture, the law label shall use the format adopted by the IABFLO, as listed in the "Manual of Labeling Laws" of the International Sleep Products Association (ISPA). A copy of the current edition of the "Manual of Labeling Laws" is available for public inspection at the Utah Department of Agriculture and Food, 350 North Redwood Road, Salt Lake City, Utah.

(3) The law label for newly manufactured products shall meet the following requirements:

a) white on all sides of the label,

b) made of material that cannot be torn,

c) printed in black ink

d) printed in English,

e) printed clearly and legibly, and

f) firmly attached to the article

4) All required information shall be printed on one side of the label with the opposite side remaining blank.

5) Each law label shall state the following:

a) the phrase "UNDER PENALTY OF LAW THIS TAG NOT TO BE REMOVED EXCEPT BY THE CONSUMER" shall appear in bold at the top of the label in capital letters no less than 1/8 inches in height,

b) the phrase "ALL NEW MATERIAL" shall appear in the next section in bold, capital letters no less than 1/8 inch in height, followed by the phrase "CONSISTING OF", no case or height requirements, followed by the filling contents in bold capital letters no less than 1/8 inch in height,

c) the phrase, "Certification is made that the materials in this article are described in accordance with law" shall appear in the next section of the tag,

d) the URN issued by the state in which the firm is first registered shall appear next,

e) the Sterilization Permit Number of the sterilization facility from which the material was obtained, in bold capital letters no less than 1/8 inch in height,

f) the words "CONTENTS STERILIZED" in bold capital letters no less than 1/8 inch in height, and

g) the name and complete address of the manufacturer, importer, or vendor of the article shall appear next.

6) The law label shall be easily accessible to the consumer for examination.

a) Products which are offered for sale in boxes or in some other packaging which make the law labels inaccessible shall reproduce a legible facsimile of the law label on the outer container or covering.

7) No mark, label, printed matter, illustration, sticker, or any other device shall be placed upon the label.

8) The firm's license with the state that issued the URN must be kept current for the number to be valid in the state of Utah.

9) Every firm doing business under more than one state-issued URN or permit shall obtain a license or permit for each number used on products that are offered for sale in Utah.

R70-101-13. Second Hand Law Tags and Tagging Requirements.

1) Tags for second hand materials shall be:

a) a minimum of 2 inches by 3 inches,

b) yellow on both sides of the tag,

c) made of material that cannot be torn,

d) printed in English,

e) printed in black ink,

f) printed clearly and legibly, and

g) firmly attached to the article.

2) All required information shall be printed on one side of the tag with the opposite side remaining blank.

3) Second hand tag shall contain the following information:

a) the phrase "UNDER PENALTY OF LAW THIS TAG NOT TO BE REMOVED EXCEPT BY THE CONSUMER" shall appear in bold at the top of the label in capital letters, no less than 1/8 inch in height,

b) the phrase, "THIS ARTICLE CONTAINS SECOND HAND MATERIAL CONSISTING OF CONTENTS UNKNOWN" shall appear in the next section of the tag. The words "second hand material" and "contents unknown" shall be in capital letters, size not less than 1/8 inches in height,

c) the phrase, "Certification is made that the materials in this article are described in accordance with law" shall appear in the next section of the tag, and

d) the store name and complete corporate address shall appear next.

4) The tag shall be easily accessible to the consumer for examination.

5) No mark, label, printed matter, illustration, sticker, or any other device shall be placed upon the tag.

R70-101-14. Second Hand Tag and Tagging Requirements for Repaired, Reupholstered, and Renovated Products.

1) Tags for repaired, reupholstered, and renovated products shall be:

a) a minimum of 2 inches by 3 inches,

b) yellow on both sides of the tag,

c) made of material that cannot be torn,

d) have the required information printed on one side of the tag with the opposite side remaining blank,

e) printed in English,

f) printed in black ink,

g) printed clearly and legibly, and

h) firmly attached to the article.

2) Second hand tag shall contain the following information:

a) the phrase, "UNDER PENALTY OF LAW THIS TAG NOT TO BE REMOVED EXCEPT BY THE CONSUMER" shall appear in bold at the top of the label in capital letters, no less than 1/8 inch in height,

b) the phrase, "THIS ARTICLE IS NOT FOR SALE OWNER'S MATERIAL" shall appear next in bold in capital letters, no less than 1/8 inch in height,

c) the phrase, "CERTIFICATION IS MADE THAT THIS ARTICLE CONTAINS THE SAME MATERIAL IT DID WHEN RECEIVED FROM THE OWNER AND THAT ADDED MATERIALS ARE DESCRIBED IN THE ACCODANCE WITH LAW, AND CONSIST OF THE FOLLOWING:" followed by a description of the filling materials,

d) a description of the work that was done on the product,

e) the URN number,

f) the name and address of the renovator or repairer, and

g) the date of pick-up, owner's name, and address.

R70-101-15. Used Mattresses.

1) Retailers selling customer returns, refurbished, or used mattresses shall follow the second hand law tag requirements as set out in R70-101-13.

2) In addition, retailers must also display on such mattresses a tag stating "USED" in bold capital letters.

3) The Used tag shall be:

a) a minimum 3 inches by 6 inches,

b) yellow on both sides of the tag,

c) the font shall be a minimum of one inch in height,

d) printed in black ink, and

e) printed in English.

4) All required information shall be printed on one side of the tag with the opposite side remaining blank.

5) The USED tag shall be clearly visible to the consumer at all times.

R70-101-16. Variance.

1) The department may issue variances on labeling and tagging requirements.

2) Requests for a variance must be made to the department in writing and must contain the following information:

a) For what product you are requesting the variance,

b) where you are going to be using the variance,

c) an explanation of the need for a variance,

d) a description of how the variance will be used in practice, and

e) an example of the label or tag that will be used in place of the required label or tag.

3) Approval of variances will be given from the department in writing.

4) All variances shall be subject to a period of review.

R70-101-17. Making or Selling Material or Parts.

1) A person shall not purchase, make, process, prepare, or sell, directly or indirectly, at wholesale or retail, or otherwise, any filling material or other component parts to be used in bedding, upholstered furniture, or quilted clothing, unless such material is appropriately tagged.

R70-101-18. Retailer Responsibilities.

1) Retailers shall:

a) ensure that any article of bedding, upholstered furniture, quilted clothing, or filling material they sell is labeled and tagged correctly,

b) comply with the department's laws and rules governing false and misleading advertisement, and

c) ensure that all manufacturers from whom they purchase products hold a valid license with the department.

2) Retailers shall provide the identity of the manufacturer or wholesaler of any article of bedding, upholstered furniture, quilted clothing, or filling material sold upon request of the department.

3) A retailer may register in lieu of the manufacturer or wholesaler if the manufacturer or wholesaler is not registered.

R70-101-19. Violation of This Rule.

1) Each improperly labeled or tagged article of bedding, upholstered furniture, quilted clothing, or filling material made or sold shall be a separate violation of this rule.

2) No person shall be in violation if he has received, from the person by whom the articles were manufactured or from whom they were received, a guarantee in good faith that the articles are not contrary to the provisions of these rules in the

form prescribed by the Federal Textile Fiber Products Identification Act, Federal Wool Products Labeling Act, and the Federal Trade Commission Rules and Regulations.

3) No person shall remove, or cause to be removed, any tag, or device placed upon any article of bedding, upholstered furniture, quilted clothing, or filling material by an inspector.

4) No person may remove an article that has been condemned and ordered held on inspection notice.

5) No person shall interfere with, obstruct, or hinder any inspector of the department in the performance of their duties.

6) Any article of bedding, upholstered furniture, quilted clothing, or filling material manufactured or wholesaled by the manufacturer or wholesaler who is not registered or permitted may be withheld from sale until the manufacturer or wholesaler registers or obtains a permit.

R70-101-20. Products Not Intended for Use Subject to This Rule.

1) The Commissioner may exclude from this rule textile fiber products which:

a) Have insignificant or inconsequential textile fiber content, or

b) The disclosure of the textile fiber content is not necessary for the protection of the consumer.

KEY: inspections, labeling, quality control, registration
January 26, 2017 4-10-3
Notice of Continuation March 16, 2015

R70. Agriculture and Food, Regulatory Services.
R70-530. Food Protection.
R70-530-1. Authority and Purpose.

(1) Authority.

This rule is promulgated under the authority of Section 4-5-17 UCA.

(2) Purpose.

This rule shall be liberally construed and applied to promote its underlying purpose of safeguarding public health and providing to consumers food that is safe, unadulterated, and honestly presented.

R70-530-2. Scope.

This rule establishes definitions; sets standards for management and personnel, food operations, equipment, and facilities; and provides for food establishment plan review, inspection, and employee restriction. It shall be used to regulate bakeries, grocery and convenience stores, meat markets, food and grain processors, warehouses and any other establishment meeting the definition of a food establishment.

R70-530-3. Incorporation by Reference.

(1) The food standards, labeling requirements and procedures as specified in 21 CFR, 1 through 200, 2013 edition, 40 CFR 185, April 17, 2012 edition, and 9 CFR 200 to End, January 1, 2012 edition, are incorporated by reference.

(2) The requirements as found in the U.S. Public Health Service, Food and Drug Administration, Food Code 2013, Chapters 1 through 8 with the exclusion of Subparagraphs 8-302.14(C)(1),Paragraphs 8-302.14(D) and (E), Paragraph 8-304.11(K), Paragraph 5-203.15(B), Paragraphs 5-402.11(B), (C) and (D); and exclusion of Section 8-905.40, Subparagraphs 8-905.90(A)(1) and (2), Section 8-909.20, Subparagraphs 8-911.10(B)(1) and (2), Annex 1 comprising Parts 8-6 through 8-9 with the exclusion of Section 8-905.40, Subparagraphs 8-905.90(A)(1) and (2), Section 8-909.20, Subparagraphs 8-911.10(B)(1) and (2); and Annex 2, Federal Food, Drug, and Cosmetic Act, 21, U.S.S. 342, Sec. 402 are adopted and incorporated by reference, and with the following additions or amendments:

(a) In Paragraph 1-201.10(B), insert a new subparagraph after subparagraph (b) in subparagraph (2) under "Food Establishment" to read: "(c) A catering operation which is a business entity that operates from a permitted food establishment that contracts with a client for food service to be provided to a client, the client's guests and/or customers at a different location. A catering operation may cook or perform final preparation of foods at the service location. A catering operation does not include routine services offered at the same location, or meals that are individually purchased with the exception of cash bars."

(b) In paragraph-201.10(B), insert a new subparagraph after subparagraph (2) under "Core Item" to read: "(3) "Core Item" will also be referred to as "non-critical" in the state rule."

(c) In Paragraph 1-201.10(B) under "Priority Item", replace the semicolon and the word "and" at the end of subparagraph (2) with a period; replace the period at the end of subparagraph (3) with "; and"; and insert a new subparagraph after paragraph (3) to read: "(4) 'Priority Item' will also be referred to as 'critical 1' in the state rule."

(d) In paragraph 1-201.10(B) under "Priority Foundation Item," replace the semicolon and the word "and" at the end of subparagraph (2) with a period; replace the period at the end of subparagraph (3) with,"; and"; and add a new subparagraph after subparagraph (3) to read: "(4) 'Priority foundation item' will also be referred to as 'critical 2' in the state rule."

(e) After subparagraph 2-102.11 (17), add a new section to read: "2-102-12 Food Employee Training. Food employees shall be trained in food safety as required under 26-15-5 and shall hold a valid food handler's permit issued by a local health department."

(f) Amend Paragraph 3-201.16 (A) to read: "Except as specified in paragraph (B) of this section, mushroom species picked in the wild shall not be offered for sale or service by a food establishment."

(g) After Paragraph 3-501.17 (G), add a new paragraph to read: "(H) A date marking system that meets the criteria stated in paragraph (A) of this section shall use one of two types of date marks, and that date mark must be used consistently throughout the food establishment. The date mark will either be of the date: (1) before which food must be used as specified in paragraph (A) of this section; or (2) be the date of Day 1."

(h) Amend Subparagraph 3-501.19(B)(2) to read: "(2) Only one time marking scheme may be used, and it must be used consistently throughout the food establishment. The food shall be marked with either: (a) the time the food is removed from temperature control; or (b) the time before which the food shall be -cooked and served, served at any temperature if ready-to-eat, or discarded."

(i) After Paragraph 4-204.123(B), add a section to read: "4-204.124 Restraint of Pressurized Containers.Carbon dioxide, helium or other similar pressurized containers must be restrained or secured to prevent the tanks from falling over."

(j) At the end of section 5-101.12, add: "The process shall be in accordance with the American Water Works Association (AWWA) C651-2005 for disinfection and testing."

(k) Replace section 5-202.13, with the following: "(A) Where the horizontal distance from the water supply inlet to an adjacent single wall or obstruction is greater than three times the diameter of the inlet, or greater than four times for intersecting walls, an air gap between the water supply inlet and the floor level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 millimeters (1 inch). (B) Where the horizontal distance from the water supply inlet to an adjacent single wall or obstruction is less than three times the diameter of the inlet, or less than four times for intersecting walls, an air gap between the water supply inlet and the floor level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least three times the diameter of the water supply inlet and may not be less than 38 millimeters (1.5 inches)."

(l) Amend Paragraph 5-203.15(A) to read: "If not provided with an air gap as specified under Section 5-202.13, an American Society of Sanitary Engineering (ASSE) 1022 dual check valve with an intermediate vent shall be installed upstream from a carbonating device and downstream from an copper in the water supply line."

(m) Amend Paragraph 5-402.11(A) to read: "A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are place."

(n) Amend section 8-103.11 to add:

(D) In addition, a variance from section 3-301.11 may be issued only when:

(1) the variance is limited to a specific task or work station;

(2) the applicant has demonstrated good cause why section 3-301.11 cannot be met;

(3) suitable utensils are used to the fullest extent possible with ready-to-eat foods in the rest of the establishment; and

(4) the applicant can demonstrate active managerial control of this risk factor at all times.

(o) Amend section 8-302.14 to renumber (F) to (D), (G) to (E), and (H) to (F).

(p) Amend Paragraph 8-304.10(A) to read:

(A) Upon request, the regulatory authority shall provide a copy of the Utah Food Protection Rule according to the policy

of the local regulatory agency.

(q) Amend subparagraph 8-401.10(A)to read: "(A) Except as specified in paragraphs (B) and (C) of this section, the regulatory authority shall inspect a food establishment at least once every 6 months. (B)(2) to read: "The food establishment is assigned a less frequent inspection frequency based on a written risk-based inspection schedule that is being uniformly applied throughout the jurisdiction".

(r) Add Paragraph 8-501.10(C) to read: (C) Meeting reporting requirements under Communicable Disease Rule R386-702 and Injury Reporting Rule R386-703.

(s) Amend section 8-601.10 to read: Due process and equal protection shall be afforded as required by law in all enforcement and regulatory actions. Enforcement of this Rule shall be in accordance with title 4-2-2(J), Title 4-2-12, and R70-201.

(t) Add "8-7 Penalties; 8-701.10 State Construction Code

All parts of the food establishment shall be designed, constructed, maintained, and operated to meet the standards of the state construction code adopted by the Utah Legislature under Title 15A UCA. A copy of the construction code is available at the office of the local building inspector."

(3) All references to food that requires time or temperature control for safety, TCS, in this rule are equivalent to references in past editions of the U.S. Public Health Service, Food and Drug Administration, Food Code to potentially hazardous food, PHF.

KEY: food, inspections
February 2, 2016 **4-5-17**
Notice of Continuation March 6, 2017

R105. Attorney General, Administration.
R105-1. Attorney General's Selection of Outside Counsel, Expert Witnesses and Other Litigation Support Services.
R105-1-1. Purpose and Authority.

(1) The purpose of this rule is to provide the requirements for procurements that are managed by the Attorney General, including the hiring of Outside Counsel, expert witnesses, and litigation support services.

(2) This rule is adopted pursuant to authority granted by the Utah Procurement Code and Section 67-5-32(1)(a), including authority to manage procurement of procurement items directly or by delegation of the Chief Procurement Officer of the Division of Purchasing of the Department of Administrative Services.

(3) The Attorney General may procure any procurement item and exercise any action authorized by the Procurement Code and this Rule.

R105-1-2. Definitions.

Terms in this Rule R105-1 shall be as defined in Title 63G, Chapter 6a, Utah Procurement Code. The definitions in Rule R33-1 also apply to this Rule R105-1, except in case of conflict, the definitions in this Rule R105-1 shall control. Additional definitions are provided below.

(1) "Agency" is as defined in Section 67-5-3.

(2) "Attorney General" means the Attorney General of the State of Utah, or the Attorney General's designee.

(3) "Contingent fee case" means a legal matter for which legal services are provided under a contingent fee contract.

(4) "Contingent fee contract" means a contract for legal services under which the compensation for legal services is a percentage of the amount recovered in the legal matter for which the legal services are provided.

(5) "Expert witness" means a person whose knowledge, skill, experience, training or education in a scientific, technical, or other specialized area, would enable the person to give testimony under the Utah Rules of Evidence, Rule 702.

(6) "Legal matter" means a legal issue or administrative or judicial proceeding within the scope of the attorney general's authority.

(7) "Litigation Support Services" includes goods, services, software, or technology.

(8) "Outside Counsel" means an attorney or attorneys who are not, or a law firm whose attorneys are not, employed by the Attorney General's office, pursuant to Section 67-5-7 et seq., which the Attorney General hires, pursuant to Section 67-5-5, to represent, provide legal advice, or counsel to an agency of the State. "Outside Counsel" may or may not be designated as "Special Assistant Attorney General", as the Attorney General determines.

(9) "Procurement item" or "Procurement items" is as defined in Section 63G-6a-103.

(10) "Securities class action" means an action brought as a class action alleging a violation of federal securities law, including a violation of the Securities Act of 1933, 15 U.S.C. Sec. 77a et seq., or the Securities Exchange Act of 1934, 15 U.S.C. Sec. 78a et seq.

(11) "Small purchase" means a purchase under Rule R105-1-6.

(12) "Sole source" means a determination by the Attorney General, in writing, that the sole source requirements of the Utah Procurement Code and this Rule have been met.

(13) "State" means the State of Utah.

R105-1-3. General Process.

(1) This rule applies to the procurement and appointment of Outside Counsel, expert witnesses, litigation support services, litigation related consultants, as well as management software and services by the Attorney General.

(2) In order to properly fulfill the responsibilities of the Office, the procurement of Outside Counsel, expert witnesses, litigation support services, litigation related consultants, and management software and services may require that public notice of a particular procurement not be provided. Public notice of a procurement may only be waived in the event of an emergency procurement or as authorized by the Procurement Code.

(3) The Attorney General may select Outside Counsel, expert witnesses, professional litigation support services, litigation related consultants, as well as management software and services pursuant to any authorized process under the Utah Procurement Code. In any such selection process, it may be specified that the Outside Counsel is responsible for providing the expert witnesses or other litigation goods and services through the selection process for Outside Counsel and pursuant to the contract provisions with the Attorney General.

(4) The Attorney General shall comply with the Utah Procurement Code.The Attorney General shall comply with Rule R33 only when necessary to comply with Utah Code, except when Rule R33 is in conflict with or preempted by this Rule R105-1.

(5) The Attorney General may, in a multistate case involving other states as parties aligned with Utah, elect to enter into a fee sharing agreement in which each state contributes to a litigation fund that is used to purchase expert witnesses and/or other litigation support services including litigation related consultants, as well as management software and services, or through a similar group procurement agreement. The agreement shall be treated collectively as a sole source procurement of all goods and services purchased under the terms of the agreement.

(6) The Attorney General may, in a multistate case involving other states as parties aligned with Utah, select Outside Counsel jointly with some or all of the other states as a sole source procurement.

(7) The Attorney General's office shall ensure that the procurement of outside counsel is supported by a determination by the Attorney General that the procurement is in the best interests of the state, in light of available resources of the Attorney General's office.

(8) The Attorney General's office shall provide for the fair and equitable treatment of all potential providers of outside counsel, expert witnesses, and other litigation support services including, litigation related consultants, as well as management software and services consistent with the limitations and procedures set forth in this Rule R105-1.

(9) The Attorney General's office shall ensure that fees for outside counsel, whether based on an hourly rate, contingency fee, or other arrangement, are reasonable and do not exceed industry standards.

(10) The procurement and requirements regarding a Contingency Fee Contract must meet the requirements of this Rule R105-1 and the applicable provisions of the Utah Code.

R105-1-4. Available Procurement Processes.

Prior to any procurement for legal services, the Attorney General shall determine which process under the Utah Procurement Code shall be used.

R105-1-5. Request for Proposals Process.

(1) The Request for Proposals shall contain, in addition to the requirements of Rule R33-7-102, at a minimum, the following information:

(a) A description of the project.

(b) Fee arrangements.

(c) The persons or entities being sought in the procurement, including whether an individual person, firm or association of firms may respond.

(d) The qualification criteria and the relative importance

of the criteria. The Attorney General shall request qualifications from outside counsel being considered to provide services under a contingent fee contract unless the Attorney General:

(i) determines that requesting qualifications is not feasible under the circumstances; and

(ii) sets forth the basis for this determination in writing.

(e) Examples of criteria include:

(i) Identification by name and experience of the proposed service provider(s);

(ii) A description of the duties and responsibilities of each person providing the service; and

(iii) The ability of the persons providing the service to meet the needs of the project, including the consideration of any association with other persons, expert witnesses or firms;

(f) The Contractual Requirements, which may be accomplished by including a copy of the contract.

(g) A request for a conflicts analysis, including potential conflicts of interest or other related matters concerning the offeror's ability to ethically perform the requested services.

(2) In any selection process for outside counsel, it may be specified that the outside counsel is responsible for providing the expert witnesses or other litigation goods and services including litigation related consultants, as well as management software and services through the outside counsel's selection process and pursuant to the contract provisions with the Attorney General.

(3) Minimum scores for any of the criteria may be established.

R105-1-6. Small Purchases.

(1) The maximum thresholds for small purchases shall be as described in this Rule R105-1-6.

(2) For Outside Counsel, litigation related consultants, management software and services, as well as expert witnesses, the small purchase maximum threshold is $250,000 per contract. A written justification statement shall be filed explaining the reason(s) for selection of the contractor.

(3) For the selection of litigation support services that are not included under Rule R105-1-6(2), including but not limited to court reporting, litigation related copying and printing services, the small purchase maximum threshold is $50,000 per contract. For a purchase of litigation support services that are not included under Rule R105-1-6(2) between $2,500 and $50,000, a minimum of two quotes shall be obtained or there shall be developed a rotation system of qualified persons or firms that meet the qualifications for the service. For any purchase of litigation support services that are not included under Rule R105-1-6(2) of $2500 or less, a direct award may be made.

(4) Under Section 63G-6a-506(3), a threshold stated in this Rule may be exceeded if the Attorney General or a person specifically designated in writing by the Attorney General gives written authorization to exceed the threshold that includes the reasons for exceeding the threshold.

R105-1-7. Sole Source.

Unless the Attorney General determines that a publication of a sole source shall be published, sole sourced procurement items need not be published regardless of cost.

R105-1-8. Emergency Procurements.

(1) An emergency procurement may only be used when an emergency exists as described in, and in compliance with, Section 63G-6a-803.

(2) Emergency procurements are limited to those necessary to mitigate the emergency.

R105-1-9. Confidentiality of Procurement Records.

(1) The Attorney General shall comply with Title 63G, Chapter 2, Governmental Records Access and Management Act (GRAMA).

(2) Pricing may not be classified as protected and is considered public information.

(3) An entire response to a solicitation may not be designated as "PROTECTED", "CONFIDENTIAL" or "PROPRIETARY" and shall be considered non-responsive unless the vendor removes the designation.

(4) Publicizing Awards.

(a) In addition to the requirements of Section 63G-6a-709.5, the following shall be disclosed after receipt of a GRAMA request and applicable fees:

(i) the executed contract(s) and the successful proposal(s), except for those portions that are not Public;

(ii) unsuccessful proposals, except for those portions that are not Public;

(iii) the rankings of the proposals;

(iv) the names of the members of any evaluation committee;

(v) the final scores used by the evaluation committee to make the selection, except that the names of the individual scorers shall not be associated with their individual scores or rankings; and

(vi) the written justification statement supporting the selection, except for those portions that are not Public.

(b) After due consideration and public input, the following has been determined by the Procurement Policy Board and the Attorney General's Office to impair governmental procurement proceedings or give an unfair advantage to any person proposing to enter into a contract or agreement with a governmental entity, and will not be disclosed by the Attorney General's Office:

(i) the names of individual scorers/evaluators in relation to their individual scores or rankings;

(ii) any individual scorer's/evaluator's notes, drafts, and working documents;

(iii) non-public financial statements; and

(iv) past performance and reference information which is not provided by the vendor and which is obtained as a result of the efforts of the Attorney General's Office. To the extent such past performance or reference information is included in the written justification statement, the justification statement is still subject to public disclosure.

(c) In regard to an Invitation for bids issued by the Attorney General's Office, the Attorney General's Office shall, on the day on which the award of a contract is announced, make available to each vendor and to the public, a notice that includes:

(i) the name of the vendor to which the contract is awarded and the price(s) of the procurement item(s); and

(ii) the names and the prices of each vendor to which the contract is not awarded.

R105-1-10. Special Provisions regarding Procurement of Outside Counsel.

(1) The Attorney General shall not enter into a contract for outside counsel unless the requirements of this Rule R105-1-10 are met throughout the contract period and any extensions.

(2) The Attorney General shall review the proposed fee arrangement to hire outside counsel to ensure that there is a reasonable, good faith legal basis to pursue the litigation in the interest of the citizens of the State.

(3) The Attorney General shall retain oversight and control over the course and conduct of the litigation or anticipated litigation.

(4) The Attorney General shall designate a member of the Attorney General's Office to personally oversee the litigation.

(5) The Attorney General shall retain veto power over any decisions made by outside counsel, and no lawsuit will be filed,

or party added to or served with process in any lawsuit, by outside counsel, without express written permission of the Attorney General.

(6) The Attorney General shall be apprised of, attend, and participate in all settlement offers or conferences.

(7) Decisions regarding settlement of the case shall be made by the Attorney General and not the outside counsel, provided that the Attorney General may give outside counsel a reasonable range of specific settlement authority in writing, within which outside counsel is authorized to settle the case.

(8) Written Determination regarding using a Contingency Fee Contracts. The Attorney General may not enter into a contingent fee contract with outside counsel unless the Attorney General makes a written determination that the contingent fee contract is cost-effective and in the public interest. This written determination shall:

(a) be made before or within a reasonable time after the Attorney General enters into a contingent fee contract; and

(b) include specific findings regarding:

(i) whether sufficient and appropriate legal and financial resources exist in the Attorney General's office to handle the legal matter that is the subject of the contingent fee contract; and

(ii) the nature of the legal matter, unless information conveyed in the findings would violate an ethical responsibility of the Attorney General or a privilege held by the state.

(9) Contingency Fee Limit. The Attorney General may not enter into a contingent fee contract with outside counsel that provides for outside counsel to receive a contingent fee, exclusive of reasonable costs and expenses, that exceeds:

(a) 25% of the amount recovered, if the amount recovered is no more than $10,000,000;

(b) 25% of the first $10,000,000 recovered, plus 20% of the amount recovered that exceeds $10,000,000, if the amount recovered is over $10,000,000 but no more than $15,000,000;

(c) 25% of the first $10,000,000 recovered, plus 20% of the next $5,000,000 recovered, plus 15% of the amount recovered that exceeds $15,000,000, if the amount recovered is over $15,000,000 but no more than $20,000,000; and

(d) 25% of the first $10,000,000 recovered, plus 20% of the next $5,000,000 recovered, plus 15% of the next $5,000,000 recovered, plus 10% of the amount recovered that exceeds $20,000,000, if the amount recovered is over $20,000,000; or

(e) $50,000,000.

(10) Opt-out regarding Contingency Fee Contracts.

(a) A provision of a contingent fee contract that is inconsistent with a provision of this section is invalid unless, before the contract is executed, the contingent fee contract provision is approved by a majority of the Attorney General, state treasurer, and state auditor.

(11) Exceptions regarding Contingency Fee Contracts:

(a) A contingent fee under a contingent fee contract may not be based on the imposition or amount of a penalty or civil fine.

(b) A contingent fee under a contingent fee contract may be paid only on amounts actually recovered by the state.

(c) Throughout the period covered by a contingent fee contract, including any extension of the contingent fee contract:

(i) outside counsel that is a party to the contingent fee contract shall acknowledge that the Attorney General retains complete control over the course and conduct of the contingent fee case for which outside counsel provides legal services under the contingent fee contract;

(ii) the Attorney General with supervisory authority shall oversee any litigation involved in the contingent fee case;

(iii) the Attorney General retains final authority over any pleading or other document that outside counsel submits to court;

(iv) an opposing party in a contingent fee case may contact the Attorney General directly, without having to confer with outside counsel;

(v) the Attorney General with supervisory authority over the contingent fee case may attend all settlement conferences; and

(vi) the outside counsel shall acknowledge that final approval regarding settlement of the contingent fee case is reserved exclusively to the discretion of the Attorney General.

(d) Nothing in Rule R105-1-10(11) may be construed to limit the authority of the client regarding the course, conduct, or settlement of the contingent fee case.

(12) Website Posting regarding Contingency Fee Contracts. Within five business days after entering into a contingent fee contract, the Attorney General shall post on the Attorney General's website:

(a) the contingent fee contract;

(b) the written determination under R105-1-10 (8) relating to that contingent fee; and

(c) if applicable, any written determination made under Rule R105-1-5(1)(d) relating to that contingent fee contract.

(d) The Attorney General shall keep the contingent fee contract and written determination posted on the Attorney General's website throughout the term of the contingent fee contract.

(13) Contingency Fee Contract Records. The outside counsel that enters into a contingent fee contract with the Attorney General shall:

(a) from the time the contingent fee contract is entered into until three years after the contract expires, maintain detailed records relating to the legal services provided by outside counsel under the contingent fee contract, including documentation of all expenses, disbursements, charges, credits, underlying receipts and invoices, and other financial records that relate to the legal services provided by outside counsel; and

(b) maintain detailed contemporaneous time records for the outside counsel's attorneys and paralegals working on the contingent fee case and promptly provide the records to the Attorney General upon request.

(14) Exemption regarding Contingency Fee Contracts. Rule R105-1-10(8) through (13) as well as Rule R105-1-11(3) do not apply to:

(a) to a contingent fee contract in existence before May 12, 2015, or to any renewal or modification of a contingent fee contract in existence before that date;

(b) to a contingent fee contract with outside counsel that the Attorney General hires to collect a debt that the Attorney General is authorized by law to collect; and

(c) with respect to a contingent fee contract with outside counsel in a securities class action in which the state is appointed as lead plaintiff under Section 27(a)(3)(B)(i) of the Securities Act of 1933 or Section 21D(a)(3)(B)(i) of the Securities Exchange Act of 1934 or in which any state is a class representative, or in any other action in which the state is participating with one or more other states:

(i) apply only with respect to the state's share of any judgment, settlement amount, or common fund; and

(ii) do not apply to attorney fees awarded to outside counsel for representing other members of a class certified under Rule 23 of the Federal Rules of Civil Procedure or applicable state class action procedural rules.

(15) Notwithstanding any other provision of this Rule R105-1-10, the solicitation for outside counsel may provide a lower fee limitation and/or provide for weights and scoring of the proposed fees in accordance with the Utah Procurement Code, which will allow for a competitive process and may provide for fees below the limitations set forth in this Rule.

R105-1-11. Transparency in Contingency Fee Contracts with Outside Counsel.

(1) Except as otherwise provided by GRAMA, applicable

law, Rules of Professional Conduct or this Rule, a copy of the executed contract with outside counsel shall be made available for public inspection in accordance with GRAMA.

(2) Any payment by the Attorney General under a contingency fee contract shall be made available for public inspection in accordance with GRAMA.

(3) After June 30 but on or before September 1 of each year, the Attorney General shall submit a written report to the president of the Senate and the speaker of the House of Representatives describing the Attorney General's use of contingent fee contracts with outside counsel during the fiscal year that ends the immediately preceding June 30.

(a) A report under Rule R105-1-11(3) shall identify:

(i) each contingent fee contract the Attorney General entered into during the fiscal year that ends the immediately preceding June 30; and

(ii) each contingent fee contract the Attorney General entered into during any earlier fiscal year if the contract remained in effect for any part of the fiscal year that ends the immediately preceding June 30.

(iii) state the name of the outside counsel that is a party to the contingent fee contract, including the name of the outside counsel's law firm if the outside counsel is an individual;

(iv) describe the nature of the legal matter that is the subject of the contingent fee contract, unless describing the nature of the legal matter would violate an ethical responsibility of the Attorney General or a privilege held by the state;

(v) identify the state agency which the outside counsel was engaged to represent or counsel;

(vi) state the total amount of attorney fees approved by the Attorney General for payment to an outside counsel for legal services under a contingent fee contract during the fiscal year that ends the immediately preceding June 30; and

(vii) be accompanied by each written determination under R105-1-10(8) and Rule R105-1-5(1)(d) made during the fiscal year that ends the immediately preceding June 30.

R105-1-12. Contracts.

Those awarded a contract under this Rule shall be required to enter into a written contract with the Attorney General. The written contract shall contain all material terms set forth in:

(1) The final procurement documents issued by the Utah Attorney General;

(2) The provisions in documents submitted by the provider to the extent such provisions are accepted by the Attorney General;

(3) A termination for cause and a termination for convenience clause; and

(4) Any terms required by law, whether by the constitutions, statutes, or rules or regulations of the United States or the State of Utah.

(5) Nothing in this Rule regarding contingency fee contracts may be construed to expand the authority of a state department, division, or other agency to enter into a contract if that authority does not otherwise exist.

R105-1-13. Retention and Non-availability of Files.

(1) All proposals submitted to the Attorney General under this rule become the property of the State of Utah and the office of the Attorney General.

(2) All information in all proposals shall be placed in a file relating to the project for which the proposal was submitted. Each file shall contain:

(a) If applicable, a copy of all written determinations of the Attorney General required by the Utah Procurement Code or this Rule;

(b) A copy of the procurement documents and any written documentation related to notification requirements; and

(c) All responses to procurements and modifications, in writing, to any procurement if those modifications have been negotiated by the Attorney General.

(d) All records shall be maintained or disposed of in accordance with Part 20 of the Utah Procurement Code.

KEY: Attorney General, litigation support, outside counsel, expert witnesses

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R156. Commerce, Occupational and Professional Licensing.
R156-1. General Rule of the Division of Occupational and Professional Licensing.
R156-1-101. Title.

This rule is known as the "General Rule of the Division of Occupational and Professional Licensing."

R156-1-102. Definitions.

In addition to the definitions in Title 58, as used in Title 58 or this rule:

(1) "Active and in good standing" means a licensure status which allows the licensee full privileges to engage in the practice of the occupation or profession subject to the scope of the licensee's license classification.

(2) "Aggravating circumstances" means any consideration or factors that may justify an increase in the severity of an action to be imposed upon an applicant or licensee. Aggravating circumstances include:

(a) prior record of disciplinary action, unlawful conduct, or unprofessional conduct;

(b) dishonest or selfish motive;

(c) pattern of misconduct;

(d) multiple offenses;

(e) obstruction of the disciplinary process by intentionally failing to comply with rules or orders of the Division;

(f) submission of false evidence, false statements or other deceptive practices during the disciplinary process including creating, destroying or altering records after an investigation has begun;

(g) refusal to acknowledge the wrongful nature of the misconduct involved, either to the client or to the Division;

(h) vulnerability of the victim;

(i) lack of good faith to make restitution or to rectify the consequences of the misconduct involved;

(j) illegal conduct, including the use of controlled substances; and

(k) intimidation or threats of withholding clients' records or other detrimental consequences if the client reports or testifies regarding the unprofessional or unlawful conduct.

(3) "Cancel" or "cancellation" means nondisciplinary action by the Division to rescind, repeal, annul, or void a license:

(a) issued to a licensee in error, such as where a license is issued to an applicant:

(i) whose payment of the required application fee is dishonored when presented for payment;

(ii) who has been issued a conditional license pending a criminal background check and the check cannot be completed due to the applicant's failure to resolve an outstanding warrant or to submit acceptable fingerprint cards;

(iii) who has been issued the wrong classification of licensure; or

(iv) due to any other error in issuing a license; or

(b) not issued erroneously, but where subsequently the licensee fails to maintain the ongoing qualifications for licensure, when such failure is not otherwise defined as unprofessional or unlawful conduct.

(4) "Charges" means the acts or omissions alleged to constitute either unprofessional or unlawful conduct or both by a licensee, which serve as the basis to consider a licensee for inclusion in the diversion program authorized in Section 58-1-404.

(5) "Conditional licensure" means an interim non-adverse licensure action, in which a license is issued to an applicant for initial, renewal, or reinstatement of licensure on a conditional basis in accordance with Section R156-1-308f, while an investigation or audit is pending.

(6) "Denial of licensure" means action by the Division refusing to issue a license to an applicant for initial licensure, renewal of licensure, reinstatement of licensure or relicensure.

(7)(a) "Disciplinary action" means adverse licensure action by the Division under the authority of Subsections 58-1-401(2)(a) through (2)(b).

(b) "Disciplinary action", as used in Subsection 58-1-401(5), shall not be construed to mean an adverse licensure action taken in response to an application for licensure. Rather, as used in Subsection 58-1-401(5), it shall be construed to mean an adverse action initiated by the Division.

(8) "Diversion agreement" means a formal written agreement between a licensee, the Division, and a diversion committee, outlining the terms and conditions with which a licensee must comply as a condition of entering in and remaining under the diversion program authorized in Section 58-1-404.

(9) "Diversion committees" mean diversion advisory committees authorized by Subsection 58-1-404(2)(a)(i) and created under Subsection R156-1-404a.

(10) "Duplicate license" means a license reissued to replace a license which has been lost, stolen, or mutilated.

(11) "Emergency review committees" mean emergency adjudicative proceedings review committees created by the Division under the authority of Subsection 58-1-108(2).

(12) "Expire" or "expiration" means the automatic termination of a license which occurs:

(a) at the expiration date shown upon a license if the licensee fails to renew the license before the expiration date; or

(b) prior to the expiration date shown on the license:

(i) upon the death of a licensee who is a natural person;

(ii) upon the dissolution of a licensee who is a partnership, corporation, or other business entity; or

(iii) upon the issuance of a new license which supersedes an old license, including a license which:

(A) replaces a temporary license;

(B) replaces a student or other interim license which is limited to one or more renewals or other renewal limitation; or

(C) is issued to a licensee in an upgraded classification permitting the licensee to engage in a broader scope of practice in the licensed occupation or profession.

(13) "Inactive" or "inactivation" means action by the Division to place a license on inactive status in accordance with Sections 58-1-305 and R156-1-305.

(14) "Investigative subpoena authority" means, except as otherwise specified in writing by the director, the Division regulatory and compliance officer, or if the Division regulatory and compliance officer is unable to so serve for any reason, a Department administrative law judge, or if both the Division regulatory and compliance officer and a Department administrative law judge are unable to so serve for any reason, an alternate designated by the director in writing.

(15) "License" means a right or privilege to engage in the practice of a regulated occupation or profession as a licensee.

(16) "Limit" or "limitation" means nondisciplinary action placing either terms and conditions or restrictions or both upon a license:

(a) issued to an applicant for initial licensure, renewal or reinstatement of licensure, or relicensure; or

(b) issued to a licensee in place of the licensee's current license or disciplinary status.

(17) "Mitigating circumstances" means any consideration or factors that may justify a reduction in the severity of an action to be imposed upon an applicant or licensee.

(a) Mitigating circumstances include:

(i) absence of prior record of disciplinary action, unlawful conduct or unprofessional conduct;

(ii) personal, mental or emotional problems provided such problems have not posed a risk to the health, safety or welfare of the public or clients served such as drug or alcohol abuse while engaged in work situations or similar situations where the

licensee or applicant should know that they should refrain from engaging in activities that may pose such a risk;

(iii) timely and good faith effort to make restitution or rectify the consequences of the misconduct involved;

(iv) full and free disclosure to the client or Division prior to the discovery of any misconduct;

(v) inexperience in the practice of the occupation and profession provided such inexperience is not the result of failure to obtain appropriate education or consultation that the applicant or licensee should have known they should obtain prior to beginning work on a particular matter;

(vi) imposition of other penalties or sanctions if the other penalties and sanctions have alleviated threats to the public health, safety, and welfare; and

(vii) remorse.

(b) The following factors may not be considered as mitigating circumstances:

(i) forced or compelled restitution;

(ii) withdrawal of complaint by client or other affected persons;

(iii) resignation prior to disciplinary proceedings;

(iv) failure of injured client to complain;

(v) complainant's recommendation as to sanction; and

(vi) in an informal disciplinary proceeding brought pursuant to Subsection 58-1-501(2)(c) or (d) or Subsections R156-1-501(1) through (5):

(A) argument that a prior proceeding was conducted unfairly, contrary to law, or in violation of due process or any other procedural safeguard;

(B) argument that a prior finding or sanction was contrary to the evidence or entered without due consideration of relevant evidence;

(C) argument that a respondent was not adequately represented by counsel in a prior proceeding; and

(D) argument or evidence that former statements of a respondent made in conjunction with a plea or settlement agreement are not, in fact, true.

(18) "Nondisciplinary action" means adverse licensure action by the Division under the authority of Subsections 58-1-401(1) or 58-1-401(2)(c) through (2)(d).

(19) "Peer committees" mean advisory peer committees to boards created by the legislature in Title 58 or by the Division under the authority of Subsection 58-1-203(1)(f).

(20) "Probation" means disciplinary action placing terms and conditions upon a license;

(a) issued to an applicant for initial licensure, renewal or reinstatement of licensure, or relicensure; or

(b) issued to a licensee in place of the licensee's current license or disciplinary status.

(21) "Public reprimand" means disciplinary action to formally reprove or censure a licensee for unprofessional or unlawful conduct, with the documentation of the action being classified as a public record.

(22) "Regulatory authority" as used in Subsection 58-1-501(2)(d) means any governmental entity who licenses, certifies, registers, or otherwise regulates persons subject to its jurisdiction, or who grants the right to practice before or otherwise do business with the governmental entity.

(23) "Reinstate" or "reinstatement" means to activate an expired license or to restore a license which is restricted, as defined in Subsection (26)(b), or is suspended, or placed on probation, to a lesser restrictive license or an active in good standing license.

(24) "Relicense" or "relicensure" means to license an applicant who has previously been revoked or has previously surrendered a license.

(25) "Remove or modify restrictions" means to remove or modify restrictions, as defined in Subsection (25)(a), placed on a license issued to an applicant for licensure.

(26) "Restrict" or "restriction" means disciplinary action qualifying or limiting the scope of a license:

(a) issued to an applicant for initial licensure, renewal or reinstatement of licensure, or relicensure in accordance with Section 58-1-304; or

(b) issued to a licensee in place of the licensee's current license or disciplinary status.

(27) "Revoke" or "revocation" means disciplinary action by the Division extinguishing a license.

(28) "Suspend" or "suspension" means disciplinary action by the Division removing the right to use a license for a period of time or indefinitely as indicated in the disciplinary order, with the possibility of subsequent reinstatement of the right to use the license.

(29) "Surrender" means voluntary action by a licensee giving back or returning to the Division in accordance with Section 58-1-306, all rights and privileges associated with a license issued to the licensee.

(30) "Temporary license" or "temporary licensure" means a license issued by the Division on a temporary basis to an applicant for initial licensure, renewal or reinstatement of licensure, or relicensure in accordance with Section 58-1-303.

(31) "Unprofessional conduct" as defined in Title 58 is further defined, in accordance with Subsection 58-1-203(1)(e), in Section R156-1-502.

(32) "Warning or final disposition letters which do not constitute disciplinary action" as used in Subsection 58-1-108(3) mean letters which do not contain findings of fact or conclusions of law and do not constitute a reprimand, but which may address any or all of the following:

(a) Division concerns;

(b) allegations upon which those concerns are based;

(c) potential for administrative or judicial action; and

(d) disposition of Division concerns.

R156-1-102a. Global Definitions of Levels of Supervision.

(1) Except as otherwise provided by statute or rule, the global definitions of levels of supervision herein shall apply to supervision terminology used in Title 58 and Title R156, and shall be referenced and used, to the extent practicable, in statutes and rules to promote uniformity and consistency.

(2) Except as otherwise provided by statute or rule, all unlicensed personnel specifically allowed to practice a regulated occupation or profession are required to practice under an appropriate level of supervision defined herein, as specified by the licensing act or licensing act rule governing each occupation or profession.

(3) Except as otherwise provided by statute or rule, all license classifications required to practice under supervision shall practice under an appropriate level of supervision defined herein, as specified by the licensing act or licensing act rule governing each occupation or profession.

(4) Levels of supervision are defined as follows:

(a) "Direct supervision" and "immediate supervision" mean the supervising licensee is present and available for face-to-face communication with the person being supervised when and where occupational or professional services are being provided.

(b) "Indirect supervision" means the supervising licensee:

(i) has given either written or verbal instructions to the person being supervised;

(ii) is present within the facility in which the person being supervised is providing services; and

(iii) is available to provide immediate face-to-face communication with the person being supervised as necessary.

(c) "General supervision" means that the supervising licensee:

(i) has authorized the work to be performed by the person being supervised;

(ii) is available for consultation with the person being supervised by personal face-to-face contact, or direct voice contact by telephone, radio or some other means, without regard to whether the supervising licensee is located on the same premises as the person being supervised; and

(iii) can provide any necessary consultation within a reasonable period of time and personal contact is routine.

(5) "Supervising licensee" means a licensee who has satisfied any requirements to act as a supervisor and has agreed to provide supervision of an unlicensed individual or a licensee in a classification or licensure status that requires supervision in accordance with the provisions of this chapter.

R156-1-103. Authority - Purpose.

This rule is adopted by the Division under the authority of Subsection 58-1-106(1)(a) to enable the Division to administer Title 58.

R156-1-106. Division - Duties, Functions, and Responsibilities.

(1) In accordance with Subsection 58-1-106(2), the following responses to requests for lists of licensees may include multiple licensees per request and may include home telephone numbers, home addresses, and e-mail addresses, subject to the restriction that the addresses and telephone numbers shall only be used by a requester for purposes for which the requester is properly authorized:

(a) responses to requests from another governmental entity, government-managed corporation, a political subdivision, the federal government, another state, or a not-for-profit regulatory association to which the Division is a member;

(b) responses to requests from an occupational or professional association, private continuing education organizations, trade union, university, or school, for purposes of education programs for licensees;

(c) responses to a party to a prelitigation proceeding convened by the Division under Title 78, Chapter 14;

(d) responses to universities, schools, or research facilities for the purposes of research;

(e) responses to requests from licensed health care facilities or third party credentialing services, for the purpose of verifying licensure status for issuing credentialing or reimbursement purposes; and

(f) responses to requests from a person preparing for, participating in, or responding to:

(i) a national, state or local emergency;

(ii) a public health emergency as defined in Section 26-23b-102; or

(iii) a declaration by the President of the United States or other federal official requesting public health-related activities.

(2) In accordance with Subsection 58-1-106(3)(a) and (b), the Division may deny a request for an address or telephone number of a licensee to an individual who provides proper identification and the reason for the request, in writing, to the Division, if the reason for the request is deemed by the Division to constitute an unwarranted invasion of privacy or a threat to the public health, safety, and welfare.

(3) In accordance with Subsection 58-1-106(3)(c), proper identification of an individual who requests the address or telephone number of a licensee and the reason for the request, in writing, shall consist of the individual's name, mailing address, and daytime number, if available.

R156-1-107. Organization of Rules - Content, Applicability and Relationship of Rules.

(1) The rules and sections in Title R156 shall, to the extent practicable, follow the numbering and organizational scheme of the chapters in Title 58.

(2) Rule R156-1 shall contain general provisions applicable to the administration and enforcement of all occupations and professions regulated in Title 58.

(3) The provisions of the other rules in Title R156 shall contain specific or unique provisions applicable to particular occupations or professions.

(4) Specific rules in Title R156 may supplement or alter Rule R156-1 unless expressly provided otherwise in Rule R156-1.

R156-1-109. Presiding Officers.

In accordance with Subsection 63G-4-103(1)(h), Sections 58-1-104, 58-1-106, 58-1-109, 58-1-202, 58-1-203, 58-55-103, and 58-55-201, except as otherwise specified in writing by the Director, or for Title 58, Chapter 55, the Construction Services Commission, the designation of presiding officers is clarified or established as follows:

(1) The Division Regulatory and Compliance Officer is designated as the presiding officer for issuance of notices of agency action and for issuance of notices of hearing issued concurrently with a notice of agency action or issued in response to a request for agency action, provided that if the Division Regulatory and Compliance Officer is unable to so serve for any reason, a replacement specified by the Director is designated as the alternate presiding officer.

(2) Subsections 58-1-109(2) and 58-1-109(4) are clarified with regard to defaults as follows. Unless otherwise specified in writing by the Director, or with regard to Title 58, Chapter 55, by the Construction Services Commission, a department administrative law judge is designated as the presiding officer for entering an order of default against a party, for conducting any further proceedings necessary to complete the adjudicative proceeding, and for issuing a recommended order to the Director or Commission, respectively, determining the discipline to be imposed, licensure action to be taken, relief to be granted, etc.

(3) Except as provided in Subsection (4) or otherwise specified in writing by the Director, the presiding officer for adjudicative proceedings before the Division are as follows:

(a) Director. The Director shall be the presiding officer for:

(i) formal adjudicative proceedings described in Subsections R156-46b-201(1)(b), and R156-46b-201(2)(a) through (c), however resolved, including stipulated settlements and hearings; and

(ii) informal adjudicative proceedings described in Subsections R156-46b-202(1)(g), (i), (l), (m), (o), (p), and (r), and R156-46b-202(2)(a), (b)(ii), (c), and (d), however resolved, including memoranda of understanding and stipulated settlements.

(b) Bureau Managers or Program Coordinators. Except for Title 58, Chapter 55, the bureau manager or program coordinator over the occupation or profession or program involved shall be the presiding officer for:

(i) formal adjudicative proceedings described in Subsection R156-46b-201(1)(c), for purposes of determining whether a request for a board of appeal is properly filed as set forth in Subsections R156-15A-210(1) through (4); and

(ii) informal adjudicative proceedings described in Subsections R156-46b-202(1)(a) through (d),(f), (h), (j), (n) and R156-46b-202(2)(b)(iii).

(iii) At the direction of a bureau manager or program coordinator, a licensing technician or program technician may sign an informal order in the name of the licensing technician or program technician provided the wording of the order has been approved in advance by the bureau manager or program coordinator and provided the caption "FOR THE BUREAU MANAGER" or "FOR THE PROGRAM COORDINATOR" immediately precedes the licensing technician's or program technician's signature.

(c) Citation Hearing Officer. The Division Regulatory and Compliance Officer or other citation hearing officer designated in writing by the Director shall be the presiding officer for the adjudicative proceeding described in Subsection R156-46b-202(1)(k).

(d) Uniform Building Code Commission. The Uniform Building Code Commission shall be the presiding officer for the adjudicative proceeding described in Subsection R156-46b-202(1)(e) for convening a board of appeal under Subsection 15A-1-207(3), for serving as fact finder at any evidentiary hearing associated with a board of appeal, and for entering the final order associated with a board of appeal. An administrative law judge shall perform the role specified in Subsection 58-1-109(2).

(e) Residence Lien Recovery Fund Advisory Board. The Residence Lien Recovery Fund Advisory Board shall be the presiding officer to serve as the factfinder for formal adjudicative proceedings involving the Residence Lien Recovery Fund.

(f) Residence Lien Recovery Fund Manager. The Residence Lien Recovery Fund manager, bureau manager, or program coordinator designated in writing by the Director shall be the presiding officer for the informal adjudicative proceeding described in Subsection R156-46b-202(1)(q), for approval or denial of an application for a tax credit certificate.

(4) Unless otherwise specified in writing by the Construction Services Commission, the presiding officers and process for adjudicative proceedings under Title 58, Chapter 55, are established or clarified as follows:

(a) Commission.

(i) The Construction Services Commission shall be the presiding officer for all adjudicative proceedings under Title 58, Chapter 55, except as otherwise delegated by the Commission in writing or as otherwise provided in this rule; provided, however, that all orders adopted by the Commission as a presiding officer shall require the concurrence of the Director.

(ii) Unless otherwise specified in writing by the Construction Services Commission, the Commission is designated as the presiding officer:

(A) for informal adjudicative proceedings described in Subsections R156-46b-202(1)(l), (m), (o), (p), and (q), and R156-46b-202(2)(b)(i), (c), and (d), however resolved, including memoranda of understanding and stipulated settlements;

(B) to serve as fact finder and adopt orders in formal evidentiary hearings associated with adjudicative proceedings involving persons licensed as or required to be licensed under Title 58, Chapter 55; and

(C) to review recommended orders of a board, an administrative law judge, or other designated presiding officer who acted as the fact finder in an evidentiary hearing involving a person licensed or required to be licensed under Title 58, Chapter 55, and to adopt an order of its own. In adopting its order, the Commission may accept, modify or reject the recommended order.

(iii) If the Construction Services Commission is unable for any reason to act as the presiding officer as specified, it shall designate another presiding officer in writing to so act.

(iv) Orders of the Construction Services Commission shall address all issues before the Commission and shall be based upon the record developed in an adjudicative proceeding conducted by the Commission. In cases in which the Commission has designated another presiding officer to conduct an adjudicative proceeding and submit a recommended order, the record to be reviewed by the Commission shall consist of the findings of fact, conclusions of law, and recommended order submitted to the Commission by the presiding officer based upon the evidence presented in the adjudicative proceeding before the presiding officer.

(v) The Construction Services Commission or its designee shall submit adopted orders to the director for the Director's concurrence or rejection within 30 days after it receives a recommended order or adopts an order, whichever is earlier. An adopted order shall be deemed issued and constitute a final order upon the concurrence of the Director.

(vi) In accordance with Subsection 58-55-103(10), if the Director or the Director's designee refuses to concur in an adopted order of the Construction Services Commission or its designee, the Director or the Director's designee shall return the order to the Commission or its designee with the reasons set forth in writing for refusing to concur. The Commission or its designee shall reconsider and resubmit an adopted order, whether or not modified, within 30 days of the date of the initial or subsequent return. The Director or the Director's designee shall consider the Commission's resubmission of an adopted order and either concur rendering the order final, or refuse to concur and issue a final order, within 90 days of the date of the initial recommended order. Provided the time frames in this subsection are followed, this subsection shall not preclude an informal resolution such as an executive session of the Commission or its designee and the Director or the Director's designee to resolve the reasons for the Director's refusal to concur in an adopted order.

(vii) The record of the adjudicative proceeding shall include recommended orders, adopted orders, refusals to concur in adopted orders, and final orders.

(viii) The final order issued by the Construction Services Commission and concurred in by the Director or the Director's designee, or nonconcurred in by the Director or the Director's Designee, and issued by the Director or the Director's designee, may be appealed by filing a request for agency review with the Executive Director or the Director's designee within the Department.

(ix) The content of all orders shall comply with the requirements of Subsection 63G-4-203(1)(i) and Sections 63G-4-208 and 63G-4-209.

(b) Director. The Director or the Director's designee is designated as the presiding officer for the concurrence role, except where the Director or the Director's designee refuses to concur and issues the final order as provided by Subsection (a), on disciplinary proceedings under Subsections R156-46b-202(2)(b)(i), (c), and (d) as required by Subsection 58-55-103(1)(b)(iv).

(c) Administrative Law Judge. Unless otherwise specified in writing by the Construction Services Commission, a Department administrative law judge is designated as the presiding officer to conduct formal adjudicative proceedings before the Commission and its advisory boards, as specified in Subsection 58-1-109(2).

(d) Bureau Manager. Unless otherwise specified in writing by the Construction Services Commission, the responsible bureau manager is designated as the presiding officer for conducting informal adjudicative proceedings specified in Subsections R156-46b-202(1)(a) through (d),(h), and (n).

(e) At the direction of a bureau manager, a licensing technician may sign an informal order in the name of the licensing technician provided the wording of the order has been approved in advance by the bureau manager and provided the caption "FOR THE BUREAU MANAGER" immediately precedes the licensing technician's signature.

(f) Plumbers Licensing Board. Except as set forth in Subsection (c) or as otherwise specified in writing by the commission, the Plumbers Licensing Board is designated as the presiding officer to serve as the fact finder and to issue recommended orders to the Construction Services Commission in formal evidentiary hearings associated with adjudicative proceedings involving persons licensed as or required to be

licensed as plumbers.

(g) Electricians Licensing Board. Except as set forth in Subsection (c) or as otherwise specified in writing by the commission, the Electricians Licensing Board is designated as the presiding officer to serve as the fact finder and to issue recommended orders to the Construction Services Commission in formal evidentiary hearings associated with adjudicative proceedings involving persons licensed as or required to be licensed as electricians.

(h) Alarm System Security and Licensing Board. Except as set forth in Subsection (c) or as otherwise specified in writing by the Commission, the Alarm System Security and Licensing Board is designated as the presiding officer to serve as the fact finder and to issue recommended orders to the Construction Services Commission in formal evidentiary hearings associated with adjudicative proceedings involving persons licensed as or required to be licensed as alarm companies or agents.

R156-1-110. Issuance of Investigative Subpoenas.

(1) All requests for subpoenas in conjunction with a Division investigation made pursuant to Subsection 58-1-106(1)(c), shall be made in writing to the investigative subpoena authority and shall be accompanied by an original of the proposed subpoena.

(a) Requests to the investigative subpoena authority shall contain adequate information to enable the subpoena authority to make a finding of sufficient need, including: the factual basis for the request, the relevance and necessity of the particular person, evidence, documents, etc., to the investigation, and an explanation why the subpoena is directed to the particular person upon whom it is to be served.

(b) Approved subpoenas shall be issued under the seal of the Division and the signature of the subpoena authority.

(2) The person who requests an investigative subpoena is responsible for service of the subpoena.

(3)(a) Service may be made:

(i) on a person upon whom a summons may be served pursuant to the Utah Rules of Civil Procedure; and

(ii) personally or on the agent of the person being served.

(b) If a party is represented by an attorney, service shall be made on the attorney.

(4)(a) Service may be accomplished by hand delivery or by mail to the last known address of the intended recipient.

(b) Service by mail is complete upon mailing.

(c) Service may be accomplished by electronic means.

(d) Service by electronic means is complete on transmission if transmission is completed during normal business hours at the place receiving the service; otherwise, service is complete on the next business day.

(5) There shall appear on all investigative subpoenas a certificate of service.

(6) The investigative subpoena authority may quash or modify an investigative subpoena if it is shown to be unreasonable or oppressive.

(a) A motion to quash or modify an investigative subpoena shall be filed with and served upon the subpoena authority no later than ten days after service of the investigative subpoena.

(b) A response by the Division to a motion to quash or modify an investigative subpoena shall be filed with and served upon the subpoena authority no later than five business days after receipt of a motion to quash or modify an investigative subpoena.

(c) No final reply by the recipient of an investigative subpoena who files a motion to quash or modify shall be permitted.

R156-1-111a. Qualifications for Tax Certificate - Definitions.

In addition to the definitions in Title 58, Chapter 1, as used in Title 58, Chapter 1, or in this rule:

(1) "Psychiatrist", as defined under Subsection 58-1-111(1)(d, is further defined to include a licensed physician who is board certified for a psychiatry specialization recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (BOS).

(2) Under Subsection 58-1-111(1)(f)(ii), the definition of a "volunteer retired psychiatrist" is further defined to mean a physician or osteopathic physician licensed under Title 58, Chapter 81, Retired Volunteer Health Practitioner Act, who is previously or currently board certified for a psychiatry specialization recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association's Bureau of Osteopathic Specialists (BOS).

R156-1-111b. Qualifications for Tax Certificate - Application Requirements.

An applicant for a tax credit certificate under Section 58-1-111 shall provide to the Division:

(1) the original application made available on the Division's website, containing the signed attestation of compliance; and

(2) any additional documentation that may be required by the Division to verify the applicant's representations made in the application.

R156-1-205. Peer or Advisory Committees - Executive Director to Appoint - Terms of Office - Vacancies in Office - Removal from Office - Quorum Requirements - Appointment of Chairman - Division to Provide Secretary - Compliance with Open and Public Meetings Act - Compliance with Utah Administrative Procedures Act - No Provision for Per Diem and Expenses.

(1) The executive director shall appoint the members of peer or advisory committees established under Title 58 or Title R156.

(2) Except for ad hoc committees whose members shall be appointed on a case-by-case basis, the term of office of peer or advisory committee members shall be for four years. The executive director shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of committee members are staggered so that approximately half of the peer or advisory committee is appointed every two years.

(3) No peer or advisory committee member may serve more than two full terms, and no member who ceases to serve may again serve on the peer or advisory committee until after the expiration of two years from the date of cessation of service.

(4) If a vacancy on a peer or advisory committee occurs, the executive director shall appoint a replacement to fill the unexpired term. After filling the unexpired term, the replacement may be appointed for only one additional full term.

(5) If a peer or advisory committee member fails or refuses to fulfill the responsibilities and duties of a peer or advisory committee member, including the attendance at peer committee meetings, the executive director may remove the peer or advisory committee member and replace the member in accordance with this section. After filling the unexpired term, the replacement may be appointed for only one additional full term.

(6) Committee meetings shall only be convened with the approval of the appropriate board and the concurrence of the Division.

(7) Unless otherwise approved by the Division, peer or advisory committee meetings shall be held in the building occupied by the Division.

(8) A majority of the peer or advisory committee members shall constitute a quorum and may act in behalf of the peer or

advisory committee.

(9) Peer or advisory committees shall annually designate one of their members to serve as peer or advisory committee chairman. The Division shall provide a Division employee to act as committee secretary to take minutes of committee meetings and to prepare committee correspondence.

(10) Peer or advisory committees shall comply with the procedures and requirements of Title 52, Chapter 4, Open and Public Meetings, in their meetings.

(11) Peer or advisory committees shall comply with the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act, in their adjudicative proceedings.

(12) Peer or advisory committee members shall perform their duties and responsibilities as public service and shall not receive a per diem allowance, or traveling or accommodations expenses incurred in peer or advisory committees business, except as otherwise provided in Title 58 or Title R156.

R156-1-206. Emergency Adjudicative Proceeding Review Committees - Appointment - Terms - Vacancies - Removal - Quorum - Chairman and Secretary - Open and Public Meetings Act - Utah Administrative Procedures Act - Per Diem and Expenses.

(1) The chairman of the board for the profession of the person against whom an action is proposed may appoint the members of emergency review committees on a case-by-case or period-of-time basis.

(2) With the exception of the appointment and removal of members and filling of vacancies by the chairman of a board, emergency review committees, committees shall serve in accordance with Subsections R156-1-205(7), and (9) through (12).

R156-1-301. Application for Licensure - Filing Date - Applicable Requirements for Licensure - Issuance Date.

(1) The filing date for an application for licensure shall be the postmark date of the application or the date the application is received and date stamped by the Division, whichever is earlier.

(2) Except as otherwise provided by statute, rule or order, the requirements for licensure applicable to an application for licensure shall be the requirements in effect on the filing date of the application.

(3) The issuance date for a license issued to an applicant for licensure shall be as follows:

(a) the date the approval is input into the Division's electronic licensure database for applications submitted and processed manually; or

(b) the date printed on the verification of renewal certificate for renewal applications submitted and processed electronically via the Division's Internet Renewal System.

R156-1-302. Consideration of Good Moral Character, Unlawful Conduct, Unprofessional Conduct, or Other Mental or Physical Condition.

(1) This section applies in circumstances where an applicant or licensee:

(a) is not automatically disqualified from licensure pursuant to a statutory provision; and

(b)(i) has history that reflects negatively on the person's moral character, including past unlawful or unprofessional conduct; or

(ii) has a mental or physical condition that, when considered with the duties and responsibilities of the license held or to be held, demonstrates a threat or potential threat to the public health, safety or welfare.

(2) In a circumstance described in Section (1), the following factors are relevant to a licensing decision:

(a) aggravating circumstances, as defined in Subsection R156-1-102(2);

(b) mitigating circumstances, as defined in Subsection R156-1-102(17);

(c) the degree of risk to the public health, safety or welfare;

(d) the degree of risk that a conduct will be repeated;

(e) the degree of risk that a condition will continue;

(f) the magnitude of the conduct or condition as it relates to the harm or potential harm;

(g) the length of time since the last conduct or condition has occurred;

(h) the current criminal probationary or parole status of the applicant or licensee;

(i) the current administrative status of the applicant or licensee;

(j) results of previously submitted applications, for any regulated profession or occupation;

(k) results from any action, taken by any professional licensing agency, criminal or administrative agency, employer, practice monitoring group, entity or association;

(l) evidence presented indicating that restricting or monitoring an individual's practice, conditions or conduct can protect the public health, safety or welfare;

(m) psychological evaluations; or

(n) any other information the Division or the board reasonably believes may assist in evaluating the degree of threat or potential threat to the public health, safety or welfare.

R156-1-303. Temporary Licenses in Declared Disaster or Emergency.

(1) In accordance with Section 53-2a-1203, persons who provide services under this exemption from licensure, shall within 30 days file a notice with the Division as provided under Subsection 53-2a-1205(1) using forms posted on the Division internet site.

(2) In accordance with Section 53-2a-1205 and Subsection 58-1-303(1), a person who provides services under the exemption from licensure as provided in Section 53-2a-1203 for a declared disaster or emergency shall, after the disaster period ends and before continuing to provide services, meet all the normal requirements for occupational or professional licensure under this title, unless:

(a) prior to practicing after the declared disaster the person is issued a temporary license under the provisions of Subsection 58-1-303(1)(c); or

(b) the person qualifies under another exemption from licensure.

R156-1-305. Inactive Licensure.

(1) In accordance with Section 58-1-305, except as provided in Subsection (2), a licensee may not apply for inactive licensure status.

(2) The following licenses issued under Title 58 that are active in good standing may be placed on inactive licensure status:

(a) architect;
(b) audiologist;
(c) certified public accountant emeritus;
(d) certified court reporter;
(e) certified social worker;
(f) chiropractic physician;
(g) clinical mental health counselor;
(h) clinical social worker;
(i) contractor;
(j) deception detection examiner;
(k) deception detection intern;
(l) dental hygienist;
(m) dentist;

(n) dispensing medical practitioner - advanced practice registered nurse;
(o) dispensing medical practitioner - physician and surgeon;
(p) dispensing medical practitioner - physician assistant;
(q) dispensing medical practitioner - osteopathic physician and surgeon;
(r) dispensing medical practitioner - optometrist;
(s) dispensing medical practitioner - clinic pharmacy;
(t) genetic counselor;
(u) health facility administrator;
(v) hearing instrument specialist;
(w) landscape architect;
(x) licensed advanced substance use disorder counselor;
(y) marriage and family therapist;
(z) naturopath/naturopathic physician;
(aa) optometrist;
(bb) osteopathic physician and surgeon;
(cc) pharmacist;
(dd) pharmacy technician;
(ee) physician assistant;
(ff) physician and surgeon;
(gg) podiatric physician;
(hh) private probation provider;
(ii) professional engineer;
(jj) professional land surveyor;
(kk) professional structural engineer;
(ll) psychologist;
(mm) radiology practical technician;
(nn) radiologic technologist;
(oo) security personnel;
(pp) speech-language pathologist;
(qq) substance use disorder counselor; and
(rr) veterinarian.

(3) Applicants for inactive licensure shall apply to the Division in writing upon forms available from the Division. Each completed application shall contain documentation of requirements for inactive licensure, shall be verified by the applicant, and shall be accompanied by the appropriate fee.

(4) If all requirements are met for inactive licensure, the Division shall place the license on inactive status.

(5) A license may remain on inactive status indefinitely except as otherwise provided in Title 58 or rules which implement Title 58.

(6) An inactive license may be activated by requesting activation in writing upon forms available from the Division. Unless otherwise provided in Title 58 or rules which implement Title 58, each reactivation application shall contain documentation that the applicant meets current renewal requirements, shall be verified by the applicant, and shall be accompanied by the appropriate fee.

(7) An inactive licensee whose license is activated during the last 12 months of a renewal cycle shall, upon payment of the appropriate fees, be licensed for a full renewal cycle plus the period of time remaining until the impending renewal date, rather than being required to immediately renew their activated license.

(8) A Controlled Substance license may be placed on inactive status if attached to a primary license listed in Subsection R156-1-305(2) and the primary license is placed on inactive status.

R156-1-308a. Renewal Dates.

(1) The following standard two-year renewal cycle renewal dates are established by license classification in accordance with the Subsection 58-1-308(1):

TABLE
RENEWAL DATES

Acupuncturist	May 31	even years
Advanced Practice Registered Nurse	January 31	even years
Advanced Practice Registered Nurse-CRNA	January 31	even years
Architect	May 31	even years
Athlete Agent	September 30	even years
Athletic Trainer	May 31	odd years
Audiologist	May 31	odd years
Barber	September 30	odd years
Barber Apprentice	September 30	odd years
Barber School	September 30	odd years
Behavior Analyst and Assistant Behavior Analyst	September 30	even years
Behavior Specialist and Assistant Behavior Specialist	September 30	even years
Building Inspector	November 30	odd years
Burglar Alarm Security	March 31	odd years
C.P.A. Firm	September 30	even years
Certified Court Reporter	May 31	even years
Certified Dietitian	September 30	even years
Certified Medical Language Interpreter	March 31	odd years
Certified Nurse Midwife	January 31	even years
Certified Public Accountant	September 30	even years
Certified Social Worker	September 30	even years
Chiropractic Physician	May 31	even years
Clinical Mental Health Counselor	September 30	even years
Clinical Social Worker	September 30	even years
Construction Trades Instructor	November 30	odd years
Contractor	November 30	odd years
Controlled Substance License	Attached to primary license renewal	
Controlled Substance Precursor	May 31	odd years
Controlled Substance Handler	September 30	odd years
Cosmetologist/Barber	September 30	odd years
Cosmetologist/Barber Apprentice	September 30	odd years
Cosmetology/Barber School	September 30	odd years
Deception Detection Deception Detection Examiner, Deception Detection Intern, Deception Detection Administrator	November 30	even years
Dental Hygienist	May 31	even years
Dentist	May 31	even years
Direct-entry Midwife	September 30	odd years
Dispensing Medical Practitioner Advanced Practice Registered Nurse, Optometrist, Osteopathic Physician and Surgeon, Physician and Surgeon, Physician Assistant	September 30	odd years
Dispensing Medical Practitioner Clinic Pharmacy	September 30	odd years
Electrician Apprentice, Journeyman, Master, Residential Journeyman, Residential Master	November 30	even years
Electrologist	September 30	odd years
Electrology School	September 30	odd years
Elevator Mechanic	November 30	even years
Environmental Health Scientist	May 31	odd years
Esthetician	September 30	odd years
Esthetician Apprentice	September 30	odd years
Esthetics School	September 30	odd years
Factory Built Housing Dealer	September 30	even years
Funeral Service Director	May 31	even years
Funeral Service Establishment	May 31	even years
Genetic Counselor	September 30	even years
Health Facility Administrator	May 31	odd years
Hearing Instrument Specialist	September 30	even years
Internet Facilitator	September 30	odd years
Landscape Architect	May 31	even years
Licensed Advanced Substance Use Disorder Counselor	May 31	odd years
Licensed Practical Nurse	January 31	even years
Licensed Substance Use Disorder Counselor	May 31	odd years
Marriage and Family Therapist	September 30	even years
Massage Apprentice	May 31	odd years
Massage Therapist	May 31	odd years
Master Esthetician	September 30	odd years
Master Esthetician Apprentice	September 30	odd years
Medication Aide Certified	March 31	odd years
Music Therapist	March 31	odd years
Nail Technologist	September 30	odd years
Nail Technologist Apprentice	September 30	odd years
Nail Technology School	September 30	odd years
Naturopath/Naturopathic Physician	May 31	even years
Occupational Therapist	May 31	odd years
Occupational Therapy Assistant	May 31	odd years
Optometrist	September 30	even years
Osteopathic Physician and		

Surgeon, Online Prescriber	May 31	even years
Outfitter/Hunting Guide	May 31	even years
Pharmacy Class A-B-C-D-E, Online Contract Pharmacy	September 30	odd years
Pharmacist	September 30	odd years
Pharmacy Technician	September 30	odd years
Physical Therapist	May 31	odd years
Physical Therapist Assistant	May 31	odd years
Physician Assistant	May 31	even years
Physician and Surgeon, Online Prescriber	January 31	even years
Plumber Apprentice, Journeyman, Master, Residential Master, Residential Journeyman	November 30	even years
Podiatric Physician	September 30	even years
Pre Need Funeral Arrangement Sales Agent	May 31	even years
Private Probation Provider	May 31	odd years
Professional Engineer	March 31	odd years
Professional Geologist	March 31	odd years
Professional Land Surveyor	March 31	odd years
Professional Structural Engineer	March 31	odd years
Psychologist	September 30	even years
Radiologic Technologist, Radiology Practical Technician Radiologist Assistant	May 31	odd years
Recreational Therapy Therapeutic Recreation Technician, Therapeutic Recreation Specialist, Master Therapeutic Recreation Specialist	May 31	odd years
Registered Nurse	January 31	odd years
Respiratory Care Practitioner	September 30	even years
Security Personnel	November 30	even years
Social Service Worker	September 30	even years
Speech-Language Pathologist	May 31	odd years
State Certified Commercial Interior Designer	March 31	odd years
Veterinarian	September 30	even years
Vocational Rehabilitation Counselor	March 31	odd years

(2) The following non-standard renewal terms and renewal or extension cycles are established by license classification in accordance with Subsection 58-1-308(1) and in accordance with specific requirements of the license:

(a) Associate Clinical Mental Health Counselor licenses shall be issued for a three year term and may be extended if the licensee presents satisfactory evidence to the Division and the Board that reasonable progress is being made toward passing the qualifying examinations or is otherwise on a course reasonably expected to lead to licensure.

(b) Associate Marriage and Family Therapist licenses shall be issued for a three year term and may be extended if the licensee presents satisfactory evidence to the Division and the board that reasonable progress is being made toward passing the qualifying examinations or is otherwise on a course reasonably expected to lead to licensure; but the period of the extension may not exceed two years past the date the minimum supervised experience requirement has been completed.

(c) Certified Advanced Substance Use Disorder Counselor licenses shall be issued for a period of four years and may be extended if the licensee presents satisfactory evidence to the Division and Board that reasonable progress is being made toward completing the required hours of supervised experience necessary for the next level of licensure.

(d) Certified Advanced Substance Use Disorder Counselor Intern licenses shall be issued for a period of six months or until the examination is passed whichever occurs first.

(e) Certified Substance Use Disorder Counselor licenses shall be issued for a period of two years and may be extended if the licensee presents satisfactory evidence to the Division and Board that reasonable progress is being made toward completing the required hours of supervised experience necessary for the next level of licensure.

(f) Certified Social Worker Intern licenses shall be issued for a period of six months or until the examination is passed whichever occurs first.

(g) Certified Substance Use Disorder Counselor Intern licenses shall be issued for a period of six months or until the examination is passed, whichever occurs first.

(h) Funeral Service Intern licenses shall be issued for a two year term and may be extended for an additional two year term if the licensee presents satisfactory evidence to the Division and the board that reasonable progress is being made toward passing the qualifying examinations or is otherwise on a course reasonably expected to lead to licensure.

(i) Hearing Instrument Intern licenses shall be issued for a three year term and may be extended if the licensee presents satisfactory evidence to the Division and the Board that reasonable progress is being made toward passing the qualifying examination, but a circumstance arose beyond the control of the licensee, to prevent the completion of the examination process.

(j) Pharmacy technician trainee licenses shall be issued for a period of two years and may be extended if the licensee presents satisfactory evidence to the Division and the Board that reasonable progress is being made toward completing the requirements necessary for the next level of licensure.

(k) Psychology Resident licenses shall be issued for a two year term and may be extended if the licensee presents satisfactory evidence to the Division and the board that reasonable progress is being made toward passing the qualifying examinations or is otherwise on a course reasonably expected to lead to licensure; but the period of the extension may not exceed two years past the date the minimum supervised experience requirement has been completed.

(l) Type I Foreign Trained Physician-Educator licenses will be issued initially for a one-year term and thereafter renewed every two years following issuance.

(m) Type II Foreign Trained Physician-Educator licenses will be issued initially for an annual basis and thereafter renewed annually up to four times following issuance if the licensee continues to satisfy the requirements described in Subsection 58-67-302.7(3) and completes the required continuing education requirements established under Section 58-67-303.

R156-1-308b. Renewal Periods - Adjustment of Renewal Fees for an Extended or Shortened Renewal Period.

(1) Except as otherwise provided by statute or as required to establish or reestablish a renewal period, each renewal period shall be for a period of two years.

(2) The renewal fee for a renewal period which is extended or shortened by more than one month to establish or reestablish a renewal period shall increased or decreased proportionately.

R156-1-308c. Renewal of Licensure Procedures.

The procedures for renewal of licensure shall be as follows:

(1) The Division shall send a renewal notice to each licensee at least 60 days prior to the expiration date shown on the licensee's license. The notice shall include directions for the licensee to renew the license via the Division's website.

(2) Except as provided in Subsection(4), renewal notices shall be sent by mail deposited in the post office with postage prepaid, addressed to the last mailing address shown on the Division's automated license system.

(3) In accordance with Subsection 58-1-301.7(1), each licensee is required to maintain a current mailing address with the Division. In accordance with Subsection 58-1-301.7(2), mailing to the last mailing address furnished to the Division constitutes legal notice.

(4) If a licensee has authorized the Division to send a renewal notice by email, a renewal notice may be sent by email to the last email address shown on the Division's automated license system. If selected as the exclusive method of receipt of renewal notices, such mailing shall constitute legal notice. It shall be the duty and responsibility of each licensee who

authorizes the Division to send a renewal notice by email to maintain a current email address with the Division.

(5) Renewal notices shall provide that the renewal requirements are outlined in the online renewal process and that each licensee is required to document or certify that the licensee meets the renewal requirements prior to renewal.

(6) Renewal notices shall advise each licensee that a license that is not renewed prior to the expiration date shown on the license automatically expires and that any continued practice without a license constitutes a criminal offense under Subsection 58-1-501(1)(a).

(7) Licensees licensed during the last 12 months of a renewal cycle shall be licensed for a full renewal cycle plus the period of time remaining until the impending renewal date, rather than being required to immediately renew their license.

R156-1-308d. Waiver of Continuing Education Requirements - Renewal Requirements.

(1)(a) In accordance with Subsection 58-1-203(1)(g), a licensee may request a waiver of any continuing education requirement established under this title or an extension of time to complete any requirement on the basis that the licensee was unable to complete the requirement due to a medical or related condition, humanitarian or ecclesiastical services, extended presence in a geographical area where continuing education is not available, etc.

(b) A request must be submitted no later than the deadline for completing any continuing education requirement.

(c) A licensee submitting a request has the burden of proof and must document the reason for the request to the satisfaction of the Division.

(d) A request shall include the beginning and ending dates during which the licensee was unable to complete the continuing education requirement and a detailed explanation of the reason why. The explanation shall include the extent and duration of the impediment, extent to which the licensee continued to be engaged in practice of his profession, the nature of the medical condition, the location and nature of the humanitarian services, the geographical area where continuing education is not available, etc.

(e) The Division may require that a specified number of continuing education hours, courses, or both, be obtained prior to reentering the practice of the profession or within a specified period of time after reentering the practice of the profession, as recommended by the appropriate board, in order to assure competent practice.

(f) While a licensee may receive a waiver from meeting the minimum continuing education requirements, the licensee shall not be exempted from the requirements of Subsection 58-1-501(2)(i), which requires that the licensee provide services within the competency, abilities and education of the licensee. If a licensee cannot competently provide services, the waiver of meeting the continuing education requirements may be conditioned upon the licensee limiting practice to areas in which the licensee has the required competency, abilities and education.

R156-1-308e. Automatic Expiration of Licensure Upon Dissolution of Licensee.

(1) A license that automatically expires prior to the expiration date shown on the license due to the dissolution of the licensee's registration with the Division of Corporations, with the registration thereafter being retroactively reinstated pursuant to Section 16-10a-1422, shall:

(a) upon written application for reinstatement of licensure submitted prior to the expiration date shown on the license, be retroactively reinstated to the date of expiration of licensure; and

(b) upon written application for reinstatement submitted after the expiration date shown on the current license, be reinstated on the effective date of the approval of the application for reinstatement, rather than relating back retroactively to the date of expiration of licensure.

R156-1-308f. Denial of Renewal of Licensure - Classification of Proceedings - Conditional Renewal of Licensure During Adjudicative Proceedings - Conditional Initial, Renewal, or Reinstatement Licensure During Audit or Investigation.

(1) When an initial, renewal or reinstatement applicant under Subsections 58-1-301(2) through (3) or 58-1-308(5) or (6)(b) is selected for audit or is under investigation, the Division may conditionally issue an initial license to an applicant for initial licensure, or renew or reinstate the license of an applicant pending the completion of the audit or investigation.

(2) The undetermined completion of a referenced audit or investigation rather than the established expiration date shall be indicated as the expiration date of a conditionally issued, renewed, or reinstated license.

(3) A conditional issuance, renewal, or reinstatement shall not constitute an adverse licensure action.

(4) Upon completion of the audit or investigation, the Division shall notify the initial license, renewal, or reinstatement applicant whether the applicant's license is unconditionally issued, renewed, reinstated, denied, or partially denied or reinstated.

(5) A notice of unconditional denial or partial denial of licensure to an applicant the Division conditionally licensed, renewed, or reinstated shall include the following:

(a) that the applicant's unconditional initial issuance, renewal, or reinstatement of licensure is denied or partially denied and the basis for such action;

(b) the Division's file or other reference number of the audit or investigation; and

(c) that the denial or partial denial of unconditional initial licensure, renewal, or reinstatement of licensure is subject to review and a description of how and when such review may be requested.

R156-1-308g. Reinstatement of Licensure which was Active and in Good Standing at the Time of Expiration of Licensure - Requirements.

The following requirements shall apply to reinstatement of licensure which was active and in good standing at the time of expiration of licensure:

(1) In accordance with Subsection 58-1-308(5), if an application for reinstatement is received by the Division between the date of the expiration of the license and 30 days after the date of the expiration of the license, the applicant shall:

(a) submit a completed renewal form as furnished by the Division demonstrating compliance with requirements and/or conditions of license renewal; and

(b) pay the established license renewal fee and a late fee.

(2) In accordance with Subsection 58-1-308(5), if an application for reinstatement is received by the Division between 31 days after the expiration of the license and two years after the date of the expiration of the license, the applicant shall:

(a) submit a completed renewal form as furnished by the Division demonstrating compliance with requirements and/or conditions of license renewal; and

(b) pay the established license renewal fee and reinstatement fee.

(3) In accordance with Subsection 58-1-308(6)(a), if an application for reinstatement is received by the Division more than two years after the date the license expired and the applicant has not been active in the licensed occupation or profession while in the full-time employ of the United States government or under license to practice that occupation or profession in any other state or territory of the United States during the time the license was expired, the applicant shall:

(a) submit an application for licensure complete with all supporting documents as is required of an individual making an initial application for license demonstrating the applicant meets all current qualifications for licensure;

(b) provide information requested by the Division and board to clearly demonstrate the applicant is currently competent to engage in the occupation or profession for which reinstatement of licensure is requested; and

(c) pay the established license fee for a new applicant for licensure.

(4) In accordance with Subsection 58-1-308(6)(b), if an application for reinstatement is received by the Division more than two years after the date the license expired but the applicant has been active in the licensed occupation or profession while in the full-time employ of the United States government or under license to practice that occupation or profession in any other state or territory of the United States shall:

(a) provide documentation that the applicant has continuously, since the expiration of the applicant's license in Utah, been active in the licensed occupation or profession while in the full-time employ of the United States government or under license to practice that occupation or profession in any other state or territory of the United States;

(b) provide documentation that the applicant has completed or is in compliance with any renewal qualifications;

(c) provide documentation that the applicant's application was submitted within six months after reestablishing domicile within Utah or terminating full-time government service; and

(d) pay the established license renewal fee and the reinstatement fee.

R156-1-308h. Reinstatement of Restricted, Suspended, or Probationary Licensure During Term of Restriction, Suspension, or Probation - Requirements.

(1) Reinstatement of restricted, suspended, or probationary licensure during the term of limitation, suspension, or probation shall be in accordance with the disciplinary order which imposed the discipline.

(2) Unless otherwise specified in a disciplinary order imposing restriction, suspension, or probation of licensure, the disciplined licensee may, at reasonable intervals during the term of the disciplinary order, petition for reinstatement of licensure.

(3) Petitions for reinstatement of licensure during the term of a disciplinary order imposing restriction, suspension, or probation, shall be treated as a request to modify the terms of the disciplinary order, not as an application for licensure.

R156-1-308i. Reinstatement of Restricted, Suspended, or Probationary Licensure After the Specified Term of Suspension of the License or After the Expiration of Licensure in a Restricted, Suspended or Probationary Status - Requirements.

Unless otherwise provided by a disciplinary order, an applicant who applies for reinstatement of a license after the specified term of suspension of the license or after the expiration of the license in a restricted, suspended or probationary status shall:

(1) submit an application for licensure complete with all supporting documents as is required of an individual making an initial application for license demonstrating the applicant meets all current qualifications for licensure and compliance with requirements and conditions of license reinstatement;

(2) pay the established license renewal fee and the reinstatement fee;

(3) provide information requested by the Division and board to clearly demonstrate the applicant is currently competent to be reinstated to engage in the occupation or profession for which the applicant was suspended, restricted, or placed on probation; and

(4) pay any fines or citations owed to the Division prior to the expiration of license.

R156-1-308j. Relicensure Following Revocation of Licensure - Requirements.

An applicant for relicensure following revocation of licensure shall:

(1) submit an application for licensure complete with all supporting documents as is required of an individual making an initial application for license demonstrating the applicant meets all current qualifications for licensure and compliance with requirements and/or conditions of license reinstatement;

(2) pay the established license fee for a new applicant for licensure; and

(3) provide information requested by the Division and board to clearly demonstrate the applicant is currently competent to be relicensed to engage in the occupation or profession for which the applicant was revoked.

R156-1-308k. Relicensure Following Surrender of Licensure - Requirements.

The following requirements shall apply to relicensure applications following the surrender of licensure:

(1) An applicant who surrendered a license that was active and in good standing at the time it was surrendered shall meet the requirements for licensure listed in Sections R156-1-308a through R156-1-308l.

(2) An applicant who surrendered a license while the license was active but not in good standing as evidenced by the written agreement supporting the surrender of license shall:

(a) submit an application for licensure complete with all supporting documents as is required of an individual making an initial application for license demonstrating the applicant meets all current qualifications for licensure and compliance with requirements and/or conditions of license reinstatement;

(b) pay the established license fee for a new applicant for licensure;

(c) provide information requested by the Division and board to clearly demonstrate the applicant is currently competent to be relicensed to engage in the occupation or profession for which the applicant was surrendered;

(d) pay any fines or citations owed to the Division prior to the surrender of license.

R156-1-308l. Reinstatement of Licensure and Relicensure - Term of Licensure.

Except as otherwise governed by the terms of an order issued by the Division, a license issued to an applicant for reinstatement or relicensure issued during the last 12 months of a renewal cycle shall, upon payment of the appropriate fees, be issued for a full renewal cycle plus the period of time remaining until the impending renewal date, rather than requiring the licensee to immediately renew their reinstated or relicensed license.

R156-1-310. Cheating on Examinations.

(1) Policy.

The passing of an examination, when required as a condition of obtaining or maintaining a license issued by the Division, is considered to be a critical indicator that an applicant or licensee meets the minimum qualifications for licensure. Failure to pass an examination is considered to be evidence that an applicant or licensee does not meet the minimum qualifications for licensure. Accordingly, the accuracy of the examination result as a measure of an applicant's or licensee's competency must be assured. Cheating by an applicant or licensee on any examination required as a condition of obtaining a license or maintaining a license shall be considered unprofessional conduct and shall result in imposition of an

appropriate penalty against the applicant or licensee.

(2) Cheating Defined.

Cheating is defined as the use of any means or instrumentality by or for the benefit of an examinee to alter the results of an examination in any way to cause the examination results to inaccurately represent the competency of an examinee with respect to the knowledge or skills about which they are examined. Cheating includes:

(a) communication between examinees inside of the examination room or facility during the course of the examination;

(b) communication about the examination with anyone outside of the examination room or facility during the course of the examination;

(c) copying another examinee's answers or looking at another examinee's answers while an examination is in progress;

(d) permitting anyone to copy answers to the examination;

(e) substitution by an applicant or licensee or by others for the benefit of an applicant or licensee of another person as the examinee in place of the applicant or licensee;

(f) use by an applicant or licensee of any written material, audio material, video material or any other mechanism not specifically authorized during the examination for the purpose of assisting an examinee in the examination;

(g) obtaining, using, buying, selling, possession of or having access to a copy of any portion of the examination prior to administration of the examination.

(3) Action Upon Detection of Cheating.

(a) The person responsible for administration of an examination, upon evidence that an examinee is or has been cheating on an examination shall notify the Division of the circumstances in detail and the identity of the examinees involved with an assessment of the degree of involvement of each examinee;

(b) If cheating is detected prior to commencement of the examination, the examinee may be denied the privilege of taking the examination; or if permitted to take the examination, the examinee shall be notified of the evidence of cheating and shall be informed that the Division may consider the examination to have been failed by the applicant or licensee because of the cheating; or

(c) If cheating is detected during the examination, the examinee may be requested to leave the examination facility and in that case the examination results shall be the same as failure of the examination; however, if the person responsible for administration of the examination determines the cheating detected has not yet compromised the integrity of the examination, such steps as are necessary to prevent further cheating shall be taken and the examinee may be permitted to continue with the examination.

(d) If cheating is detected after the examination, the Division shall make appropriate inquiry to determine the facts concerning the cheating and shall thereafter take appropriate action.

(e) Upon determination that an applicant has cheated on an examination, the applicant may be denied the privilege of retaking the examination for a reasonable period of time, and the Division may deny the applicant a license and may establish conditions the applicant must meet to qualify for a license including the earliest date on which the Division will again consider the applicant for licensure.

R156-1-404a. Diversion Advisory Committees Created.

(1) There are created diversion advisory committees of at least three members for the professions regulated under Title 58. The diversion committees are not required to be impaneled by the director until the need for the diversion committee arises. Diversion committees may be appointed with representatives from like professions providing a multi-disciplinary committee.

(2) Committee members are appointed by and serve at the pleasure of the director.

(3) A majority of the diversion committee members shall constitute a quorum and may act on behalf of the diversion committee.

(4) Diversion committee members shall perform their duties and responsibilities as public service and shall not receive a per diem allowance, or traveling or accommodations expenses incurred in diversion committees business.

R156-1-404b. Diversion Committees Duties.

The duties of diversion committees shall include:

(1) reviewing the details of the information regarding licensees referred to the diversion committee for possible diversion, interviewing the licensees, and recommending to the director whether the licensees meet the qualifications for diversion and if so whether the licensees should be considered for diversion;

(2) recommending to the director terms and conditions to be included in diversion agreements;

(3) supervising compliance with all terms and conditions of diversion agreements;

(4) advising the director at the conclusion of a licensee's diversion program whether the licensee has completed the terms of the licensee's diversion agreement; and

(5) establishing and maintaining continuing quality review of the programs of professional associations and/or private organizations to which licensees approved for diversion may enroll for the purpose of education, rehabilitation or any other purpose agreed to in the terms of a diversion agreement.

R156-1-404c. Diversion - Eligible Offenses.

In accordance with Subsection 58-1-404(4), the unprofessional conduct which may be subject to diversion is set forth in Subsections 58-1-501(2)(e) and (f).

R156-1-404d. Diversion - Procedures.

(1) No later than 60 days following the referral of a licensee to the diversion committee for possible diversion, diversion committees shall complete the duties described in Subsection R156-1-404b(1) and (2).

(2) Following the completion of diversion committee duties, the Division shall prepare and serve upon the licensee a proposed diversion agreement. The licensee shall have a period of time determined by the Division not to exceed 30 days from the service of the proposed diversion agreement, to negotiate a final diversion agreement with the director. The final diversion agreement shall comply with Subsection 58-1-404.

(3) If a final diversion agreement is not reached with the director within 30 days from service of the proposed diversion agreement, or if the director finds that the licensee does not meet the qualifications for diversion, the Division shall pursue appropriate disciplinary action against the licensee in accordance with Section 58-1-108.

(4) In accordance with Subsection 58-1-404(5), a licensee may be represented, at the licensee's discretion and expense, by legal counsel during negotiations for diversion, at the time of execution of the diversion agreement, and at any hearing before the director relating to a diversion program.

R156-1-404e. Diversion - Agreements for Rehabilitation, Education or Other Similar Services or Coordination of Services.

(1) The Division may enter into agreements with professional or occupational organizations or associations, education institutions or organizations, testing agencies, health care facilities, health care practitioners, government agencies or other persons or organizations for the purpose of providing rehabilitation, education or any other services necessary to

facilitate an effective completion of a diversion program for a licensee.

(2) The Division may enter into agreements with impaired person programs to coordinate efforts in rehabilitating and educating impaired professionals.

(3) Agreements shall be in writing and shall set forth terms and conditions necessary to permit each party to properly fulfill its duties and obligations thereunder. Agreements shall address the circumstances and conditions under which information concerning the impaired licensee will be shared with the Division.

(4) The cost of administering agreements and providing the services thereunder shall be borne by the licensee benefiting from the services. Fees paid by the licensee shall be reasonable and shall be in proportion to the value of the service provided. Payments of fees shall be a condition of completing the program of diversion.

(5) In selecting parties with whom the Division shall enter agreements under this section, the Division shall ensure the parties are competent to provide the required services. The Division may limit the number of parties providing a particular service within the limits or demands for the service to permit the responsible diversion committee to conduct quality review of the programs given the committee's limited resources.

R156-1-501. Unprofessional Conduct.

"Unprofessional conduct" includes:

(1) surrendering licensure to any other licensing or regulatory authority having jurisdiction over the licensee or applicant in the same occupation or profession while an investigation or inquiry into allegations of unprofessional or unlawful conduct is in progress or after a charging document has been filed against the applicant or licensee alleging unprofessional or unlawful conduct;

(2) practicing a regulated occupation or profession in, through, or with a limited liability company which has omitted the words "limited company," "limited liability company," or the abbreviation "L.C." or "L.L.C." in the commercial use of the name of the limited liability company;

(3) practicing a regulated occupation or profession in, through, or with a limited partnership which has omitted the words "limited partnership," "limited," or the abbreviation "L.P." or "Ltd." in the commercial use of the name of the limited partnership;

(4) practicing a regulated occupation or profession in, through, or with a professional corporation which has omitted the words "professional corporation" or the abbreviation "P.C." in the commercial use of the name of the professional corporation;

(5) using a DBA (doing business as name) which has not been properly registered with the Division of Corporations and with the Division of Occupational and Professional Licensing;

(6) failing, as a prescribing practitioner, to follow the "Model Policy for the Use of Controlled Substances for the Treatment of Pain", 2004, established by the Federation of State Medical Boards, which is hereby adopted and incorporated by reference;

(7) failing, as a prescribing practitioner, to follow the "Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain", July 2013, adopted by the Federation of State Medical Boards, which is incorporated by reference; or

(8) violating any term, condition, or requirement contained in a "diversion agreement", as defined in Subsection 58-1-404(6)(a).

R156-1-502. Administrative Penalties.

(1) In accordance with Subsection 58-1-401(5) and Section 58-1-502, except as otherwise provided by a specific chapter under Title R156, the following fine schedule shall apply to citations issued under the referenced authority:

TABLE

FINE SCHEDULE

FIRST OFFENSE

Violation	Fine
58-1-501(1)(a)	$ 500.00
58-1-501(1)(c)	$ 800.00
58-1-501(2)(o)	$ 0 - $250.00

SECOND OFFENSE

58-1-501(1)(a)	$1,000.00
58-1-501(1)(c)	$1,600.00
58-1-501(2)(o)	$251.00 - $500.00

THIRD OFFENSE

Double the amount for a second offense with a maximum amount not to exceed the maximum fine allowed under Subsection 58-1-502(2)(j)(iii).

(2) Citations shall not be issued for third offenses, except in extraordinary circumstances approved by the investigative supervisor.

(3) If multiple offenses are cited on the same citation, the fine shall be determined by evaluating the most serious offense.

(4) An investigative supervisor or chief investigator may authorize a deviation from the fine schedule based upon the aggravating or mitigating circumstances.

(5) The presiding officer for a contested citation shall have the discretion, after a review of the aggravating and mitigating circumstances, to increase or decrease the fine amount imposed by an investigator based upon the evidence reviewed.

R156-1-503. Reporting Disciplinary Action.

The Division may report disciplinary action to other state or federal governmental entities, state and federal data banks, the media, or any other person who is entitled to such information under the Government Records Access and Management Act.

R156-1-506. Supervision of Cosmetic Medical Procedures.

The 80 hours of documented education and experience required under Subsection 58-1-506(2)(f)(iii) to maintain competence to perform nonablative cosmetic medical procedures is defined to include the following:

(1) the appropriate standards of care for performing nonablative cosmetic medical procedures;

(2) physiology of the skin;

(3) skin typing and analysis;

(4) skin conditions, disorders, and diseases;

(5) pre and post procedure care;

(6) infection control;

(7) laser and light physics training;

(8) laser technologies and applications;

(9) safety and maintenance of lasers;

(10) cosmetic medical procedures an individual is permitted to perform under this title;

(11) recognition and appropriate management of complications from a procedure; and

(12) current cardio-pulmonary resuscitation (CPR) certification for health care providers from one of the following organizations:

(a) American Heart Association;

(b) American Red Cross or its affiliates; or

(c) American Safety and Health Institute.

KEY: diversion programs, licensing, supervision, evidentiary restrictions

April 11, 2017 58-1-106(1)(a)

Notice of Continuation December 6, 2016 **58-1-308**
58-1-501(2)

R156. Commerce, Occupational and Professional Licensing.
R156-37f. Controlled Substance Database Act Rule.
R156-37f-101. Title.

This rule shall be known as the "Controlled Substance Database Act Rule".

R156-37f-102. Definitions.

In addition to the definitions in Sections 58-17b-102, 58-37-2 and 58-37f-102, as used in this chapter:

(1) "ASAP" means the American Society for Automation in Pharmacy system.

(2) "DEA" means Drug Enforcement Administration.

(3) "NABP" means the National Association of Boards of Pharmacy.

(4) "NCPDP" means National Council for Prescription Drug Programs.

(5) "NDC" means National Drug Code.

(6) "ORI" means Originating Agency Identifier Number.

(7) "Positive identification" means:

(a) one of the following photo identifications issued by a foreign or domestic government:

(i) driver's license;

(ii) non-driver identification card;

(iii) passport;

(iv) military identification; or

(v) concealed weapons permit; or

(b) if the individual does not have government-issued identification, alternative evidence of the individual's identity as deemed appropriate by the pharmacist, as long as the pharmacist documents in a prescription record a description of how the individual was positively identified.

(8) "Research facility" means a facility in which research takes place that has policies and procedures describing such research.

(9) "Rx" means a prescription.

R156-37f-103. Authority - Purpose.

This rule is adopted by the Division under the authority of Subsection 58-1-106(1)(a) to enable the Division to administer Title 58, Chapter 37f.

R156-37f-104. Organization - Relationship to Rule R156-1.

The organization of this rule and its relationship to Rule R156-1 is as described in Section R156-1-107.

R156-37f-203. Submission, Collection, and Maintenance of Data.

(1) The format used as a guide for submission to the Database shall be in accordance with version 4.2 of the ASAP Telecommunications Format for Controlled Substances published by the American Society for Automation in Pharmacy. The Division may approve alternative formats substantially similar to this standard. This standard is further classified by the Database as follows:

(a) Mandatory Data. The following Database data fields are mandatory:

(i) pharmacy NABP or NCPDP number;

(ii) identification number of person picking up filled prescription;

(iii) patient birth date;

(iv) patient gender code;

(v) date filled;

(vi) Rx number;

(vii) new-refill code;

(viii) metric quantity;

(ix) days supply;

(x) NDC number;

(xi) prescriber identification number;

(xii) date Rx written;

(xiii) number refills authorized;

(xiv) patient last name;

(xv) patient first name;

(xvi) patient address;

(xvii) five-digit zip code; and

(xviii) date sold (point of sale).

(b) Preferred Data. The following Database data fields are strongly suggested:

(i) compound code;

(ii) DEA suffix;

(iii) Rx origin code;

(iv) customer location;

(v) alternate prescriber number;

(vi) state in which the prescription is filled;

(vii) method of payment; and

(viii) dispensing pharmacist state license number.

(c) Optional Data. All other data fields in the ASAP 4.2 Format not included in Subsections (a) and (b) are optional.

(2) Upon request, the Division will consider approving alternative formats, or adjustments to the ASAP Format, as might be necessary due to the capability or functionality of Database collection instruments. A proposed alternative format shall contain all mandatory data elements.

(3) In accordance with Subsection 58-37f-203(1)(a), the data required in Subsection (1) shall be submitted to the Database through one of the following methods:

(a) electronic data sent via a secured internet transfer method, including sFTP site transfer;

(b) secure web base service; or

(c) any other electronic method approved by the Database manager prior to submission.

(4) In accordance with Subsection 58-37f-203(1)(a):

(a) Effective January 1, 2016, each pharmacy or pharmacy group shall submit data collected on a daily basis either in real time or daily batch file reporting. The submitted data shall be from the point of sale (POS) date.

(i) If the data is submitted by a single pharmacy entity, the data shall be submitted in chronological order according to the date each prescription was filled.

(ii) If the data is submitted by a pharmacy group, the data is required to be sorted by individual pharmacy within the group, and the data of each individual pharmacy within the group is required to be submitted in chronological order according to the date each prescription was filled.

(b)(i) A Class A, B, or D pharmacy or pharmacy group that has a controlled substance license but is not dispensing controlled substances and does not anticipate doing so in the immediate future may request a waiver or submit a certification of such, in a form preapproved by the Division, in lieu of daily null reporting.

(ii) The waiver or certification must be resubmitted at the end of each calendar year.

(iii) If a pharmacy or pharmacy group that has submitted a waiver or certification under this Subsection (4)(b) dispenses a controlled substance:

(A) the waiver or certification shall immediately and automatically terminate;

(B) the pharmacy or pharmacy group shall provide written notice of the waiver or certification termination to the Division within seven days of dispensing the controlled substance; and

(C) the Database reporting requirements shall be applicable to the pharmacy or pharmacy group immediately upon the dispensing of the controlled substance.

R156-37f-301. Access to Database Information.

In accordance with Subsections 58-37f-301(1)(a) and (b):

(1) The Division Director may designate those individuals employed by the Division who may have access to the information in the Database (Database staff).

(2)(a) A request for information from the Database may be made:

(i) directly to the Database by electronic submission, if the requester is registered to use the Database; or

(ii) by oral or written submission to the Database staff, if the requester is not registered to use the Database.

(b) An oral request may be submitted by telephone or in person.

(c) A written request may be submitted by facsimile, email, regular mail, or in person except as otherwise provided herein.

(d) The Division may in its discretion require a requestor to verify the requestor's identity.

(3) The following Database information may be disseminated to a verified requestor who is permitted to obtain the information:

(a) dispensing/reporting pharmacy ID number/name;

(b) subject's birth date;

(c) date prescription was filled;

(d) prescription (Rx) number;

(e) metric quantity;

(f) days supply;

(g) NDC code/drug name;

(h) prescriber ID/name;

(i) date prescription was written;

(j) subject's last name;

(k) subject's first name; and

(l) subject's street address;

(4)(a) Federal, state and local law enforcement authorities and state and local prosecutors requesting information from the Database under Subsection 58-37f-301(2)(k) must provide a valid search warrant authorized by the courts, which may be provided using one of the following methods:

(i) in person;

(ii) by email to csd@utah.gov;

(iii) facsimile; or

(iv) U.S. Mail.

(b) Information in the search warrant should be limited to subject's name and birth date.

(c) Information provided as a result of the search warrant shall be in accordance with Subsection (3).

(5) In accordance with Subsection 58-37f-301(2)(n), a probation or parole officer employed by the Department of Corrections or a political subdivision may have access to the database without a search warrant, for supervision of a specific probationer or parolee under the officer's direct supervision, if the following conditions have been met:

(a) a security agreement signed by the officer is submitted to the division for access, which contains:

(i) the agency's name;

(ii) the agency's complete address, including city and zip code;

(iii) the agency's ORI number;

(iv) a copy of the officer's driver's license;

(v) the officer's full name;

(vi) the officer's contact phone number;

(vii) the officer's email address; and

(b) the online database account includes the officer's:

(i) full name;

(ii) email address;

(iii) complete home address, including city and zip code;

(iv) work title;

(v) contact phone number;

(vi) complete work address including city and zip code;

(vii) work phone number; and

(viii) driver's license number.

(6)(a) In accordance with Subsection 58-37f-302(q), an individual may receive an accounting of persons or entities that have requested or received Database information about the individual.

(b) An individual may request the information in person or in writing by the following means:

(i) email;

(ii) facsimile; or

(iii) U.S. Mail.

(c) The request for information shall include the following:

(i) individuals' full name, including all aliases;

(ii) birth date;

(iii) home address;

(iv) government issued identification; and

(v) date-range.

(d) The results may be disseminated in accordance with Subsection (17).

(e) The information provided in the report may include the following:

(i) the role of the person that accessed the information;

(ii) the date and a description of the information that was accessed;

(iii) the name of the person or entity that requested the information; and

(iv) the name of the practitioner on behalf of whom the request for information was made, if applicable.

(7) An individual whose records are contained within the Database may obtain his or her own information and records by:

(a) personally appearing before the Database staff with government-issued picture identification confirming the requester's identity; or

(b) submitting a signed and notarized request that includes the requester's:

(i) full name;

(ii) complete home address;

(iii) date of birth; and

(iv) driver license or state identification card number.

(8) A requester holding power of attorney for an individual whose records are contained within the Database may obtain the individual's information and records by:

(a) personally appearing before the Database staff with government-issued picture identification confirming the requester's identity; and

(b) providing:

(i) an original, properly executed power of attorney designation; and

(ii) a signed and notarized request, executed by the individual whose information is contained within the Database, and including the individual's:

(A) full name;

(B) complete home address;

(C) date of birth; and

(D) driver license or state identification card number verifying the individual's identity.

(9) A requestor who is the legal guardian of a minor or incapacitated individual whose records are contained within the Database may obtain the individual information and records by:

(a) personally appearing before the Database staff with government-issued picture identification confirming the requester's identity;

(b) submitting the minor or incapacitated individual's:

(i) full name;

(ii) complete home address;

(iii) date of birth; and

(iv) if applicable, state identification card number verifying the individual's identity; and

(c) submitting legal proof that the requestor is the guardian of the individual who is the subject of the request for information from the Database.

(10) A requestor who has a release-of-records from an individual whose records are contained within the Database may obtain the individual's information and records by:

(a) submitting a request in writing;
(b) submitting an original, signed and notarized release-of-records in a format acceptable to the Database staff, identifying the purpose of the release; and
(c) submitting the individual's:
(i) full name;
(ii) complete home address;
(iii) telephone number;
(iv) date of birth; and
(v) driver license or state identification card number verifying the identity of the person who is the subject of the request.
(11) An employee of a licensed practitioner who is authorized to prescribe controlled substances may obtain Database information to the extent permissible under Subsection 58-37f-301(2)(i)if, prior to making the request:
(a) the licensed practitioner has provided to the Division a written designation that includes the designating practitioner's DEA number and the designated employee's:
(i) full name;
(ii) complete home address;
(iii) e-mail address;
(iv) date of birth;
(v) driver license number or state identification card number; and
(vi) the written designation is manually signed by the licensed practitioner and designated employee.
(b) the designated employee has registered for an account for access to the Database and provided a unique user identification;
(c) the designated employee has passed a Database background check of available criminal court and Database records; and
(d) the Database has issued the designated employee a user personal identification number (PIN) and activated the employee's Database account.
(12) An employee of a business that employs a licensed practitioner who is authorized to prescribe controlled substances may obtain Database information to the extent permissible under Subsection 58-37f-301(2)(i) if, prior to making the request:
(a) the licensed practitioner and employing business have provided to the Division a written designation that includes:
(i) the designating practitioner's DEA number;
(ii) the name of the employing business; and
(iii) the designated employee's:
(A) full name;
(B) complete home address;
(C) e-mail address;
(D) date of birth; and
(E) driver license number or state identification card number;
(b) the designated employee has registered for an account for access to the Database and provided a unique user identification and password;
(c) the designated employee has passed a Database background check of available criminal court and Database records; and
(d) the Database has issued the designated employee a user personal identification number (PIN) and activated the employee's Database account.
(13) An individual who is employed in the emergency room of a hospital that employs a licensed practitioner who is authorized to prescribe controlled substances may obtain Database information to the extent permissible under Subsection 58-37f-301(2)(d) if, prior to making the request:
(a) the practitioner and the hospital operating the emergency room have provided to the Division a written designation that includes:
(i) the designating practitioner's DEA number;
(ii) the name of the hospital;
(iii) the names of all emergency room practitioners employed at the hospital; and
(iv) the designated employee's:
(A) full name;
(B) complete home address;
(C) e-mail address;
(C) date of birth; and
(D) driver license number or state identification card number;
(b) the designated employee has registered for an account for access to the Database and provided a unique user identification and password;
(c) the designated employee has passed a Database background check of available criminal court and Database records; and
(d) the Database has issued the designated employee a user personal identification number (PIN) and activated the employee's Database account.
(14) In accordance with Subsection 58-37f-301(5), an individual's requests to the division regarding third-party notice when a controlled substance prescription is dispensed to that individual, shall be made as follows:
(a) A request to provide notice to a third party shall be made in writing dated and signed by the requesting individual, and shall include the following information:
(i) the requesting individual's:
(A) birth date;
(B) complete home address including city and zip code;
(C) email address; and
(D) contact phone number; and
(ii) the designated third party's:
(A) complete home address, including city and zip code;
(B) email address; and
(C) contact phone number.
(b) A request to discontinue providing notice to a designated third party shall be made by a writing dated and signed by the requesting individual, after which the division shall:
(i) provide notice to the requesting individual that the discontinuation notice was received; and
(ii) provide notice to the designated third party that the notification has been rescinded.
(c) A requesting individual may only have one active designated third party.
(15) A licensed pharmacy technician or pharmacy intern employed by a pharmacy may obtain Database information to the extent permissible under Subsection 58-37f-301(2)(l) if, prior to making the request:
(a) the pharmacist-in-charge (PIC) has provided to the Division a written designation authorizing access to the pharmacy technician or pharmacy intern on behalf of a licensed pharmacist employed by the pharmacy;
(b) the written designation includes the pharmacy technician's or pharmacy intern's:
(i) full name;
(ii) professional license number assigned by the Division;
(iii) email address;
(iv) contact phone number;
(v) pharmacy name and location;
(vi) pharmacy DEA number;
(vii) pharmacy phone number;
(c) the written designation includes the pharmacist-in-charge's (PIC's):
(i) full name;
(ii) professional license number assigned by the Division;
(iii) email address;
(iv) contact phone number;
(d) the written designation includes the assigned

pharmacist's:
(i) full name;
(ii) professional license number assigned by the Division;
(iii) email address;
(iv) contact phone number; and
(e) the written designation includes the following signatures:
(i) pharmacy technician or pharmacy intern;
(ii) pharmacist-in-charge (PIC); and
(iii) assigned pharmacist if different than the PIC.
(16) The Utah Department of Health may access Database information for purposes of scientific study regarding public health. To access information, the scientific investigator shall:
(a) demonstrate to the satisfaction of the Division that the research is part of an approved project of the Utah Department of Health;
(b) provide a description of the research to be conducted, including:
(i) a research protocol for the project; and
(ii) a description of the data needed from the Database to conduct that research;
(c) provide assurances and a plan that demonstrates all Database information will be maintained securely, with access being strictly restricted to the requesting scientific investigator;
(d) provide for electronic data to be stored on a secure database computer system with access being strictly restricted to the requesting scientific investigator; and
(e) pay all relevant expenses for data transfer and manipulation.
(17) Database information that may be disseminated under Section 58-37f-301 may be disseminated by the Database staff either:
(a) verbally;
(b) by facsimile;
(c) by email;
(d) by U.S. mail; or
(e) by electronic access, where adequate technology is in place to ensure that a record will not be compromised, intercepted, or misdirected.

R156-37f-302. Other Restrictions on Access to Database.
Subsection 58-37f-302(2), which prohibits any individual or organization with lawful access to the data from being compelled to testify with regard to the data, includes deposition testimony.

R156-37f-303. Access to Opioid Prescription Information Via an Electronic Data System.
In accordance with Subsection 58-37f-301(1) and Section 58-37f-303:
(1) Pursuant to Subsection 58-37f-303(4)(a)(i), to access opioid prescription information in the database, an electronic data system must:
(a) interface with the database through the Appriss Prescription Monitoring Program (PMP) Gateway system; and
(b) comply with all restrictions on database access and use of database information, as established by the Utah Controlled Substances Database Act and the Controlled Substance Database Act Rule.
(2) Pursuant to Subsection 58-37f-303(4)(a)(ii), to access opioid prescription information in the database via an electronic data system, an EDS user must:
(a) register to use the database;
(b) use a unique personal identification number (PIN) that is identical to the PIN the EDS user was issued to access database information through the original internet access system;
(c) comply with all restrictions on database access established by the Utah Controlled Substance Database Act and the Controlled Substance Database Act Rule; and
(d) use opioid prescription information in the database only for the purposes and uses designated in Section 58-37f-201, and as more particularly described in the Utah Controlled Substances Database Act and the Controlled Substances Database Act Rule.
(3) The division may immediately suspend, without notice or opportunity to be heard, an electronic data system's or an EDS user's access to the database, if the division determines by audit or other means that such access may lead to a violation of Section 58-37f-601 or may otherwise compromise the integrity, privacy, or security of the database's opioid prescription information. This remedy shall be in addition to the criminal and civil penalties imposed by Section 58-37f-601 for unlawful release or use of database information, and the division's obligation under Subsections 58-37f-303(5) and (6) to immediately suspend or revoke database access and pursue appropriate corrective or disciplinary action against a non-compliant electronic data system or EDS user.

KEY: controlled substance database, licensing
December 22, 2016 **58-1-106(1)(a)**
58-37f-301(1)

R156. Commerce, Occupational and Professional Licensing.
R156-44a. Nurse Midwife Practice Act Rule.
R156-44a-101. Title.

This rule is known as the "Nurse Midwife Practice Act Rule."

R156-44a-102. Definitions.

In addition to the definitions in Title 58, Chapters 1 and 44a, as used in Title 58, Chapters 1 and 44a or this rule:

(1) "Approved certified nurse midwifery education program" means an educational program which is accredited by the American Midwifery Certification Board (AMCB), affiliated with the American College of Nurse-Midwives (ACNM).

(2) "CNM" means a certified nurse midwife.

(3) "Delegation" means transferring to an individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.

(4) "Direct supervision" as used in Section 58-44a-305 means that the person providing supervision shall be available on the premises at which the supervisee or consultee is engaged in practice.

(5) "Generally recognized scope and standards of nurse midwifery" means the scope and standards of practice set forth in the "Core Competencies for Basic Midwifery Practice", June 2012, and the "Standards for the Practice of Midwifery", September 2011, published by the American College of Nurse-Midwives which are hereby adopted and incorporated by reference, or as established by the professional community.

(6) "Intrapartum referral plan":

(a) is as defined in Section 58-44a-102; and

(b) as provided in Section 58-44a-102, does not require the signature of a physician.

(7) "Supervision" in Section R156-44a-601 means the provision of guidance or direction, evaluation and follow up by the certified nurse midwife for accomplishment of tasks delegated to unlicensed assistive personnel or other licensed individuals.

(8) "Unprofessional conduct," as defined in Title 58, Chapters 1 and 44a, is further defined in Section R156-44a-502.

R156-44a-103. Authority - Purpose.

This rule is adopted by the Division under the authority of Subsection 58-1-106(1)(a) to enable the Division to administer Title 58, Chapter 44a.

R156-44a-104. Organization - Relationship to Rule R156-1.

The organization of this rule and its relationship to Rule R156-1 is as described in Section R156-1-107.

R156-44a-302. Qualifications for Licensure - Examination Requirements.

In accordance with Subsection 58-44a-302(6), the examination required for licensure is the national certifying examination administered by the American Midwifery Certification Board, Inc.

R156-44a-303. Renewal Cycle - Procedures.

(1) In accordance with Subsection 58-1-308(1), the renewal date for the two-year renewal cycle applicable to licensees under Title 58, Chapter 44a is established by rule in Section R156-1-308a(1).

(2) Renewal procedures shall be in accordance with Section R156-1-308c.

(3) Each applicant for licensure renewal shall hold a valid certification from the American Midwifery Certification Board, Inc.

R156-44a-305. Inactive Licensure.

(1) A licensee may apply for inactive licensure status in accordance with Sections 58-1-305 and R156-1-305.

(2) To reactivate a license which has been inactive for five years or less, the licensee must document current compliance with the continuing competency requirements as established in Subsection R156-44a-303(3).

(3) To reactivate a license which has been inactive for more than five years, the licensee must document one of the following:

(a) active licensure in another state or jurisdiction;

(b) completion of a refresher program approved by the American College of Nurse Midwives; or

(c) passing score on the required examinations as defined in Section R156-44a-302 within six months prior to making application to reactivate a license.

R156-44a-402. Administrative Penalties.

In accordance with Subsections 58-44a-102(1) and 58-44a-402(1), unless otherwise ordered by the presiding officer, the following fine schedule shall apply.

(1) Engaging in practice as a CNM or RN when not licensed or exempt from licensure: initial offense: $2,000 - $5,000
subsequent offense(s): $5,000 - $10,000

(2) Representing oneself as a CNM or RN when not licensed:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(3) Using any title that would indicate that one is licensed under this chapter:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(4) Practicing or attempting to practice nursing without a license or with a restricted license:
initial offense: $2,000 - $5,000
subsequent offense(s): $5,000 - $10,000

(5) Impersonating a licensee or practicing under a false name:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(6) Knowingly employing an unlicensed person:
initial offense: $500 - $1,000
subsequent offense(s): $1,000 - $5,000

(7) Knowingly permitting the use of a license by another person:
initial offense: $500 - $1,000
subsequent offense(s): $1,000 - $5,000

(8) Obtaining a passing score, applying for or obtaining a license, or otherwise dealing with the Division or board through the use of fraud, forgery, intentional deception, misrepresentation, misstatement, or omission:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(9) Violating or aiding or abetting any other person to violate any statute, rule, or order regulating nurse midwifery:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(10) Violating, or aiding or abetting any other person to violate any generally accepted professional or ethical standard:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(11) Engaging in conduct that results in convictions or, or a plea of nolo contendere to a crime of moral turpitude or other crime:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000

(12) Engaging in conduct that results in disciplinary action by any other jurisdiction or regulatory authority:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

(13) Engaging in conduct, including the use of intoxicants, drugs to the extent that the conduct does or may impair the ability to safely engage in practice as a CNM:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(14) Practicing or attempting to practice as a CNM when physically or mentally unfit to do so:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(15) Practicing or attempting to practice as a CNM through gross incompetence, gross negligence, or a pattern of incompetency or negligence:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000
(16) Practicing or attempting to practice as a CNM by any form of action or communication which is false, misleading, deceptive, or fraudulent:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(17) Practicing or attempting to practice as a CNM beyond the individual's scope of competency, abilities, or education:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(18) Practicing or attempting to practice as a CNM beyond the scope of licensure:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(19) Verbally, physically, mentally, or sexually abusing or exploiting any person through conduct connected with the licensee's practice:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(20) Disregarding for a patient's dignity or right to privacy as to his person, condition, possessions, or medical record:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(21) Engaging in an act, practice, or omission which does or could jeopardize the health, safety, or welfare of a patient or the public:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000
(22) Failing to confine one's practice to those acts permitted by law:
initial offense: $500 - $2,000
subsequent offense(s): $2,000 - $10,000
(23) Failure to file or impeding the filing of required reports:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000
(24) Breach of confidentiality:
initial offense: $200 - $1,000
subsequent offense(s): $500 - $2,000
(25) Failure to pay a penalty:
Double the original penalty amount up to $10,000
(26) Prescribing a Schedule II-III controlled substance without a consulting physician or outside of a consultation and referral plan:
initial offense: $500 - $1,000
subsequent offense(s): $500 - $2,000
(27) Failure to have and maintain a safe mechanism for obtaining medical consultation, collaboration, and referral with a consulting physician, including failure to identify one or more consulting physicians in the written documents required by Subsection 58-44a-102(9)(b)(iii):
initial offense: $500 - $1,000
subsequent offense(s): $500 - $2,000
(28) Representing that the certified nurse midwife is in compliance with Subsection 58-44a-502(8)(a) when the certified nurse midwife is not in compliance with Subsection 58-44a-502(8)(a):
initial offense: $500 - $1,000
subsequent offense(s): $500 - $2,000
(29) Any other conduct which constitutes unprofessional or unlawful conduct:
initial offense: $100 - $500
subsequent offense(s): $200 - $1,000

R156-44a-502. Unprofessional Conduct.

"Unprofessional conduct" includes failure to abide by the "Code of Ethics" published by the American College of Nurse-Midwives, October 2008, which is hereby adopted and incorporated by reference.

R156-44a-601. Delegation of Nursing Tasks.

In accordance with Subsection 58-44a-102(11), the delegation of nursing tasks is further defined, clarified, or established as follows:
(1) The certified nurse midwife delegating tasks retains the accountability for the appropriate delegation of tasks and for the nursing care of the patient/client. The licensed nurse shall not delegate any task requiring the specialized knowledge, judgment and skill of a licensed nurse to an unlicensed assistive personnel. It is the licensed nurse who shall use professional judgment to decide whether or not a task is one that must be performed by a nurse or may be delegated to an unlicensed assistive personnel. This precludes a list of nursing tasks that can be routinely and uniformly delegated for all patients/clients in all situations. The decision to delegate must be based on careful analysis of the patient's/client's needs and circumstances.
(2) The licensed nurse who is delegating a nursing task shall:
(a) verify and evaluate the orders;
(b) perform a nursing assessment;
(c) determine whether the task can be safely performed by an unlicensed assistive personnel or whether it requires a licensed health care provider;
(d) verify that the delegatee has the competence to perform the delegated task prior to performing it;
(e) provide instruction and direction necessary to safely perform the specific task; and
(f) provide ongoing supervision and evaluation of the delegatee who is performing the task.
(3) The delegator shall evaluate the situation to determine the degree of supervision required to ensure safe care.
(a) The following factors shall be evaluated to determine the level of supervision needed:
(i) the stability of the condition of the patient/client;
(ii) the training and capability of the delegatee;
(iii) the nature of the task being delegated; and
(iv) the proximity and availability of the delegator to the delegatee when the task will be performed.
(b) The delegating nurse or another qualified nurse shall be readily available either in person or by telecommunication. The delegator responsible for the care of the patient/client shall make supervisory visits at appropriate intervals to:
(i) evaluate the patient's/client's health status;
(ii) evaluate the performance of the delegated task;
(iii) determine whether goals are being met; and
(iv) determine the appropriateness of continuing delegation of the task.
(4) Nursing tasks, to be delegated, shall meet the following criteria as applied to each specific patient/client situation:
(a) be considered routine care for the specific patient/client;
(b) pose little potential hazard for the patient/client;
(c) be performed with a predictable outcome for the patient/client;
(d) be administered according to a previously developed

plan of care; and

(e) not inherently involve nursing judgment which cannot be separated from the procedure.

(5) If the nurse, upon review of the patient's/client's condition, complexity of the task, ability of the unlicensed assistive personnel and other criteria as deemed appropriate by the nurse, determines that the unlicensed assistive personnel cannot safely provide care, the nurse shall not delegate the task.

R156-44a-609. Standards for Out-of-State Programs Providing Certified Nurse Midwife Clinical Experiences in Utah.

(1) In order to qualify for the exemption set forth in Subsection 58-1-304(1)(b), approval of a nurse midwifery education program located in another state that uses Utah health care facilities for clinical experiences with certified nurse midwives for one or more students shall, prior to placing a student, submit a request for approval in writing to the Certified Nurse Midwife Board and demonstrate to the satisfaction of the Board that the program:

(a) has been approved, if required, by the regulatory body responsible for certified nurse midwives in the program's home state;

(b) holds current accreditation from the Accreditation Commission for Midwifery Education (ACME);

(c) has clinical faculty who are employed by the nurse midwifery education program;

(d) is affiliated with an institution of higher education; and

(e) has established criteria for selection and supervision of:

(i) onsite preceptors; and

(ii) the clinical activities.

(2) Following approval by the Board, the nurse midwifery program shall:

(a) reapply for Board review and approval when the program's ACME accreditation is reaffirmed; and

(b) notify the Board, in writing, of any change in its accreditation status.

KEY: licensing, midwifery, certified nurse midwife

May 11, 2015	**58-1-106(1)(a)**
Notice of Continuation January 16, 2014	**58-1-202(1)(a)**
	58-44a-101

R156. Commerce, Occupational and Professional Licensing.
R156-46b. Division Utah Administrative Procedures Act Rule.
R156-46b-101. Title.

This rule is known as the "Division Utah Administrative Procedures Act Rule."

R156-46b-103. Authority - Purpose.

This rule is adopted by the Division under the authority of Title 63G, Chapter 4, Subsection 58-1-108(1), and Subsection 58-1-106(1)(a). The purposes of this rule include:

(a) classifying Division adjudicative proceedings;

(b) clarifying the identity of presiding officers at Division adjudicative proceedings; and

(c) defining procedures for Division adjudicative proceedings which are consistent with the requirements of Titles 58 and 63G and Rule R151-4.

R156-46b-201. Formal Adjudicative Proceedings.

(1) The following adjudicative proceedings initiated by a request for agency action are classified as formal adjudicative proceedings:

(a) special appeals board held in accordance with Section 58-1-402;

(b) declaratory order determining the applicability of statute, rule or order to specified circumstances, when determined by the director to be conducted as a formal adjudicative proceeding; and

(c) board of appeal held in accordance with Subsection 15A-1-207(3).

(2) The following adjudicative proceedings initiated by a Notice of Agency Action are classified as formal adjudicative proceedings:

(a) disciplinary proceedings, except those classified as informal proceedings under Section R156-46b-202, that result in the following sanctions:

(i) revocation of licensure;

(ii) suspension of licensure;

(iii) restricted licensure;

(iv) probationary licensure;

(v) issuance of a cease and desist order except when imposed through a citation;

(vi) administrative fine except when imposed through a citation; and

(vii) issuance of a public reprimand;

(b) unilateral modification of a disciplinary order; and

(c) termination of diversion agreements.

R156-46b-202. Informal Adjudicative Proceedings.

(1) The following adjudicative proceedings initiated by other than a notice of agency action are classified as informal adjudicative proceedings:

(a) approval of application for initial licensure, renewal or reinstatement of licensure, or relicensure;

(b) denial of application for initial licensure or relicensure;

(c) denial of application for renewal or reinstatement of licensure;

(d) approval or denial of application for inactive or emeritus licensure status;

(e) board of appeal under Subsection 15A-1-207(3);

(f) approval or denial of claims against the Residence Lien Recovery Fund created under Title 38, Chapter 11;

(g) payment of approved claims against the Residence Lien Recovery Fund described in Subparagraph (g);

(h) approval or denial of request to surrender licensure;

(i) approval or denial of request for entry into diversion program under Section 58-1-404;

(j) matters relating to diversion program;

(k) citation hearings held in accordance with citation authority established under Title 58;

(l) approval or denial of request for modification of disciplinary order;

(m) declaratory order determining the applicability of statute, rule or order to specified circumstances, when determined by the director to be conducted as an informal adjudicative proceeding;

(n) approval or denial of request for correction of procedural or clerical mistakes;

(o) approval or denial of request for correction of other than procedural or clerical mistakes;

(p) disciplinary sanctions imposed in a stipulation or memorandum of understanding with an applicant for licensure;

(q) approval or denial of application for a tax credit certificate by a psychiatrist, psychiatric mental health nurse practitioner, or volunteer retired psychiatrist under Section 58-1-111; and

(r) all other requests for agency action permitted by statute or rule governing the Division not specifically classified as formal adjudicative proceedings in Subsection R156-46b-201(1).

(2) The following adjudicative proceedings initiated by a notice of agency action are classified as informal adjudicative proceedings:

(a) nondisciplinary proceeding which results in cancellation of licensure;

(b) disciplinary proceedings against:

(i) a contractor, plumber, electrician, or alarm company licensed under Title 58, Chapter 55;

(ii) a controlled substance licensee under Subsection 58-37-6(4)(g); and

(iii) a contract security company or armored car company for failure to replace a qualifier as required under Section 58-63-306.

(c) disciplinary proceedings initiated by a notice of agency action and order to show cause concerning violations of an order governing a license;

(d) disciplinary proceedings initiated by a notice of agency action in which the allegations of misconduct are limited to one or more of the following:

(i) Subsection 58-1-501(2)(c) or (d); or

(ii) Subsections R156-1-501(1) through (5).

R156-46b-301. Designation.

The presiding officers for Division adjudicative proceedings are as defined at Subsection 63G-4-103(1)(h) and as specifically established by Section 58-1-109 and by Section R156-1-109.

R156-46b-401. In General.

(1) The procedures for formal Division adjudicative proceedings are set forth in Sections 63G-4-204 through 63G-4-208, Rule R151-4-114, and this rule.

(2) The procedures for informal Division adjudicative proceedings are set forth in Section 63G-4-203, Rule R151-4-114, and this rule.

R156-46b-402. Response to Notice of Agency Action in an Informal Proceeding.

A written response or answer to the allegations in a notice of agency action or incorporated by reference into a notice of agency action that initiates an informal adjudicative proceeding may, as set forth in a notice of agency action, be required to be filed within 30 days of the mailing date of the notice of agency action or other date specified in the notice of agency action.

R156-46b-403. Evidentiary Hearings in Informal Adjudicative Proceedings.

(1) Evidentiary hearings are not required for informal

Division adjudicative proceedings unless required by statute or rule, or permitted by rule and requested by a party within the time prescribed by rule.

(2) Unless otherwise provided, a request for an evidentiary hearing permitted by rule must be submitted in writing no later than 20 days following the issuance of the notice of agency action if the proceeding was initiated by the Division, or together with the request for agency action if the proceeding was not initiated by the Division.

(3) An evidentiary hearing is required for the following informal proceedings:

(a) R156-46b-202(1)(f), board of appeal held in accordance with Subsection 15A-1-207(3); and

(b) R156-46b-202(1)(l), citation hearings held in accordance with Title 58.

(4) An evidentiary hearing is permitted for an informal proceeding pertaining to matters relating to a diversion program in accordance with R156-46b-202(1)(k).

(5) Unless otherwise agreed by the parties, no evidentiary hearing shall be held in an informal adjudicative proceeding unless timely notice of the hearing has been served upon the parties as required by Subsection 63G-4-203(1)(d). Timely notice means service of a Notice of Hearing upon all parties not later than ten days prior to any scheduled evidentiary hearing.

(6) Parties shall be permitted to testify, present evidence, and comment on the issues at an evidentiary hearing in a Division informal adjudicative proceeding.

R156-46b-404. Orders in Informal Adjudicative Proceedings.

(1) Orders issued in Division informal adjudicative proceedings shall comply with Subsection 63G-4-203(1)(i).

(2) Issuance of a license or approval of related requests in response to a request for agency action is sufficient to satisfy the requirements of Subsection 63G-4-203(1)(i).

(3) Issuance of a letter denying a license or related requests is sufficient to satisfy the requirements of Subsection 63G-4-203(1)(i). The letter must explain the reasons for the denial and the rights of the parties to seek agency review, including the time limits for requesting review.

(4) Unless otherwise specified by the director, the fact finder who serves as the presiding officer at an evidentiary hearing convened in Division informal adjudicative proceedings shall issue a final order.

(5) Orders issued in Division informal adjudicative proceedings in which an evidentiary hearing is convened shall comply with the requirements of Subsection 63G-4-208(1).

R156-46b-405. Informal Agency Advice.

(1) The Division may issue an informal guidance letter in response to a request for advice unless the request specifically seeks a declaratory order.

(2) A notice shall appear in the informal guidance letter notifying the subject of the letter that the letter is an informal guidance letter only and is not intended as a formal declaratory order. The notice shall also provide the citation where the requirements which govern declaratory orders are found.

KEY: administrative procedures, government hearings, occupational licensing
March 13, 2017 63G-4-102(6)
Notice of Continuation January 5, 2016 58-1-106(1)(a)

R156. Commerce, Occupational and Professional Licensing.
R156-47b. Massage Therapy Practice Act Rule.
R156-47b-101. Title.

This rule is known as the "Massage Therapy Practice Act Rule."

R156-47b-102. Definitions.

In addition to the definitions in Title 58, Chapters 1 and 47b, as used in Title 58, Chapters 1 and 47b, or this rule:

(1) "Accrediting agency" means an organization, association or commission nationally recognized by the United States Department of Education as a reliable authority in assessing the quality of education or training provided by the school or institution.

(2) "Body wrap" means a body treatment that:

(a) may include one or more therapeutic preparations;

(b) is not for cosmetic purposes; and

(c) maintains modesty by draping the body fully or partially.

(3) "Clinic" means performing the techniques and skills learned as a student under the curriculum of a registered school or an accredited school on the public, while in a supervised student setting.

(4) "Direct supervision" as used in Subsection 58-47b-302(3)(e) means that the apprentice supervisor, acting within the scope of the supervising licensee's license, is in the facility where massage is being performed and directs the work of an apprentice pursuant to this chapter under Subsection R156-1-102a(4)(a) while the apprentice is engaged in performing massage.

(5) "Distance learning" means the acquisition of knowledge and skills through information and instruction encompassing all technologies and other forms of learning at a distance, outside a school of massage meeting the standards in Section R156-47b-302 including internet, audio/visual recordings, mail or other correspondence.

(6) "FSMTB" means the Federation of State Massage Therapy Boards.

(7) "Hands on instruction" means direct experience with or application of the education or training in either a school of massage therapy or apprenticeship.

(8) "Industry organization", as used in Subsection 58-47b-304(1)(m), means any of the following organizations:

(a) American FootZonology Practitioners Association (AFZPA);

(b) American Reflexology Certification Board (ARCB);

(c) Butterfly Expressions, LLC;

(d) Reflexology Association of America (RAA);

(e) Society of Ortho-Bionomy International; or

(f) Utah Foot Zone Association.

(9) "Lymphatic massage" means a method using light pressure applied by the hands to the skin in specific maneuvers to promote drainage of the lymphatic fluid from the tissue.

(10) "Manipulation", as used in Subsection 58-47b-102(6)(b), means contact with movement, involving touching the clothed or unclothed body.

(11) "Massage client services" means practicing the techniques and skills learned as an apprentice on the public in training under direct supervision.

(12) "NCBTMB" means the National Certification Board for Therapeutic Massage and Bodywork.

(13) "Recognized school" means a school located in a state other than Utah, whose students, upon graduation, are recognized as having completed the educational requirements for licensure in that jurisdiction.

(14) "Unprofessional conduct" as defined in Title 58, Chapters 1 and 47b, is further defined, in accordance with Subsection 58-1-203(1)(e) in Section R156-47b-502.

R156-47b-103. Authority - Purpose.

This rule is adopted by the Division under the authority of Subsection 58-1-106(1)(a) to enable the Division to administer Title 58, Chapter 47b.

R156-47b-104. Organization - Relationship to Rule R156-1.

The organization of this rule and its relationship to Rule R156-1 is as described in Section R156-1-107.

R156-47b-202. Massage Therapy Education Peer Committee.

(1) There is created under Subsection 58-1-203(1)(f), the Massage Therapy Education Peer Committee.

(a) The Education Peer Committee shall:

(i) advise the Utah Board of Massage Therapy regarding massage therapy educational issues;

(ii) recommend to the Board standards for massage school curricula, apprenticeship curricula, and animal massage training; and

(iii) periodically review the current curriculum requirements.

(b) The composition of this committee shall be:

(i) two individuals who are instructors in massage therapy;

(ii) two individuals, one who represents a professional massage therapy association, and one who represents the Utah Committee of Bodywork Schools; and

(iii) one individual from the Utah State Office of Education.

R156-47b-302. Qualifications for Licensure as a Massage Therapist - Massage School Curriculum Standards.

In accordance with Subsection 58-47b-302(2)(e)(i)(A), an applicant must graduate from a school of massage with a curriculum, which at the time of graduation, meets the standards set forth in this section.

(1) Curricula shall:

(a) be registered with the Utah Department of Commerce, Division of Consumer Protection; or

(b) be registered with an accrediting agency recognized by the United States Department of Education.

(2) Curricula shall be a minimum of 600 hours and shall include the following:

(a) anatomy, physiology and kinesiology - 125 hours;

(b) pathology - 40 hours;

(c) massage theory, massage techniques including the five basic Swedish massage strokes, and hands on instruction - 285 hours;

(d) professional standards, ethics and business practices - 35 hours;

(e) sanitation and universal precautions including CPR and first aid - 15 hours;

(f) clinic - 100 hours; and

(g) other related massage subjects as approved by the Division in collaboration with the Board.

(3) The Division, in collaboration with the Board, may consider supplemental coursework of an applicant who has completed the minimum 600 curricula hours, but has incidental deficiencies in one or more of the categories specified in R156-47b-302(2)(a) through (f).

R156-47b-302a. Qualifications for Licensure - Equivalent Education and Training.

(1) In accordance with Subsection 58-47b-302(2)(e)(i)(B), an applicant who completes equivalent education and training must provide documentation of:

(a)(i) graduation from a licensed or recognized school outside the state of Utah with a minimum of 500 hours;

(ii) completion of the examination requirements; and

(iii) practice as a licensed massage therapist for a

minimum of three years; or

(b)(i) foreign education and training approval by:

(A) Josef Silny and Associates, Inc.;

(B) International Education Consultants; or

(C) Educational Credential Evaluators, Inc.; and

(ii) practice as a licensed massage therapist for a minimum of three years; or

(c)(i) completion of an apprenticeship program outside the state of Utah, deemed substantially equivalent as determined by the Division, in collaboration with the Board of Massage Therapy;

(ii) completion of the examination requirements; and

(iii) practice as a licensed massage therapist for a minimum of three years.

(2) Hours of supervised training while licensed as a massage therapy apprentice trained in accordance with Subsection R156-47b-302c(5) may not be used to satisfy any of the required minimum of 600 hours of school instruction specified in Section R156-47b-302(2).

(3) Hours of instruction or training obtained while enrolled in a school of massage having a curriculum meeting the standards in accordance with Section R156-47b-302(2) may not be used to satisfy the required minimum of 1,000 hours of supervised apprenticeship training specified in Subsection R156-47b-302c(5).

R156-47b-302b. Qualifications for Licensure - Examination Requirements.

In accordance with Subsections 58-47b-302(2)(f) and 58-47b-302(3)(f), the examination requirements for licensure are defined, clarified, or established as follows:

(1) Applicants for licensure as a massage therapist shall pass the Federation of State Massage Therapy Boards (FSMTB) Massage and Bodywork Licensing Examination (MBLEx).

(2) Predecessor exams shall be accepted if the exam was passed during the time the exam was accepted by the Division.

R156-47b-302c. Apprenticeship Standards for a Supervisor.

In accordance with Subsection 58-47b-302(2)(e)(ii), an apprentice supervisor shall:

(1) not begin an apprenticeship program until:

(a) the apprentice is licensed; and

(b) the supervisor is approved by the Division;

(2) not begin a new apprenticeship program until:

(a) the apprentice being supervised passes the FSMTB MBLEx and becomes licensed as a massage therapist, unless otherwise approved by the Division in collaboration with the Board; and

(b) the supervisor complies with subsection (1);

(3) if an apprentice being supervised fails the FSMTB MBLEx three times:

(a) together with the apprentice being supervised, meet with the Board at the next appropriate Board meeting;

(b) explain to the Board why the apprentice is not able to pass the examination;

(c) provide to the Board a plan of study in the appropriate subject matter to assist the apprentice in passing the examination; and

(d) upon successful completion of the review as provided in Subsection (3)(c), the apprentice shall again be eligible to take the FSMTB MBLEx;

(4) supervise not more than two apprentices at one time, unless otherwise approved by the Division in collaboration with the Board;

(5) train the massage apprentice in the areas of:

(a) anatomy, physiology and kinesiology - 125 hours;

(b) pathology - 40 hours;

(c) massage theory - 50 hours;

(d) massage techniques including the five basic Swedish massage strokes - 120 hours;

(e) massage client service - 300 hours;

(f) hands on instruction - 310 hours;

(g) professional standards, ethics and business practices - 40 hours; and

(h) sanitation and universal precautions including CPR and first aid - 15 hours;

(6) submit a curriculum content outline with the apprentice application, including a list of the resource materials to be used;

(7) display a conspicuous sign near the work station of the apprentice stating "Apprentice in Training";

(8) keep a daily record which shall include:

(a) the number of hours of instruction and training completed;

(b) the number of hours of client services performed; and

(c) the number of hours of training completed;

(9) make available to the Division upon request, the apprentice's training records;

(10) verify the completion of the apprenticeship program on forms available from the Division;

(11) notify the Division within ten working days if the apprenticeship program is terminated;

(12) must not have been disciplined for any unprofessional or unlawful conduct within five years of the start of any apprenticeship program; and

(13) ensure that the massage client services required in Subsection (5)(d) only be performed on the public; all other hands on instruction or practice must be performed by the apprentice on an apprentice or supervisor.

R156-47b-302d. Good Moral Character - Disqualifying Convictions.

(1) When reviewing an application to determine the good moral character of an applicant as set forth in Subsection 58-47b-302(2)(c) and whether the applicant has been involved in unprofessional conduct as set forth in Subsections 58-1-501(2)(c), the Division and the Board shall consider the applicant's criminal record as follows:

(a) a criminal conviction for a sex offense as defined in Title 76, Chapter 5, Part 4 and Chapter 5a, and Title 76, Chapter 10, Parts 12 and 13, may disqualify an applicant from becoming licensed; or

(b) a criminal conviction for the following crimes may disqualify an applicant for becoming licensed:

(i) crimes against a person as defined in Title 76, Chapter 5, Parts 1, 2 and 3;

(ii) crimes against property as defined in Title 76, Chapter 6, Parts 1 through 6;

(iii) any offense involving controlled dangerous substances; or

(iv) conspiracy to commit or any attempt to commit any of the above offenses.

(2) An applicant who has a criminal conviction for a felony crime of violence may be considered ineligible for licensure for a period of seven years from the termination of parole, probation, judicial proceeding or date of incident, whichever is later.

(3) An applicant who has a criminal conviction for a felony involving a controlled substance may be considered ineligible for licensure for a period of five years from the termination of parole, probation, judicial proceeding or date of incident, whichever is later.

(4) An applicant who has a criminal conviction for any misdemeanor crime of violence or the use of a controlled substance may be considered ineligible for licensure for a period of three years from the termination of parole, probation, judicial proceeding or date of incident, whichever is later.

(5) Each application for licensure or renewal of licensure shall be considered in accordance with the requirements of

Section R156-1-302.

R156-47b-302e. Standards for an Apprentice.

In accordance with Subsection 58-47b-302(2)(e)(ii), an apprentice shall:

(1) not begin an apprenticeship program until:

(a) the apprentice is licensed; and

(b) the supervisor is approved by the Division;

(2) obtain training from an approved apprentice supervisor in the areas of:

(a) anatomy, physiology and kinesiology - 125 hours;

(b) pathology - 40 hours;

(c) massage theory - 50 hours;

(d) massage techniques including the five basic Swedish massage strokes - 120 hours;

(e) massage client service - 300 hours;

(f) hands on instruction - 310 hours;

(g) professional standards, ethics and business practices - 40 hours; and

(h) sanitation and universal precautions including CPR and first aid - 15 hours;

(3) follow the approved curriculum content outline:

(a) submitted with the apprentice application including the list of the resource materials to be used; or

(b) previously submitted by the approved supervisor meeting current requirements including the list of the resource materials to be used;

(4) display a conspicuous sign near the work station of the apprentice stating "Apprentice in Training";

(5) keep a daily record which shall include:

(a) the number of hours of instruction and training completed;

(b) the number of hours of client services performed; and

(c) the number of hours of training completed;

(6) make available to the Division, upon request, the training records;

(7) verify the completion of the apprenticeship program on forms available from the Division;

(8) notify the Division within ten working days if the apprenticeship program is terminated; and

(9) perform the massage client services required in Subsection (2)(d) only on the public under direct supervision; all other hands on instruction or practice must be performed by the apprentice on an apprentice or supervisor.

R156-47b-303. Renewal Cycle - Procedures.

(1) In accordance with Subsection 58-1-308(1)(a), the renewal date for the two-year renewal cycle applicable to licensees under Title 58, Chapter 47b is established by rule in Section R156-1-308a.

(2) Renewal procedures shall be in accordance with Sections R156-1-308c through R156-1-308e.

R156-47b-502. Unprofessional Conduct.

"Unprofessional conduct" includes:

(1) engaging in any lewd, indecent, obscene or unlawful behavior while acting as a massage therapist;

(2) as an apprentice supervisor, failing to provide direct supervision to a massage apprentice;

(3) practicing as a massage apprentice without direct supervision in accordance with Subsection 58-47b-102(4);

(4) as an apprentice supervisor, failing to provide and document adequate instruction or training as applicable;

(5) as an apprentice supervisor, advising, directing or instructing an apprentice in any instruction or behavior that is inconsistent, contrary or contradictory to established professional or ethical standards of the profession;

(6) failing to notify a client of any health condition the licensee may have that could present a hazard to the client;

(7) failure to use appropriate draping procedures to protect the client's personal privacy; and

(8) failing to conform to the generally accepted and recognized standards and ethics of the profession including those established in the Utah Chapter of the American Massage Therapy Association "Utah Code of Ethics and Standards of Practice", September 17, 2005 edition, which is hereby incorporated by reference.

R156-47b-503. Administrative Penalties - Unlawful Conduct.

In accordance with Subsection 58-1-501(1)(a) and (c), unless otherwise ordered by the presiding officer, the fine schedule in Section R156-1-502 shall apply to citations issued under Title 58, Chapter 47b.

R156-47b-601. Standards for Animal Massage Training.

In accordance with Subsection 58-28-307(12)(c), a massage therapist practicing animal massage shall have received 60 hours of training in the following areas:

(1) quadruped anatomy;

(2) the theory of quadruped massage; and

(3) supervised quadruped massage experience.

KEY: licensing, massage therapy, massage therapist, massage apprentice

March 8, 2016	**58-1-106(1)(a)**
Notice of Continuation April 4, 2017	**58-1-202(1)(a)**
	58-47b-101

R156. Commerce, Occupational and Professional Licensing.
R156-55c. Plumber Licensing Act Rule.
R156-55c-101. Title.

This rule is known as the "Plumber Licensing Act Rule".

R156-55c-102. Definitions.

In addition to the definitions in Title 58, Chapters 1 and 55, as used in Title 58, Chapters 1 and 55 or this rule:

(1) "Immediate supervision", as used in Subsections 58-55-102(5) and 58-55-102(23) and this rule, means the apprentice and the supervising plumber are physically present on the same project or job site but are not required to be within sight of one another.

(2) "Minor plumbing work that is incidental", as used in Subsection 58-55-305(1)(k)(i) and this rule, means:

(a) installation, repair or replacement of the following residential type Plumbing Appliances:

(i) dishwashers;

(ii) refrigerators;

(iii) freezers;

(iv) ice makers;

(v) stoves;

(vi) ranges;

(vii) clothes washers;

(viii) clothes dryers; and

(b) repair or replacement of the following residential type Plumbing Appurtenances, Fixtures and Systems, when the cost of the repair or replacement does not exceed $300 in total value, including all labor and materials, and including all changes or additions to the contracted or agreed upon work:

(i) tub or shower trim;

(ii) tub or shower valve;

(iii) toilet flush valve;

(iv) toilet removal and reset;

(v) garbage disposal;

(vi) kitchen or lavatory sink P-trap;

(vii) kitchen or lavatory faucet rebuild and install;

(viii) supply line replacement after the fixture valve; and

(3) "Minor plumbing work that is incidental", as used in Subsection 58-55-305(1)(k)(i), does not include installation or replacement of a water heater, or work to include the initial installation of Plumbing Appurtenances, Fixtures and Systems.

(4) Plumbing Appliances, Appurtenances, Fixtures, and Systems, as used in this rule, shall have the same meaning as defined by Title 15A, State Construction and Fire Codes Act.

(5) "Unprofessional conduct" as defined in Title 58, Chapters 1 and 55, is further defined in accordance with Subsection 58-1-203(1)(e), in Subsection R156-55c-501.

R156-55c-103. Authority - Purpose.

This rule is adopted by the Division under the authority of Subsection 58-1-106(1)(a) to enable the Division to administer Title 58, Chapter 55.

R156-55c-104. Organization - Relationship to Rule R156-1.

The organization of this rule and its relationship to Rule R156-1 is as described in Section R156-1-107.

R156-55c-302a. Qualification for Licensure - Training and Instruction Requirement.

In accordance with Subsections 58-1-203(2) and 58-1-301(3), the training and instruction requirements for licensure in Subsection 58-55-302(3)(c) and (d) are defined, clarified, or established as follows:

(1) An applicant for a journeyman plumber's license shall demonstrate successful completion of the requirements of either paragraph (a) or (b):

(a)(i) 8,000 hours of training and instruction in not less than four years that meets the requirements of Subsections R156-55c-302a(4) and (6).

(ii) the 8,000 hours shall include 576 clock hours of related classroom instruction that meets the requirements of Subsection R156-55c-302a(5);

(iii) the apprenticeship shall be obtained while licensed as an apprentice plumber;

(iv) the apprenticeship shall include on the job training and instruction in nine of the 11 work process areas listed in Table I; and

(v) the hours obtained in any work process area shall be at least the number of hours listed in Table I.

(b)(i) 16,000 hours of on the job training and instruction in not less than eight years;

(ii) the apprenticeship shall be obtained while licensed as an apprentice plumber;

(iii) the hours shall include on the job training and instruction in nine of the 11 work process areas listed in Table I; and

(iv) the hours obtained in any work process shall be at least the number of hours listed in Table I.

TABLE I
Training and Instruction

Work Process		Minimum Hours
A.	Use of hand tools, equipment and pipe machinery	200
B.	Installation of piping for waste, soil, sewer and vent lines	2,000
C.	Installation of hot and cold water for domestic purposes	1,400
D.	Installation and setting of plumbing appliances and fixtures	1,200
E.	Maintenance and repair of plumbing	600
F.	General pipe work including process and industrial hours	600
G.	Gas piping or service piping	400
H.	Welding, soldering and brazing as it applies to the trade	100
I.	Service and maintenance of gas controls and equipment	100
J.	Hydronics piping and equipment installation	300
K.	Fire suppression system installation	100

(2) An applicant for a residential journeyman plumber's license shall demonstrate successful completion of the requirements of paragraph (a) or (b):

(a)(i) 6,000 hours of training and instruction in not less than three years that meets the requirements of Subsections R156-55c-302a(4) and (6).

(ii) the 6,000 hours shall include 432 clock hours of related classroom instruction that meets the requirements of Subsection R156-55c-302a(5);

(iii) the 6,000 hours shall be obtained while licensed as an apprentice plumber;

(iv) the apprenticeship shall include on the job training and instruction in eight of the ten work process areas listed in Table II; and

(v) the hours obtained in any work process area shall include at least the number of hours listed in Table II.

(b)(i) 12,000 hours of experience in not less than six years which has been documented using a form provided by the Division;

(ii) the experience shall be obtained while licensed as an apprentice plumber;

(iii) at least 9,000 hours of experience shall be directly involved in the plumbing trade;

(iv) the hours shall be in eight of the ten work process areas listed in Table II; and

(v) the hours obtained in any work process area shall include at least the number of hours listed in Table II.

TABLE II

Training and Instruction

Work Process	Minimum Hours
A. Use of hand tools, equipment and pipe machinery	100
B. Installation of piping for waste, soil, sewer and vent lines	1,600
C. Installation of hot and cold water for domestic purposes	1,200
D. Installation and setting of plumbing appliances and fixtures	800
E. Maintenance and repair of plumbing	600
F. Gas piping or service piping	400
G. Service and maintenance of gas controls and equipment	100
H. Welding, soldering and brazing as it applies to the trade	100
I. Hydronics piping and equipment installation	300
J. Fire suppression system installation	100

(3) A licensed residential journeyman plumber applying for a journeyman plumber's license shall complete 2,000 hours of on the job training in industrial or commercial plumbing while licensed as an apprentice plumber, which shall include successful completion of an approved fourth year course of classroom instruction.

(4) On the job training and instruction required in this section shall include measurements of an apprentice's performance in the plumbing trade.

(5) Formal classroom instruction required by this section shall meet the following requirements:

(a) instruction shall be conducted by an entity approved by the Utah Board of Regents, Utah College of Applied Technology Board of Trustees or by another similar out of state body that approves formal plumbing educational programs; and

(b) instruction shall be conducted by competent qualified staff and shall include measures of competency and achievement level of each apprentice.

(6) Apprentice plumbers shall engage in the plumbing trades only in accordance with the following:

(a) except as provided in Subsection 58-55-302(3)(e)(ii) for fourth through tenth year apprentices, while engaging in the plumbing trade, an apprentice plumber shall be under the immediate supervision of a journeyman plumber for commercial or industrial work, and by a residential journeyman or journeyman plumber for residential work;

(b) the apprentice shall engage in the plumbing trade in accordance with the instruction of the supervising plumber; and

(c) the apprentice shall work in a ratio of not to exceed two apprentice plumbers to one supervising plumber.

R156-55c-302b. Qualifications for Licensure - Examination Requirements.

In accordance with Subsections 58-1-203(2) and 58-1-301(3), the examination requirements for licensure in Subsection 58-55-302(1)(c)(i) are as follows:

(1) The applicant shall obtain a minimum score of 70% on the Utah Plumbers Licensing Examination that shall consist of a written section and practical section.

(2) Admission to the examinations is permitted after:

(a) the applicant has completed all requirements for licensure set forth in this section and in Sections R156-55c-302a and R156-55c-302c; or

(b) the applicant has completed:

(i) the first semester of the fourth year of the apprentice education program set forth in Subsection R156-55c-302a(1)(a)(ii); and

(ii) not less than 6,000 hours of the experience required under Subsection R156-55c-302a(1)(a)(i).

(3) (a) If an applicant fails any section of the examination, the applicant shall retake that section.

(b) An applicant shall wait at least 25 days for the first two retakes, and thereafter shall wait 120 days between retakes.

(4) If an applicant passes any section of the examination but does not pass the entire examination, the passing score for that section shall be valid for one year from the pass date. After one year the applicant shall retake any previously passed section to support any subsequent application for licensure.

R156-55c-302c. Qualifications for Licensure - Master Supervisory Experience and Education Requirements.

In accordance with Subsections 58-55-302(3)(a)(i)(A) and 58-55-302(3)(b)(i), the minimum supervisory experience qualifications for licensure as a master plumber and residential master plumber are established as follows:

(1) An applicant shall demonstrate successful completion of 4000 hours of supervisory experience that includes each of the following categories and minimum number of hours:

(a) supervising employees: 700 hours;

(b) supervising construction projects: 700 hours;

(c) cost/price management: 300 hours; and

(d) miscellaneous construction experience: 300 hours in any one or more of the following: accounting/financial principles, contract negotiations, conflict resolutions, marketing, human resources and government regulation pertaining to business and the construction trades.

(2) The following, or the substantial equivalent thereof, as determined by the Board in collaboration with the Commission, shall apply to the minimum supervisory experience qualifications established in Subsection (1):

(a) supervisory experience shall be obtained while licensed in the proper license classification as either a journeyman plumber or a residential journeyman plumber;

(b) supervisory experience shall be obtained as an employee of a licensed plumbing contractor, whose employer covers the applicant with workers compensation and unemployment insurances and deducts federal and state taxes from the applicant's compensation;

(c) all supervisory experience shall be under the immediate supervision of the applicant's employer; and

(d) no more than 2000 hours of experience may be earned during any 12-month period.

(3) An associate of applied science or similar or higher educational degree, in accordance with Subsection 58-55-302(3)(a)(i)(B), shall fulfill 2000 hours of the 4000 hour supervisory experience requirement. Such an applicant shall complete the remaining minimum 2000 hour supervisory experience listed above in Subsection R156-55c-302c(1).

(a) The degree shall be accredited by one of the following:

(i) Middle States Association of Colleges and Schools;

(ii) New England Association of Colleges and Schools;

(iii) North Central Association of Colleges and Schools;

(iv) Northwest Commission on Colleges and Universities;

(v) Southern Association of Colleges and Schools; or

(vi) Western Association of Schools and Colleges.

(b) The degree shall be in one of the following courses of study:

(i) accounting;

(ii) apprenticeship;

(iii) business management;

(iv) communications;

(v) computer systems and computer information systems;

(vi) construction management;

(vii) engineering;

(viii) environmental technology;

(ix) finance;

(x) human resources; or

(xi) marketing.

R156-55c-303. Renewal Cycle - Procedures.

(1) In accordance with Subsection 58-1-308(1), the

renewal date for the two-year renewal cycle applicable to licensees under Title 58, Chapter 55, is established by rule in Section R156-1-308a(1).

(2) Renewal procedures shall be in accordance with Section R156-1-308c.

R156-55c-304. Continuing Education - Standards.

(1) Required Hours. Pursuant to Sections 58-55-302.7 and 58-55-303, each licensee shall complete 12 hours of continuing education during each two-year license term. A minimum of eight hours shall be core education. The remaining four hours may be professional education.

(2) "Core continuing education" is defined as education covering:

(a) International Building, Mechanical, Plumbing, and International Energy Conservation Codes and Utah building code amendments as adopted or proposed for adoption;

(b) the Americans with Disability Act;

(c) medical gas, National Fire Protection Association 13D and 54; and

(d) hydronics and waste water treatment.

(3) "Professional continuing education" is defined as education covering:

(a) energy conservation, management training, new technology, plan reading; and

(b) lien laws and Utah construction registry

(c) Occupational Safety and Health Administration (OSHA) training; and

(d) government regulations.

(4) Non-acceptable course subject matter includes the following types of courses and other similar courses:

(a) mechanical office and business skills, such as typing, speed reading, memory improvement, and report writing;

(b) physical well-being or personal development, such as personal motivation, stress management, time management, or dress for success;

(c) presentations by a supplier or a supplier representative to promote a particular product or line of products; and

(d) meetings held in conjunction with the general business of the licensee or employer.

(5) The Division may:

(a) waive the continuing education requirements for a licensee that is an instructor of an approved education apprenticeship program; or

(b) waive or defer the continuing education requirements as provided in Section R156-1-308d.

(6) A continuing education course shall meet the following standards:

(a) Time. Each hour of continuing education course credit shall consist of at least 50 minutes of education in the form of seminars, lectures, conferences, training sessions, or distance learning modules. The remaining ten minutes may be used for breaks.

(b) Provider. The course provider shall meet the requirements of this section and shall be one of the following:

(i) a recognized accredited college or university;

(ii) a state or federal agency;

(iii) a professional association or organization involved in the construction trades; or

(iv) a commercial continuing education provider providing a program related to the plumbing trade.

(c) Content. The content of the course shall be relevant to the practice of the plumbing trade and consistent with the laws and rules of this state.

(d) Objectives. The learning objectives of the course shall be reasonably and clearly stated.

(e) Teaching Methods. The course shall be presented in a competent, well organized and sequential manner consistent with the stated purpose and objective of the program.

(f) Faculty. The course shall be prepared and presented by individuals who are qualified by education, training, and experience.

(g) Distance learning. A course that is provided through internet or home study courses may be recognized for continuing education if the course verifies registration and participation in the course by means of a passing a test demonstrating that the participant has learned the material presented. Test questions shall be randomized for each participant.

(h) Documentation. The course provider shall have a competent method of registration of individuals who actually completed the course, shall maintain records of attendance that are available for review by the Division, and shall provide to individuals completing the course a certificate that contains the following information:

(i) the date of the course;

(ii) the name of the course provider;

(iii) the name of the instructor;

(iv) the course title;

(v) the hours of continuing education credit;

(vi) the attendee's name;

(vii) the attendee's license number; and

(viii) the signature of the course provider.

(7) On a random basis, the Division may assign monitors at no charge to attend a course for the purpose of evaluating the course and the instructor.

(8) Each licensee shall maintain adequate documentation as proof of compliance with this section, such as certificates of completion, course handouts, and materials. The licensee shall retain this proof for a period of three years from the end of the renewal period for which the continuing education is due. Each licensee shall assure that the course provider has submitted the verification of attendance to the continuing education registry on behalf of the licensee as specified in Subsection (10). Alternatively, the licensee may submit the course for approval and pay any course approval fees and attendance recording fees.

(9) Licensees who lecture in approved continuing education courses shall receive two hours of continuing education for each hour spent lecturing. However, no lecturing or teaching credit is available for participation in a panel discussion.

(10) A course provider shall submit to the continuing education registry, in the format required by the continuing education registry:

(a) applications for approval of continuing education courses; and

(b) on behalf of each licensee, verification of the licensee's attendance and completion of a continuing education course.

(11) The Division shall review continuing education courses which have been submitted through the continuing education registry and approve only those courses that meet the standards set forth under this section.

(12) Continuing Education Registry.

(a) The Division shall designate an entity to act as the Continuing Education Registry under this rule.

(b) The Continuing Education Registry, in consultation with the Division and the Commission, shall:

(i) through its internet site electronically receive applications for course approval from continuing education course providers, and submit to the Division for review and approval only those courses which meet the standards set forth under this section;

(ii) publish on its website listings of continuing education courses approved by the Division, which meet the standards for continuing education credit under this rule;

(iii) maintain accurate records of approved qualified continuing education courses;

(iv) maintain accurate records of verification of attendance

and completion for each individual licensee, which the licensee may review for compliance with this rule; and

(v) make records of approved continuing education programs and attendance and completion available for audit by representatives of the Division.

(c) Fees. The Continuing Education Registry may charge a reasonable fee to continuing education providers or licensees for services provided for review and approval of continuing education programs.

R156-55c-305. Licensure by Endorsement.

The Division may issue a license by endorsement in accordance with the provisions of Section 58-1-302.

R156-55c-401. Conduct of Apprentice and Supervising Plumber.

(1) The conduct of licensed apprentice plumbers and their licensed supervisors shall be in accordance with Subsections 58-55-302(3)(e), 58-55-501, 58-55-502 and R156-55c-501.

(2) For the purposes of Subsections 58-55-302(3)(e) and 58-55-501(12), one of the following shall apply:

(a) the supervisor and apprentice employees shall be employees of the same plumbing contractor; or

(b) the plumbing contractor may contract with a licensed professional employer organization to employ such persons.

R156-55c-501. Unprofessional Conduct.

"Unprofessional conduct" includes:

(1) failing to comply with the supervision requirements established by Subsection 58-55-302(3)(e);

(2) failing as a licensed plumber to carry a copy of his current plumber's license on his person or in close proximity to his person when performing plumbing work or to display that license upon request of a representative of the Division or any law enforcement officer;

(3) failing as a plumbing contractor to certify work experience and supervisory hours when requested by a plumber who is or has been an employee of the plumbing contractor; and

(4) failing as a licensee to provide proof of completed continuing education within 30 days of the Division's request.

R156-55c-502. Administrative Penalties.

(1) The administrative penalties defined in Section R156-55a-503 of the Utah Construction Trades Licensing Act Rule are hereby adopted as the administrative penalties under this rule.

(2) The administrative penalty for a violation of Subsection 58-1-501(2)(o) under this rule shall be in accordance with Section R156-1-502.

KEY: occupational licensing, licensing, plumbers, plumbing
April 10, 2017 **58-1-106(1)(a)**
Notice of Continuation August 8, 2016 **58-1-202(1)(a)**
58-55-101

R251. Corrections, Administration.
R251-107. Executions.
R251-107-1. Authority and Purpose.

(1) This rule is authorized by Sections 63G-3-201, 64-13-10, 77-19-10, and 77-19-11, of the Utah Code, in which the Department shall adopt and enforce rules governing procedures for the execution of judgments of death and attendance of persons at the execution.

(2) The purpose of this rule is to address public safety and security within prison facilities prior to, during and immediately following an execution.

R251-107-2. Definitions.

(1) "Department" means Utah Department of Corrections.

(2) "DIO" means Division of Institutional Operations.

(3) "news media" includes persons engaged in news gathering for newspapers, news magazines, radio, television, online news sources, excluding personal blogs, or other news services.

(4) "news media members" means persons over the age of eighteen who are primarily employed in the business of gathering or reporting news for newspapers, news magazines, national or international news services, radio or television stations licensed by the Federal Communications Commission or other recognized news services, such as online media.

(5) "newspaper" means a publication that circulates among the general public, and contains information of general interest to the public regarding political, commercial, religious or social affairs.

(6) "press" means the print media, news media, or both.

(7) "USP" means Utah State Prison.

R251-107-3. Crowd Control.

(1) Persons arriving at or driving past the USP shall be routed and controlled in a manner which does not compromise or inhibit:

(a) security;

(b) official escort or movement;

(c) the functions necessary to carry out the execution; or

(d) safety.

(2) Persons controlled/handled through this process shall be handled in a manner with no more restriction than is necessary to carry out the legitimate interests of the Department.

(3) Procedures for crowd control shall be consistent with federal, state and local laws.

(4) Only persons specifically authorized shall be permitted on USP property, except those persons congregating at a designated demonstration/public area.

(5) Persons entering USP property without authorization shall be ordered to leave and may be arrested if:

(a) the trespass was intentional;

(b) the individual failed to immediately leave the USP property following a warning;

(c) the trespass jeopardized safety or security (or) interfered with the lawful business of the Department or its staff or agents; or

(d) it involves entry onto areas clearly posted with signs prohibiting access or trespass.

R251-107-4. Location and Procedures.

(1) The executive director of the Department of Corrections or his designee shall ensure that the method of judgment of death specified in the warrant is carried out at a secure correctional facility operated by the department and at an hour determined by the department on the date specified in the warrant.

(2) When the judgment of death is to be carried out by lethal intravenous injection, the executive director of the department or his designee shall select two or more persons trained in accordance with accepted medical practices to administer intravenous injections, who shall each administer a continuous intravenous injection, one of which shall be of a lethal quantity of sodium thiopental or other equally or more effective substance to cause death.

(3) If the judgment of death is to be carried out by firing squad under Subsection 77-18-5.5(3) or (4), of the Utah Code, the executive director or his designee shall select a five-person firing squad of peace officers.

(4) Death shall be certified by a physician.

R251-107-5. Demonstration and Public Access.

(1) The Executive Director may permit limited access to a designated portion of state property on Minuteman Drive at or near the Fred House Academy for the public to gather demonstrate during an execution event.

(2) No person may violate the intent of clearly marked signs, fences, doors or other indicant relative to prohibitions against entering any prison property or facility for which permission to enter may not be marked.

(3) The Department neither recognizes, nor is bound by, the policies, allowances or arrangements which may have occurred at prior executions, events or on prior occasions, and by this rule any arrangement provided for public access at previous executions or demonstrations is invalidated.

(4) The Executive Director or Warden may at any time withdraw permission without notice in the event of riot, disturbance, or other factors that in the opinion of the Warden/designee or Executive Director/designee jeopardizes the security, peace, order or any function of the prison.

R251-107-6. Witnesses.

(1) The Department will implement the standards and procedures for inmate witnesses outlined in Section 77-19-11, of the Utah Code.

(2) As a condition to attending the execution, each designated witness shall be required by the Department to sign an agreement setting forth their willingness to conduct themselves while on prison property in a manner consistent with the legitimate penelogical, security and safety concerns as delineated by the Department.

(3) Witnesses shall be searched prior to being allowed to witness the execution.

R251-107-7. News Media.

(1) The Department shall permit press access to the execution and information concerning the execution consistent with the requirements of the constitutions and laws of the United States and State of Utah.

(2) The Department and the Utah Code recognize the need for the public to be informed concerning executions.

(a) The Department will participate and cooperate with the news media to inform the public concerning the execution; and

(b) information should be provided in a timely manner.

(3) The Executive Director shall be responsible for selecting the members of the news media who will be permitted to witness the execution.

(a) After the court sets a date for the execution of the death penalty, news directors or editors desirous to have a staff member witness the execution may submit, in writing, such request for no more than one news media staff member.The request shall be addressed to the Executive Director and received at least 30 days prior to the execution.

(b) When administrative convenience or fairness to the news media dictates, the Department, in its discretion, may extend the request deadline.

(c) Requests for consideration may be granted by the Executive Director provided they contain the following:

(i) a statement setting forth facts showing that the

requesting individual falls within the definition of member of the "press" and "news media" as set forth in this rule;

(ii) an agreement to act as a pool representative for other news gathering agencies desiring information on the execution; and

(iii) an agreement that the media member will abide by all of the conditions, rules and regulations while in attendance at the execution.

(d) Upon receipt of a news director's or editor's request for permission for news media witnesses to attend the execution, the Executive Director may take the steps necessary to verify the statements made in the request. After verifying the information in the request, selection of witnesses shall be made by the Executive Director.

(e) As a condition to attending the execution, each designated media witness shall be required by the department to execute an agreement setting forth their willingness to conduct themselves while on prison property in a manner consistent with the legitimate penological, security and safety concerns as delineated by the department.

(f) Media witnesses shall be searched prior to being allowed to witness the execution.

(g) The Department shall arrange for pre-execution briefings, distribution of media briefing packages, briefings throughout the execution event, and post-execution briefings by the news media who witnessed the execution.

(4) Persons representing the news media witnessing the execution shall be required to sign a statement or release absolving the institution or any of its staff from any legal recourse resulting from the exercise of search requirements or other provisions of the witness agreement.

(5) News media representatives shall, after being returned from the execution to the staging area, act as pool representatives for other media representatives covering the event.

(a) The pool representatives shall meet at the designated media center and provide an account of the execution and shall freely answer all questions put to them by other media members and shall not be permitted to report their coverage of the execution back to their respective news organizations until after the non-attending media members have had the benefit of the pool representatives' account of the execution.

(b) News media members attending the post-execution briefing shall agree to remain in the briefing room and not leave nor communicate with persons outside the briefing room until the briefing is over.

(c) The briefing shall end when the attending news media members are through asking questions or after 60 minutes, whichever comes first.

(d) Any film/videotape obtained by a pool photographer shall not be used in any news or other broadcast until made available to all agencies participating in the pool. All agencies receiving the film/videotape will be permitted to use them in news coverage and to retain the film/videotape for file footage.

(6) The Department may alter these processes to impose additional conditions, restrictions and limitations on media coverage of the execution when requirements become necessary for the preservation of prison security, personal safety or other legitimate interests which may be in jeopardy.

(7) If extraordinary circumstances develop, additional conditions and restrictions shall be no more restrictive than required to meet the exigent circumstances.

R251-107-8. Authority of Executive Director.

The Executive Director/designee shall be authorized to make changes in policies and procedures that are necessary to ensure the interest of security, safety, and professionalism is maintained during the planning, training, and administering of the execution order.

KEY: corrections, executions, prisons

R251. Corrections, Administration.
R251-305. Visiting at Community Correctional Centers.
R251-305-1. Authority and Purpose.

(1) This rule is authorized by Sections 63G-3-201, 64-13-10, and 64-13-17, of the Utah Code.

(2) The purpose of this rule is to provide the Department's rules governing visitation at Community Correctional Centers.

R251-305-2. Definitions.

(1) "Center" means a community corrections halfway house facility designed to facilitate an offender's readjustment to private life.

(2) "Confiscate" means to take possession or immediately seize.

(3) "Contraband" means any material, substance or other item not approved by the Department to be in the possession of residents.

(4) "Evidence" means any item which may be used in prosecution of a violation of Department policy or procedure, federal, state or local law.

(5) "Illegal contraband" means any material, substance or other item the possession of which violates criminal statutes.

(6) "Legal representatives" means court personnel, attorneys-at-law and their assistants such as paralegals and investigators.

(7) "Offender" means a probationer, parolee or inmate housed in a Community Correctional Center.

(8) "Premises" means Center's building and land, including residents' property, rooms, persons and vehicles.

(9) "Religious representative" means a priest, bishop, rabbi, religious practitioner or similar functionary of a church or legally recognized denomination or organization.

(10) "Sponsor" means an individual who is approved by Center staff members to accompany an offender while on leave time away from the Center.

(11) "Visit" means a period of time during which an offender has the opportunity to interact with family and friends on Community Correctional Center premises.

R251-305-3. Policy.

It is the policy of the Department that:

(1) Community Correctional Centers shall schedule days and times for visiting;

(2) visits at other than established visiting hours may be approved by the Center Director/designee;

(3) Community Correctional Centers shall have designated visiting areas;

(4) visitors shall not be allowed in unauthorized areas;

(5) offenders' visitors, except for non-emancipated minors, shall be approved sponsors;

(6) non-emancipated minors shall be accompanied by a parent or guardian;

(7) sponsor applicants may be subject to special conditions (i.e., visiting only, leave time only, etc.);

(8) offenders shall be advised of visiting rules during orientation;

(9) visitors will be advised of visiting rules during the sponsor application process;

(10) visiting may be prohibited for offenders in security cells and as part of restrictions ordered by the Offender Discipline Hearing Officer;

(11) visitors shall be required to sign a visitor log when entering and leaving the Center;

(12) visitors may be required to present picture identification prior to visiting;

(13) visitors shall be modestly dressed to be permitted to visit (i.e., no bare midriffs or see-through blouses or shirts, no shorts, tube tops, halters, extremely tight or revealing clothing, no dresses or skirts more than three inches above the knees, or sexually revealing attire; children under the age of twelve may wear shorts and sleeveless shirts);

(14) sexual contact between visitors and offenders (i.e., petting, prolonged kissing or bodily contact) is prohibited;

(15) visitors shall not bring animals or pets into the Center with the exception of dogs trained to aid individuals with disabilities;

(16) visitors shall visit with only one offender at a time unless approved by Center staff;

(17) offenders and visitors shall not exhibit abusive, disruptive or other inappropriate behavior;

(18) offenders and visitors shall not use loud or offensive language;

(19) visitors suspected to be under the influence of alcohol or drugs shall be denied visiting and advised by staff to arrange alternate transportation if they are operating a vehicle;

(20) if an intoxicated visitor refuses to seek alternate transportation or becomes belligerent, staff shall attempt to detain the individual and contact the local law enforcement for assistance;

(21) visitors shall be responsible for their property and the Department shall not be liable for any loss or damage to visitors' property;

(22) visitors may be subject to search of their person or property for reasonable cause;

(23) visitors attempting to bring contraband on Center premises may have visiting privileges restricted, suspended or revoked;

(24) Center staff may restrict, deny or cancel visiting privileges for the safety, security and orderly operation of the Center or program requirements;

(25) offenders may be prohibited contact with individuals as determined by the court, Board of Pardons and Parole, or Center program requirements; and

(26) an appeal process shall be available to challenge denial or restriction of visiting privileges.

KEY: corrections, visitation
July 8, 2002 **64-13-17**
Notice of Continuation April 5, 2017

R251. Corrections, Administration.
R251-306. Sponsors in Community Correctional Centers.
R251-306-1. Authority and Purpose.

(1) This rule is authorized by Sections 63G-3-201, 64-13-10, and 64-13-17, of the Utah Code.

(2) The purpose of this rule is to provide the Department's policy for sponsors accompanying offenders of Community Correctional Centers into the community and to explain the process of applying to be a sponsor.

R251-306-2. Definitions.

(1) "Applicant" means an individual requesting to be a sponsor of an offender.

(2) "BCI" means Bureau of Criminal Identification, Department of Public Safety.

(3) "Center" means a community corrections halfway house facility designed to facilitate an offender's readjustment to private life.

(4) "Immediate family" means spouse, children, stepchildren, mother, father, brother, sister, mother-in-law, father-in-law, step-mother, step-father, step-brother, step-sister, grandmother, and grandfather.

(5) "Leave time" means time granted away from the Center for family, recreational, religious or other approved activities.

(6) "Offender" means a probationer, parolee or inmate housed in a Community Correctional Center.

(7) "Positive identification" means a document or documents containing a photograph and date of birth, including driver's license, federal identification card or passport; does not include credit cards, social security card, or similar document.

(8) "Sponsor" means an individual who is approved by Center staff members to accompany an offender while on leave time away from the Center.

R251-306-3. Policy.

It is the policy of the Department that offenders assigned to Centers should be afforded the opportunity to develop or strengthen community support systems and family relationships through the use of sponsors.

R251-306-4. Sponsor Qualifications.

(1) Applicants, except spouses, shall be at least 18 years of age;

(2) applicants shall not be approved as sponsors of offenders of the opposite sex without the signed consent of the offender's or the applicant's spouse, or both; this prohibition does not include members of the immediate family;

(3) applicants with a criminal record shall be considered on a case-by-case basis; factors to be considered include:

(a) nature of offenses;

(b) probation or parole officer's comments;

(c) relationship to the resident;

(d) criminal history; and

(e) current involvement in criminal activity;

(4) applicants on probation or parole are required to obtain written permission from their supervising agents; Center staff shall make a notation on the application verifying approval from the supervising agent; and applicants on probation or parole are required to obtain final approval from the Center director/designee; and

(5) a married applicant requesting to sponsor an offender of the opposite sex shall have the signed consent of the applicant's spouse; exceptions are immediate family members.

R251-306-5. Application Procedure.

(1) Persons wishing to sponsor residents shall complete an Application to Sponsor form;

(2) Application to Sponsor forms can be obtained from the Correctional Center at which the resident is housed;

(3) a divorced applicant requesting to sponsor an offender of the opposite sex shall provide a copy of final divorce decree; exceptions are the offender's immediate family members;

(4) a records and current warrants check shall be made on each applicant;

(5) applicants shall make a separate application for each offender they request to sponsor;

(6) a sponsor shall not be permitted to sign out and accompany more than one offender at a time except as approved by the Center Director/designee;

(7) applicants shall be required to sign the sponsor application certifying that they have been advised of the rules pertaining to sponsorship of offenders and shall agree to abide by them; the offender shall be returned to the Center on or before the date and time indicated on the Application for Leave form;

(8) applications with inaccurate, incomplete or illegibly written information shall be subject to delay until additional information or clarification is obtained;

(9) applicants providing false information shall be denied as sponsors;

(10) Center staff members may approve, restrict or deny applicant and sponsor privileges due to safety, security, control and orderly operation of the Center, program requirements or the best interests of the Department; and

(11) each sponsor shall sign an Application for Leave form before leaving the Center.

R251-306-6. Sponsor Duties and Consequences For Violations.

(1) Sponsors shall be liable for their own actions but shall not be liable for actions of offenders unless the sponsor participated in or encouraged illegal activity;

(2) sponsors shall receive orientation regarding Center rules prior to being allowed to sign out an offender for the first time;

(3) sponsors and residents shall adhere to the rules related to sponsoring offenders; a copy of the rules shall be made available upon request; and

(4) sponsors shall remove or secure firearms or other dangerous weapons within their control where and when an offender is visiting and shall have no alcohol in their possession during the time an offender is visiting.

R251-306-7. Other Rules.

Offenders shall not be approved for overnight visits with a married sponsor of the opposite sex; this prohibition does not include members of the immediate family.

KEY: community-based corrections, halfway houses, sponsors, corrections

October 12, 2011	**63G-3-201**
Notice of Continuation April 5, 2017	**64-13-10**
	64-13-17

R251. Corrections, Administration.
R251-703. Vehicle Direction Station.
R251-703-1. Authority and Purpose.

(1) This rule is authorized under Sections 63G-3-201, 64-13-14 and 64-13-10, of the Utah Code.

(2) The purpose of this rule is to define the Department's policy, procedure and requirements for the operation of the Vehicle Direction Stations located at the South Point and Central Utah Correctional facilities.

R251-703-2. Definitions.

(1) "Central Utah Correctional Facility" or "CUCF" means the institutional housing unit located in Gunnison.

(2) "Civilian" means vendor, deliveryman, construction worker, family members, friend, or other person not acting on behalf of UDC or an allied agency in an official capacity who needs access to prison property.

(3) "Department" means Department of Corrections.

(4) "DIO" means Division of Institutional Operations.

(5) "ID" means identification issued by an authorized government agency.

(6) "South Point" means the Uinta, Wasatch and Oquirrh facilities at the Utah State Prison.

(7) "VDS" means Vehicle Direction Station.

(8) "Visitor" means any person accessing prison property other than a Utah Department of Corrections employee, an inmate, or offender.

R251-703-3. Policy.

It is the policy of the Department that:

(1) the Department shall maintain a Vehicle Direction Station at the main entrance of South Point, and Central Utah Correctional Facility to control access of vehicles and persons entering or leaving institutional property;

(2) the Vehicle Direction Station (VDS) shall be staffed by an armed member of the Security Unit. The VDS shall be staffed from 0600 to 2200 hours daily;

(3) drivers using the entrance road to the VDS shall observe state traffic laws, keep the road free from equipment or vehicles that would obstruct visibility or impede the free flow of traffic, and follow directives of VDS staff charged with maintaining entry facilities;

(4) drivers and pedestrians using the entrance road shall heed directions of VDS staff, to ensure the safety of vehicular and pedestrian traffic;

(5) visitors to the prison shall be responsible to read and follow signs posted on the entrance road to the VDS prohibiting contraband from being introduced onto prison property;

(6) since the VDS is the initial control point for controlling contraband from being brought onto prison property, visitors may be subjected to search and seizure procedures as provided by law;

(7) the VDS shall be the control point for limiting entry to institutional facilities to persons whose presence is necessary to the institution and to authorized visitors of inmates;

(8) to prevent escape of inmates, a vehicle exiting South Point or CUCF shall be subject to a search. Persons in exiting vehicles shall be required to provide identification and verification of clearance;

(9) civilians 16 years of age and older, in a vehicle or on foot, shall be required to have picture ID in their possession and to submit it for inspection, before being allowed through the VDS. If they do not have a valid ID:

(a) access to the prison through the VDS shall not be allowed;

(b) they shall not be allowed to wait or park on the entrance road to any institutional facility or on any roads adjacent to an institutional facility; but

(c) they may be allowed to wait in a designated parking area adjacent to the VDS;

(10) civilians under 16 years of age shall not be permitted access unless accompanied by an approved adult;

(11) civilians found in the possession of weapons or contraband at the VDS under circumstances which do not constitute a violation of law shall be required to leave prison property;

(12) peace officers from allied agencies shall either secure their firearms at the VDS, another approved location, or lock their weapons in their vehicle trunk if the vehicle will not penetrate the secure perimeter;

(13) persons who have a valid outstanding warrant may be arrested and either cited or transported, depending on the needs of the UDC and the agency holding the warrant;

(14) persons who have a valid outstanding warrant, if not arrested, may be denied entry to prison property until the warrant has been adjudicated; and

(15) visitors shall comply with all directives of VDS officers.

KEY: prisons, corrections
April 9, 2012 64-13-14
Notice of Continuation April 5, 2017

R251. Corrections, Administration.
R251-704. North Gate.
R251-704-1. Authority and Purpose.

A. This rule is authorized by Sections 63G-3-201, 64-13-10, and 64-13-14, of the Utah Code, which allows the Department to adopt standards and rules in accordance with its responsibilities.

B. The purpose of this chapter is to provide the Department's policy, procedures and requirements for the North Gate of the South Point Complex of the Prison.

R251-704-2. Definitions.

1. "ID" means identification.
2. "SSD" means Special Services Dormitory.

R251-704-3. Standards and Procedures.

It is the policy of the Department that:

A. access through the North Gate shall be restricted to authorized persons at authorized times to control contraband, prevent the escape of inmates and to otherwise further the legitimate security interests of the USP;

B. regulations shall be enacted to control access through the North Gate, particularly as that access involves persons who are not members of the USP staff;

C. vehicles accessing the North Gate shall be thoroughly searched to prevent the flow of contraband, prevent the possibility of escape and to otherwise further the legitimate security interests of the USP;

D. vehicles wishing to exit the North Gate which are loaded in such a manner which prohibits the North Gate officer from giving it a thorough shake down shall:

1. be accompanied by a corrections officer who witnessed the loading of the vehicle and verifies, by signing the North Gate Vehicle Security Warrant Form, that the security of the vehicle was maintained during loading to prevent escape; and

2. be detained at the North Gate until all inmates are counted.

E. vendor access through the North Gate may be allowed from 0700 to 1500 hours Monday through Friday;

F. deliveries at other than designated times shall require a special clearance signed by the Security Deputy Warden/designee.

G. the garbage truck:

1. should be allowed access to through the North Gate as needed, beginning at approximately 0400; and

2. shall have an Enforcement Officer escort while inside the secure perimeter;

H. access for contractors and construction workers should be granted between 0700 and 1700 hours, unless an emergency exists that would prevent access;

I. non-prison staff (i.e., contract professional staff including psychologists, vocational rehabilitation personnel, attorneys, legal services providers, etc.), including all volunteers shall not ordinarily be allowed access through the North Gate, but shall be required to use the Oquirrh, Wasatch, or Uinta administration building sallyport for access;

J. vendors shall be required to surrender their driver's license, or official identification to the North Gate officer while inside the compound (any exception shall be cleared through the Watch Commander);

K. construction workers and contractors shall provide name, legal address, social security number, driver's license number, date of birth to the appropriate prison personnel at least 72 hours prior to access onto prison property;

L. prior to exiting through the North Gate, all persons shall be identified;

M. all persons are subject to a search of their person, property and vehicle as a condition of entry onto prison property;

N. the North Gate officer shall search all vehicles to ensure that no unauthorized passengers or contraband items are allowed access through the North Gate; and

O. vehicle operators and passengers shall exit the vehicle during a vehicle search.

KEY: correctional institutions, security measures
April 9, 2012 64-13-14
Notice of Continuation April 5, 2017

R251. Corrections, Administration.
R251-705. Inmate Mail Procedures.
R251-705-1. Authority and Purpose.

(1) This rule is authorized by Sections 63G-3-201, 64-13-10 and 64-13-17(4), of the Utah Code, which allows the Department to adopt standards and rules in accordance with its responsibilities.

(2) The purpose of this section is to establish the UDC's policies and procedures for processing mail received in the DIO Mail Unit.

R251-705-2. Definitions.

(1) "Catalog" means a systematized list whose sole purpose is to feature descriptions of items for sale.

(2) "Department" means the Department of Corrections.

(3) "DIO" means Division of Institutional Operations.

(4) "Inspect" means open and examine a letter, correspondence or other material with the primary objective to detect false labeling, contraband, currency, or negotiable instruments.

(5) "Inter-department mail" means mail sent between departments within the state.

(6) "Inter-department mail" mean mail sent from office to office within a department.

(7) "Mail" means written material sent or received by inmates through the United States Postal Service.

(8) "Money instruments" means currency, coin, personal checks, money orders and cashier's or non-personal checks.

(9) "Nuisance contraband" means items that may include, but are not limited to, paper fasteners, hair, ribbons, pins, rubber bands, pressed leaves and/or flowers, promotional gimmicks, gum, stickers, computer disks, maps, calendars, balloons, and other such items having no intrinsic value or not approved by the department administration to be in the possession of the inmates.

(10) "Privileged mail" means correspondence with a person identified by this chapter relating to the official capacity of that person, which has been properly labeled to claim privileged status.

(11) "Publisher-only rule" means a rule limiting books, audio media, magazines, newspapers, etc. to those sent directly from the publisher, a book or tape club or a licensed book store. All media shall be new and audio shall be factory sealed and the return address should be commercially printed or stamped.

(12) "Reasonable cause" means information that could prompt a reasonable person to believe or suspect that there is or might be a threat to the safety, security or management of the UDC facility or that could be harmful to persons.

(13) "UDC" means Utah Department of Corrections.

(14) "USP" means Utah State Prison.

R251-705-3. Standards and Procedures.

It is the policy of the Department that:

(1) inmate mail shall comply with the Constitution and Laws of the United States, the Constitution and Laws of the State of Utah, and the authorized written policies and procedures of the UDC.

(2) inmates shall be permitted to send and receive mail while in custody of the UDC in the manner defined by this rule.

(3) nothing in this rule should be interpreted as creating a greater entitlement for inmates or those with whom they correspond than that currently required by law.

(4) inmate mail regulations shall:

(a) further the legitimate interests of the UDC; while

(b) balancing the UDC's interests with those of the general public and inmates.

(5) mail received for inmates at the USP shall be delivered to the USP Mail Unit for processing and:

(a) shall be opened and inspected;

(b) may be read at the discretion of the Department;

(c) may be photocopied when such copying is reasonably related to the furtherance of a legitimate Department interest;

(d) may be refused, denied or confiscated where reasonable cause exists to believe the contents may adversely impact the safety, security, order or treatment goals of the Department;

(e) may be used as evidence in criminal, civil or administrative trials or hearings;

(f) is entitled to no expectation of privacy;

(g) all forms of nuisance contraband shall be confiscated and disposed of without notice or opportunity for appeal; and

(h) shall be delivered to inmates without unreasonable delay;

(6) catalog purchases other than through the DIO Commissary catalog are not authorized and catalogs shall not be accepted through the mail, except when sent 1st or 2nd class or from a legal, school, religious or government printing office.

(7) staff-to-inmate mail shall not be sent in "Inter/Intra-department Delivery" envelopes, but in regular mailing envelopes;

(8) outgoing inmate mail and inmate inter/intra-department mail shall be deposited in the housing units' outgoing mail depository, picked up by USP Mail Unit staff, and delivered to the USP Mail Unit for processing;

(9) an inmate shall not direct nor establish a new business through the mail unless authorized by the Warden of the facility;

(10) an inmate who corresponds concerning a legitimately held business, shall correspond through his attorney or a party holding a power of attorney;

(11) an inmate is not authorized to establish credit transactions through the mail while confined unless authorized by the Warden of the facility;

(12) fund raising by inmates for personal gain is prohibited;

(13) envelopes received by the USP Mail Unit displaying threatening, negative gestures or comments, extraneous materials, or grossly offensive sexual comments, shall be confiscated, declared contraband, placed into evidence, and the inmate shall receive disciplinary action;

(14) the publisher-only rule shall govern the receipt of all incoming books, audio media, magazines, and newspapers;

(15) certain types of mail are entitled to constitutionally protected confidentiality (or privilege); accordingly, this privilege prohibits qualifying correspondence material from being read without cause by staff;

(16) incoming privileged mail:

(a) shall be inspected, but only in the presence of the inmate addressee;

(b) shall not be perused;

(c) shall not be photocopied; and

(d) may be denied only for reasonable cause and upon instruction of the DIO Director/designee;

(17) outgoing privileged mail:

(a) shall be inspected only when there is reasonable cause to believe that the correspondence:

(i) contains material which would significantly endanger the security or safety of the Institution; or

(ii) is misrepresented as legal material;

(b) shall only be inspected in the presence of the inmate sender;

(c) shall not be perused;

(d) shall not be photocopied;

(e) may only be denied for a reasonable cause, and upon instruction of the DIO Director/designee; and

(f) from an inmate that cannot be identified, shall be forwarded to the deputy warden who supervises the mail unit, or his or her designee, who will make a determination of the disposition.

(18) all inmate inter/intra-departmental mail shall be processed through the USP Mail Unit;

(19) inmate-to-inmate correspondence shall not be permitted, unless:

(a) there is a compelling justification for an exception;

(b) there is no alternate means of accomplishing that compelling need; and

(c) the inmates present a minimal risk, according to UDC standards, to security, order and/or safety;

(20) inmates have no entitlement to inmate-to-inmate correspondence created by the constitutions of the United States or the State of Utah;

(21) personal mail written in a language other than English may be delayed for purposes of translation;

(22) the USP Mail Unit shall not accept postage-due mail unless payment is waived by the deliverer;

(23) the USP Mail Unit shall not accept letters, cards, money instruments, or property items for which there is reasonable cause to believe the items are contaminated, defaced or handled in such a way as to be offensive.

(24) items received that cannot be searched without destruction or alteration (e.g., electronic greeting cards, multilayered cards, polaroid photographs, etc.) shall be denied and returned to the sender;

(25) inmates are prohibited from receiving currency or personal checks; and

(26) to be identified as incoming privileged mail, the correspondence shall be from an attorney or other sender qualified for privileged correspondence, be properly labeled as claiming privileged status, and have a return address clearly indicating a judicial agency, law firm, individual attorney, or other approved agency or person.

KEY: corrections, prisons
April 9, 2012 64-13-10
Notice of Continuation April 5, 2017 64-13-17(3)

R251. Corrections, Administration.
R251-706. Inmate Visiting.
R251-706-1. Authority and Purpose.

(1) This rule is authorized by Sections 63G-3-201, 64-13-10 and 64-13-17, of the Utah Code.

(2) The purpose of this rule is to provide the Department's policies, procedures and requirements for inmate visitation at the Division of Institutional Operations.

R251-706-2. Definitions.

(1) "abusive" means insulting or harmful.

(2) "adult" means anyone eighteen years of age or older.

(3) "approved adult" means an individual eighteen years of age or older, cleared through background checks and approved by the facility visiting staff to visit an inmate.

(4) "approved visitor" means an individual cleared through BCI and approved by the facility visiting staff to visit an inmate.

(5) "barrier visit" means a non-contact visit where the visitor and inmate are separated by glazing, screen, or other partition.

(6) "BCI" means Bureau of Criminal Identification.

(7) "contraband, illegal" means any item in the possession of an inmate or visitor which violates a federal or state law.

(8) "contraband, nuisance" means any item in the possession of an inmate or visitor which does not violate a federal or state law but does violate a prison policy.

(9) "DIO" means Division of Institutional Operations.

(10) "DMV" means Department of Motor Vehicles.

(11) "emergency visit" means visit occasioned by a verifiable emergency, such as serious illness, accident, or death of an inmate's immediate family member.

(12) "foul" means offensive to the senses; vulgar.

(13) "immediate family" means spouse, children, stepchildren, mother, father, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, step-mother, step-father, step-brother, step-sister, half-brother, half-sister, grandmother, grandfather and grandchildren.

(14) "inmate visiting request form" means a form given to inmates during the Reception and Orientation process or at a later time to add persons to their approved visitor lists.

(15) "Minor" means any person under the age of 18 years old.

(16) "NCIC" means National Crime Information Center.

(17) "NLETS" means National Law Enforcement Teletype System.

(18) "OMR" means Offender Management Review team.

(19) "positive identification" means document containing a photograph and date of birth, including but not limited to a valid driver's license, federal or state identification card, military identification or passport; does not include credit cards, social security card, employment card, or student identification card.

(20) "R and O" means reception and orientation process for new inmates and parole violators committed to the institution.

(21) "special visits" means visits authorized by the warden/designee for circumstances other than normal visiting procedures.

(22) "UDC" means Utah Department of Corrections.

(23) "Uinta" means housing unit for maximum security inmates.

(24) "USP" means Utah State Prison, including Draper and CUCF.

(25) "visit" means a short meeting with an approved visitor; a privilege, not a right, afforded to inmates/visitors at the Utah State Prison.

(26) "visitor's consent form" means a form given to an approved visitor requiring the visitor's signature indicating that the visitor has received, understands, and shall adhere to the visitor rules.

R251-706-3. Visiting Policies.

(1) Visitors shall complete a visitor's consent form prior to the initial visit.

(2) Visitors shall receive a copy of the visitor rules and regulations which are distributed at the time of the initial visit. Prior to the first visit, visitors shall read the rules and regulations and shall sign that they understand and will comply with the visiting rules.

(3) Any employee, contractor, volunteer or student who has terminated employment or services with the Department may not be cleared for visits until one year has elapsed from the time of termination of employment or services.

(4) Visitors shall be modestly dressed to be permitted to visit. Bare midriffs, hooded sweat shirts, sleeveless, or see-through blouses or shirts, shorts, tube tops, halters, extremely tight or revealing clothing, dresses or skirts more than three inches above the knees, or sexually revealing attire are not allowed. Children under the age of twelve may wear shorts and sleeveless shirts.

(5) Upon reasonable suspicion, visitors shall be subject to search, and visitation may be denied for failure to submit to the search request.

(6) Prior to entering the Utah State Prison visiting room, visitors may be screened with a metal detector.

(7) If contraband is discovered, the duty officer shall be notified, and:

(a) visitors attempting to introduce nuisance contraband, which is in violation of DIO policies and procedures, onto prison property may have their visiting privileges suspended, restricted or revoked; or

(b) visitors attempting to introduce illegal contraband onto prison property may be subject to criminal prosecution and suspension of visiting privileges.

(8) Visitors shall not be permitted to bring pets or other animals, except for seeing-eye dogs, onto prison property.

(9) Food items from outside the prison shall not be allowed.

(10) Visits should not exceed two hours. Visiting hours may be reduced or extended on any day based on facility visiting conditions or special holiday schedules. On special visits, conditions including the length of the visit are approved based on an assessment of the request and capabilities of the facility.

(11) Personal property such as purses, wallets, keys, blankets, coats and sweaters worn as outer garments, and money (except for vending machine change in facilities which allow them) are not allowed in the visiting room.

(12) Visitors with babies may bring into the visiting area infant care items that are reasonably needed during the visit. Staff shall accommodate personal need items that do not present a threat to the safety and security of the inmates, staff, and the institution.

(13) The UDC shall not be responsible for loss of personal property. Visitors may secure items in UDC lockers where available.

(14) Visitors shall not be permitted to visit during any scheduled visiting period if less than 30 minutes remain in the visiting period.

R251-706-4. Uinta Visiting.

Visitors to the Uinta facility may be required to have additional clearances by the warden/designee or unit manager, prior to visiting the facility.

R251-706-5. Processing Visiting Application.

(1) A visiting application shall be completed by inmates who wish to have a visitor. It is the inmate's responsibility to ensure that the visiting application information is complete and approved by facility visiting staff prior to the first visit.

(2) Visiting applications shall be checked by facility visiting staff through BCI, NLETS, DMV and local wants and warrants prior to the applicant being considered for visitation privileges.

(3) Visiting applications shall be denied by the captain/designee if there is reason to believe that visits would jeopardize the safety, security, management or control of the Institution.

(4) Applications may be denied when an extensive or recent history of criminal activity exists, or the visitor has:

(a) transported contraband into or out of a correctional facility;

(b) aided or attempted to aid in an escape from a jail or correctional facility;

(c) been a crime partner of the inmate applicant; or

(d) been under the supervision of UDC for a felony offense.

(5) Visiting application denials may be challenged by visitor applicants through the deputy warden/designee. If the visitor applicant is not satisfied with the deputy warden/designee decision, a second appeal may be made to the warden/designee.

(6) Except for spouses, visitors under 18 years of age shall be accompanied by their parent or legal guardian on the inmate's approved visiting list.

(7) Visitors 16 years of age and older shall present positive identification prior to being permitted to visit.

(8) An individual may not be on more than one inmate's visiting list unless that individual is a member of the immediate family of all inmates involved and is approved as a visitor by the warden/designee.

(9) Adoptions, marriages, or other methods of claiming legal relationships, performed for the purpose of circumventing existing visiting policies shall be considered invalid.

(10) Visitors may have their names removed from any visiting list by sending a written request to the facility visiting staff.

(11) Visitors removed from a visiting list at the written request of an inmate or visitor shall not be reinstated for a 90-day period without prior approval of the facility visiting staff.

(12) Except for members of the inmate's immediate family, only one single adult visitor of the opposite sex shall be permitted to be on the visiting list of any one inmate at any given time.

(13) Divorced visitors shall provide proof of divorce to the facility visiting staff before being allowed to visit an inmate of the opposite sex.

(14) Except for members of the inmate's immediate family, married persons visiting inmates of the opposite sex shall be accompanied by one or more of the following, who shall remain with the visitor for the duration of the visit:

(a) visitor's spouse who is on approved visiting list;

(b) inmate's spouse;

(c) inmate's parent or

(d) other persons approved by the facility visiting staff.

R251-706-6. Visitor Suspensions.

(1) A visit may be suspended, restricted or revoked for dress code violation, foul and abusive language/conduct, or refusal to comply with DIO policies or procedures, or when necessary to meet safety, security, management or control requirements of the Utah State Prison.

(2) The facility visiting staff may suspend, restrict or revoke visits if the behavior of the visitor or inmate jeopardizes the safety, security, management or control of the institution.

(3) If a visit is suspended, restricted, or revoked the facility visiting staff shall document the action by providing notification of the rules infraction to the inmate, visitor, inmate's OMR, and duty officer. The inmate's OMR may review the documentation and make decisions regarding visiting to the visiting staff members for modification of the suspension, restriction, or revocation. The inmate may appeal suspensions, restrictions, or revocations by submitting a written request to the warden/designee.

(4) Visiting privileges may be permanently revoked or altered as follows:

(a) visitors who bring drugs into the institution may be permanently barred from visiting; and

(b) inmates guilty of attempting to introduce drugs, weapons or contraband money to the institution through the visiting process may be placed on barrier visits.

(5) Barrier visits may be required for inmates when:

(a) visitors have not been in compliance with visiting regulations on prior occasions and have been warned or required to leave the visiting area;

(b) inmates are classified as Level 1 or 2;

(c) inmates or visitors have been suspected or attempted to introduce contraband into a correctional facility;

(d) inmates have been convicted of disciplinary infraction A13 (Possession, introduction or use of any unauthorized intoxicants, unauthorized drugs or drug paraphernalia, positive urinalysis, breath analysis, blood test, or refusal to submit to the same; or

(e) inmate or visitor behavior, or a recent history of behavior is a threat to the safety and security of the inmates, visitors, staff and the institution.

R251-706-7. Sex Offender Visiting.

(1) Inmates identified as sex offenders by R and O or visiting staff members may be restricted from visits with minors as follows:

(a) inmates shall not visit with minors identified as the victim of the inmate;

(b) inmates with a documented history of sexual misconduct with a child under the age of 18 years shall not visit with any minor while incarcerated;

(c) court orders or Board of Pardons and Parole orders regarding contact or non-contact between inmates and minors will be enforced;

(d) inmates may appeal visiting restrictions with minors by written appeal to the warden/designee; or

(e) visits between inmates and minors for therapeutic or clinical reasons may be approved on an individual visit basis by the warden/designee.

R251-706-8. Special Visits.

Requests for special visits or emergency visits from individuals not on an approved visiting list may be approved or denied for reasonable cause by the warden/designee.

KEY: corrections, prisons, inmates, inmate visiting

April 9, 2012	**63G-3-201**
Notice of Continuation April 6, 2017	**64-13-10**
	64-13-17

R251. Corrections, Administration.
R251-707. Legal Access.
R251-707-1. Authority and Purpose.

(1) This rule is authorized by Sections 63G-3-201, 64-13-7, 64-13-10 and 64-13-17, of the Utah Code, which allow the Department to adopt procedures in accordance with its responsibilities.

(2) The purpose of this rule is to provide the policy and procedures for inmates under the control of the Institutional Operations Division regarding access to courts and counsel.

R251-707-2. Definitions.

(1) "Attorney" means a member of the legal profession who has been licensed by a state and who has a current and valid license or bar card allowing him to practice law; lawyer; counsel; esquire;

(2) "Attorney Representatives" means paralegals, law clerks, investigators and other attorneys who are acting under the authority and supervision of the attorney of record;

(3) "CUCF" means Central Utah Correctional Facility located in Gunnison;

(4) "DIO" means Division of Institutional Operations;

(5) "Draper Site" means collectively, Timpanogos, Lone Peak, Promontory, Olympus, Oquirrh, Wasatch, Uinta, and SSD facilities;

(6) "Out-Count Status" means any inmate under legal supervision or confinement of the Utah Department of Corrections who is housed at any location other than the Draper or Gunnison sites;

(7) "Prison" means the Utah State Prison in Draper and CUCF in Gunnison;

(8) "Probable Cause" means sufficient knowledge of articulable facts or circumstances to lead a reasonable person to conclude that another person has committed, is committing, or is about to commit a crime or a violation of a legally enforceable policy or rule;

(9) "Service of Process" means the service of writs, summonses, warrants and subpoenas to inmate or UDC members; and

(10) "UDC" means the Utah Department of Corrections.

R251-707-3. Policy.

It is the policy of the Department that:

(1) legal assistance shall be provided to assist inmates in preparing and filing of an initial pleading in habeas corpus and civil rights suits challenging conditions of confinement arising from incarceration at the prison;

(2) inmates incarcerated at UDC facilities shall be allowed reasonable access to courts and counsel regarding any type of legal matter;

(3) access to courts and counsel shall be extended to those inmates in out-count status;

(4) the primary means of access to legal services shall be provided by contract attorneys paid by the Department, though inmates may secure legal counsel at their own expense if they prefer not to use the contracted legal firm or they may choose to represent themselves;

(5) inmate writ writers may represent themselves but may not represent other inmates;

(6) a law library shall not be provided, except that law books may be included among the books in the general inmate library system;

(7) before being admitted to the prison, attorneys shall present a current state bar card and photo I.D.;

(8) before being admitted to the prison, attorney representatives shall present a letter of introduction from the attorney of record and a photo I.D.;

(9) attorneys and their representatives shall not interfere with the safety, security or orderly operation of the prison;

(10) attorneys and their representatives shall be cleared through the Bureau of Criminal Identification prior to being approved for visitation; individuals with a criminal record shall be allowed to visit only with the approval of the Director of Institutional Operations/designee;

(11) attorneys may elect to have an attorney representative visit an inmate client instead of visiting personally;

(12) attorney representatives:

(a) have no standing on their own; their standing to visit is granted only in their role as representatives of the attorney of record;

(b) may be cleared for visits, if the attorneys they represent:

(i) submit a request, in writing, to the warden of the facility where the inmate is housed;

(ii) provide the name and title of the person assigned to represent the attorney; and

(iii) provide the name of the inmate to be visited;

(c) who have been cleared shall be afforded the same basic rights and privileges as those extended to the attorney of record;

(13) attorneys/representatives should not be denied visits, nor face inordinate delays when visits are prescheduled within the hours designated by the institution;

(14) in the event of exigent circumstances requiring an attorney/representative visit before appropriate screening can be completed, temporary approval for a visit may be approved by the Director of Institutional Operations/designee;

(15) inmate attorney/representative telephone calls shall originate from inside the institution and should not exceed thirty minutes in duration;

(16) attorneys/representatives may leave telephone messages requesting return calls;

(17) visits between inmates and counsel shall not be monitored and shall occur in facilities which permit privacy; however, privacy requirements shall not prohibit visual observation;

(18) attorneys/representatives should schedule on-site visits in advance, when possible;

(19) attorneys/representatives may schedule appointments with their inmate clients:

(a) at Draper Site and CUCF, Monday through Friday, 0800 to 1100 hours and 1300 to 1500 hours;

(b) on weekends, holidays, and evenings with prior written clearance from the Director/designee of Institutional Operations;

(c) at county jails as requested;

(d) in out-of-state institutions, consistent with receiving agencies' policies and procedures; and

(e) during non-visiting hours without prior approval in exigent circumstances if authorized by DIO Director/designee;

(20) attorneys/representatives shall:

(a) follow Department and prison rules during visits to the institution;

(b) conduct themselves in a manner consistent with safety and security requirements; and

(c) comply with instructions of staff members while in the institution;

(21) physical inspections shall be made of all material brought into and out of any facility by any attorney/representative and shall be performed only in the presence of the attorney/representative;

(22) if any written material is declared privileged, it shall not be read; however, the attorney/representative may be required to leaf through these materials in the presence of staff, to assist in inspecting for contraband;

(23) if a reasonable suspicion exists to believe an attorney/representative possesses contraband, a rub search may be required before permitting the visit and an incident report shall be filed documenting the reasonable suspicion and incident;

(24) refusal to submit to search may result in the visit being denied and the attorney/representative being asked to leave the premises;

(25) strip searches of attorneys/representatives shall be conducted only if there is reasonable suspicion of a particularized nature; an incident report shall be filed documenting the reasonable suspicion, incident and reason a strip search was necessary under the circumstances;

(26) if a warden/designee determines that a safety, security, control or management problem could result by allowing an attorney/representative access to a facility, the warden/designee may place reasonable restrictions upon access or deny access when necessary; an incident report shall be filed articulating the justification for denying access and documenting the incident;

(27) an attorney/representative may request a hearing before the Executive Director if he believes the denial of access for him or his legal representative was arbitrary, capricious, unreasonable or in violation of law or Department policy;

(28) any attorney/representative who violates any Department policy or rule or who provides false information may be denied access to the facility; and

(29) staff members authorized to accept service of process shall ensure that the requirements of proper service are appropriately satisfied at the DIO.

KEY: corrections, prisons, legal aid
October 12, 2011 **63-46a-3**
Notice of Continuation April 7, 2017 **64-13-7**
64-13-10
64-13-17

R251. Corrections, Administration.
R251-710. Search.
R251-710-1. Authority and Purpose.

(1) This rule is authorized under Sections 63G-3-201 and 64-13-10, and Subsections 64-13-14(1) and 64-13-17(2), of the Utah Code.

(2) The purpose of this rule is to provide the Department's policy, procedures, and requirements for conducting searches.

R251-710-2. Definitions.

(1) "Contraband", for purposes of this rule, means:

(a) materials, substances or other items not approved by the Department, or which are in numbers or amounts that are not approved, and which are otherwise known as regular contraband;

(b) materials, substances or other items possessed in violation of state or federal law and which are otherwise known as illegal contraband; or

(c) items that are not illegal, but are not authorized for an inmate to possess including items made from scraps of paper, wood, plastic, metal, wire, etc. and which are otherwise known as nuisance contraband.

(2) "Exigent circumstances" means circumstances that would cause a reasonable person to believe that search is necessary to prevent physical harm to the officers or other persons, the destruction of relevant evidence, the escape of the suspect, or some other consequence improperly frustrating legitimate law enforcement efforts.

(3) "Prison" means Utah State Prison in Draper and Central Utah Correctional Facility in Gunnison.

(4) "Probable cause" means sufficient knowledge of articulable facts or circumstances that would lead a reasonable person to conclude that another person has committed, is committing, or is about to commit a crime or a violation of a legally enforceable policy or rule.

(5) "Public" means persons constituting the general population of a state.

(6) "Reasonable suspicion" means suspicion based on specific articulable facts drawn from the totality of the circumstances facing the officer at the time.

(7) "Visitor" means members of the general public entering prison property.

R251-710-3. Policy.

(1) General Regulations

It is the policy of the Department that:

(a) search and seizure activities shall only be carried out by lawful means.

(2) Visitor Search

It is the policy of the Department that:

(a) the person, personal property, and/or vehicle of visitors are subject to limited, less-invasive searches by Department personnel, such as dog sniffs, metal detectors, and viewing the inside of vehicles, including trunks and compartments, as a condition of entering and remaining on the premises of the prison;

(b) an officer may seize contraband or evidence pertinent to an ongoing investigation;

(c) more invasive searches of the person, personal property, and/or vehicle of visitors may be conducted, and contraband and evidence pertinent to an ongoing investigation seized therefrom, by Department personnel upon reasonable suspicion coupled with voluntary consent;

(d) any visitor who refuses to give consent to a search based upon reasonable suspicion may be denied entrance and required to leave the premises of the prison;

(e) the alert of a police service dog shall constitute probable cause and an involuntary search may be legally conducted;

(f) mandatory searches shall be conducted of all vehicles leaving the prison; vehicle trunks and compartments shall be searched prior to exit;

(g) any person who refuses to give consent to a search of their vehicle upon exiting prison property shall have their vehicle detained until a regularly scheduled institutional count has cleared;

(h) notice shall be posted at the entrance to the prison that persons, their property and vehicles are subject to search while on prison property;

(i) an officer may assume the driver of a vehicle is the proprietary possessor and has the authority to consent to a search of the vehicle;

(j) vendors, construction workers, Department personnel, or other visitors whose presence is necessary and important to prison operation may have contraband confiscated and returned upon exiting prison property, may be asked to leave prison property, or may be arrested;

(k) all vehicles entering through a secure perimeter gate shall undergo a thorough search for contraband; discovery of contraband may result in arrest;

(l) mandatory searches shall be made of all vehicles accessing the double fence secure perimeters of the facilities; and

(m) a visitor to the prison who has an outstanding warrant may be arrested and searched or refused entry to the prison.

(3) Public Search

It is the policy of the Department that:

(a) the person and property of members of the general public may be searched, and contraband and evidence pertinent to an ongoing investigation seized therefrom, by Department personnel pursuant to the following limitations:

(i) their person, clothes, personal property, vehicle and residence based upon voluntary consent;

(ii) their person, clothes, and personal property immediately associated with their person may be involuntarily searched;

(A) to the extent necessary for an officer to determine if a person is carrying weapons, if the officer has a reasonable suspicion that the person is armed and presently dangerous to the officer or others;

(B) incident to lawful arrest;

(C) pursuant to a valid search warrant; or

(D) under exigent circumstances;

(iii) their vehicle may be involuntarily searched;

(A) based upon probable cause if the vehicle is readily mobile;

(B) incident to lawful arrest if the arrestee can access the passenger compartment of the vehicle or if failure to search could result in the loss of evidence pertaining to the crime underlying the arrest;

(C) pursuant to a valid search warrant; or

(D) pursuant to a vehicle inventory incident to the lawful impound thereof;

(iv) their residence may be involuntarily searched;

(A) pursuant to a valid search warrant;

(B) in the form of a protective sweep under exigent circumstances; or

(C) at the time of, or incident to, a lawful arrest of the owner or occupant thereof, but only that portion of the residence and personal property therein which is in the immediate control of the arrestee at that time.

KEY: corrections, search and seizure, security measures, prisons

October 12, 2011	**64-13-7**
Notice of Continuation April 5, 2017	**64-13-10**
	64-13-14(1)
	64-13-17(2)

R277. Education, Administration.
R277-519. Educator Professional Learning Procedures and Credit.
R277-519-1. Authority and Purpose.

(1) This rule is authorized by:

(a) Utah Constitution Article X, Section 3, which vests general control and supervision over public education in the Board;

(b) Subsection 53A-1-402(1)(a), which allows the Board to make rules regarding the qualifications of personnel providing direct student services and the certification of educators; and

(c) Section 53A-1-401, which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law.

(2) The purpose of this rule is to establish definitions and standards for awarding credit for professional learning, especially as it relates to teacher certification.

R277-519-2. Definitions.

"Professional learning" has the same meaning as provided in Subsection 53A-3-701(1).

R277-519-3. Professional Learning Requirements for Course Submission.

(1) An LEA shall approve proposals for professional learning.

(2) A professional learning proposal shall include:

(a) a description of how the proposal provides fidelity to the professional learning standards as provided in Section 53A-3-701;

(b) a descriptive outline of the professional learning;

(c) a schedule of meeting dates and times; and

(d) professional qualifications of each instructor.

(2) An LEA or other organization approved by the Superintendent shall request approval for professional learning credit through the online professional learning system connected to the online Board certification system.

(3) An LEA or other organization approved by the Superintendent shall make a request under Subsection (2) at least one week prior to the beginning of the scheduled professional learning.

R277-519-4. Professional Learning Credit.

(1) The Superintendent shall award credit upon completion of professional learning as follows:

(a) one-half credit for seven to thirteen contact hours plus a two hour assigned learning task or reflection;

(b) one credit for fourteen to twenty contact hours plus a four hour assigned learning task or reflection;

(2) Total credit for a professional learning course may not exceed 3 credits.

KEY: teacher certification, professional competency
April 10, 2017 Art X Sec 3
Notice of Continuation February 14, 2017 53A-1-402(1)(a)
53A-1-401

R277. Education, Administration.
R277-916. College and Career Awareness.
R277-916-1. Authority and Purpose.

(1) This rule is authorized by:

(a) Utah Constitution Article X, Section 3, which vests general control and supervision over public education in the Board;

(b) Section 53A-1-401, which allows the Board to make rules to execute the Board's duties and responsibilities under the Utah Constitution and state law;

(c) Section 53A-15-202, which allows the Board to establish minimum standards for career and technical education programs in the public education system; and

(d) Section 53A-17a-113, which directs the Board to distribute specific funds to LEAs.

(2) The purpose of this rule is to establish standards and procedures for LEAs seeking to qualify for College and Career Awareness Program funds administered by the Board.

R277-916-2. Definitions.

(1)(a) "College and Career Awareness" means a 7th grade core course comprised of activities encouraging students to explore college and career opportunities.

(b) "College and Career Awareness" is coordinated with the Comprehensive Counseling and Guidance program.

(2) "Weighted Pupil Unit" or "WPU" means the unit of measure that is computed in accordance with Title 53A, Chapter 17a, Minimum School Program Act, for the purpose of determining the costs of a program on a uniform basis for each LEA.

(3) "Work-Based Learning" or "WBL" means a continuum of awareness, exploration, preparation, and training activities that combine structured learning and authentic work experiences implemented through industry and education partnerships.

R277-916-3. Disbursement of Funds.

(1)(a) An LEA shall utilize College and Career Awareness funds to purchase and maintain needed equipment and supplies for the course, subject to the following:

(i) LEA expenditures shall be reasonable and necessary to sustain the College and Career Awareness program;

(ii) LEA expenditures shall be adequately documented;

(iii) an LEA may not use funds to cover the cost of goods and services for personal use;

(iv) an LEA may not use funds for costs associated with:

(A) entertainment;

(B) amusement;

(C) diversion; and

(D) social activities; and

(v) an LEA may only use funds for costs that will directly achieve program outcomes for students.

(b) Notwithstanding, Subsection (1)(a), an LEA may use up to 15% of available funds for teachers, counselors, and administrators to participate in on-going professional development sponsored by the Board.

(2) An LEA shall meet all requirements of this R277-916 in order to receive College and Career Awareness funding.

(3) College and Career Awareness funds shall be allocated to an LEA for an approved school using a base amount per school.

(4) The Superintendent shall distribute funds remaining after funds are distributed under Subsection (3), based on enrollment in grade 7 to approved schools based on the prior year's October 1 enrollment report for the previous year.

(5) An LEA shall annually complete a funding application with assurances of each school meeting College and Career Awareness standards.

(6) The Superintendent shall annually provide training to personnel from each school receiving funds under this Subsection (3).

(7) The Superintendent shall allocate continued funding to an LEA based on the LEA's success in meeting established standards.

R277-916-4. Standards.

(1) An LEA may qualify for College and Career Awareness funds consistent with the following:

(a) College and Career Awareness program funds may not be used for personnel costs;

(b) a school shall teach 180 days of College and Career Awareness as a stand alone course with distinct credit, incorporating each element set forth in Subsection R277-916-2(1);

(c) College and Career Awareness teachers and counselors shall have appropriate licenses and endorsements;

(d) a school shall utilize the services of a WBL coordinator, where available, to integrate grade level appropriate WBL activities into College and Career Awareness.

(e) if a WBL coordinator is not available, the College and Career Awareness team shall plan and provide WBL activities;

(f) a school shall integrate career development applications into the College and Career Awareness program and use the services of a counselor in the program;

(g) an LEA shall support staff development activities relevant to the core College and Career Awareness content adopted by the Board;

(h) College and Career Awareness personnel in a school shall fully participate in:

(i) evaluating the current program;

(ii) recommending changes or modifications; and

(iii) pilot testing and implementing new activities, materials, and resources; and

(i) College and Career Awareness personnel shall participate in the CTE Program Approval evaluation every three years.

KEY: college and career awareness, public schools

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R317. Environmental Quality, Water Quality.
R317-5. Large Underground Wastewater Disposal (LUWD) Systems.
R317-5-1. Authority, Purpose, Scope, Jurisdiction, Waiver Approval and Administrative Requirements.

1.1. Authority.

Construction and operating permits and approvals are issued pursuant to the provisions of Utah Water Quality Act Sections 19-5-104, 19-5-106, 19-5-107 and 19-5-108. Violation of these permits or approvals including compliance with the conditions thereof, or beginning construction, or modification without the director's approval, is subject to the penalties provided in Section 19-5-115.

1.2. Purpose.

A. The purpose of this rule is to protect the public health and the environment from potential adverse effects from large underground wastewater disposal systems within the boundaries of Utah.

B. This rule incorporates specific provisions contained in Rule R317-4 that are referenced herein, and pertinent to large underground wastewater disposal (LUWD) systems for the purpose of providing minimum design standards. Where the engineered design includes information supporting a deviation from the minimum requirements within this rule or referenced to in Rule R317-4, then the engineer may request a waiver. This rule also establishes the administrative requirements for obtaining from the division a LUWD system:

1. approval-in-concept;
2. construction permit;
3. authorization to use; and
4. operating permit

1.3 Scope.

This rule applies to large underground wastewater disposal systems designed to handle more than 5,000 gallons per day of domestic wastewater, or wastewater that originates in multiple units under separate ownership (except condominiums), or any other underground wastewater disposal system not covered under the definition of an onsite wastewater system per Rule R317-4.

A. The engineer shall use recognized practice standards for wastewater treatment to increase long term performance and lessen potential impacts to public health and the environment. Depending on site-specific characteristics, the division may require a LUWD system to pretreat effluent prior to disposal in the absorption system. In general, systems with high waste strength or flows over 15,000 gpd should consider pretreatment. Factors that should be evaluated include, but are not limited to, the following:

1. design flow (gpd)
2. highly variable flows, including seasonal fluctuations;
3. wastewater strength characteristics;
4. site characteristics.
5. proximity to ground water table, considering various soil types and separation distance;
6. ground water classification;
7. proximity to nearby drinking water sources, or location within a drinking water source protection zone; and
8. anticipated system life expectancy.

1.4. Jurisdiction. Large underground wastewater disposal systems are under the jurisdiction of the Division of Water Quality. Local Health Departments may petition the division to require local review for compliance with local requirements prior to the division initiating its review.

1.5 Waiver.

The director may grant a waiver from the minimum requirements stated in this rule, subject to site-specific consideration and justification, but not overriding the safeguarding of public health, protection of water quality or engineering practice. The intent of the waiver is to allow the engineer to utilize site specific information, recognized practice standards, or other acceptable justification while designing an appropriate LUWD system for the property. The engineer is encouraged to discuss waivers with the division staff prior to formal application for feasibility determination review.

R317-5-2. Definitions.

2.1. Definitions found in Rules R317-1 and R317-4 apply to large underground wastewater disposal systems except where specifically replaced by the following definitions:

"Alternative system" means a LUWD system that is not a conventional system.

"Building sewer" means the pipe that carries wastewater from the building to a public sewer, a LUWD system, or other point of dispersal. It sometimes is synonymous with "house sewer".

"Conventional system" means a LUWD system typically consisting of a building sewer, septic tank, and an absorption system utilizing absorption trenches, absorption beds, or deep wall trenches.

"Curtain drain" means any ground water interceptor or drainage system that is backfilled with gravel or other suitable material and is intended to interrupt or divert the course of shallow ground water or surface water away from the LUWD system.

"Malfunctioning or failing system" means a LUWD system that is not functioning in compliance with the requirements of this rule and may include:

1. absorption systems that seep or flow to the surface of the ground or into waters of the state;
2. systems that overflow from any of their components;
3. systems that cause backflow into any portion of a building drainage system;
4. systems discharging effluent that does not comply with applicable effluent discharge standards of its operating permit;
5. leaking septic tanks; or
6. noncompliance with standards stipulated in or by the construction permit, operating permit, or both.

"Maximum ground water table" means the highest elevation that the top of the "ground water table" or "ground water table, perched" is expected to reach for any reason over the full operating life of a LUWD system at that site.

"Mound system" means an alternative LUWD system where the bottom of the absorption system is placed above the elevation of the original site, and the absorption system is contained in a mounded fill body above that grade.

"Packed bed media system" means an alternative LUWD system that uses natural or synthetic media to treat wastewater. Biological treatment is facilitated via microbial growth on the surface of the media. The system may include a pump tank, a recirculation tank, or both.

"Public health hazard" means, for the purpose of this rule, a condition whereby there are sufficient types and amounts of biological, chemical, or physical agents relating to water or sewage that are likely to cause human illness, disorders or disability. These may include pathogenic viruses and bacteria, parasites, toxic chemicals and radioactive isotopes. A malfunctioning LUWD system constitutes a public health hazard.

"Sand lined trench system" means an alternative LUWD system consisting of a series of narrow excavated trenches utilizing sand media and pressure distribution.

"Unapproved LUWD system" means any LUWD system that is deemed by the division to be any of the following:

1. installation without the required division oversight, permits, or inspections;
2. repairs to an existing system without the required division oversight, permits, or inspections; or
3. alteration to an existing system without the required

division oversight, permits, or inspections.

"Waiver" means an acceptable deviation from the requirements established within this rule or referenced rules. The waiver must be acceptable to division staff based on the engineer providing adequate design justification to demonstrate that the deviation proposed will not override the safeguarding of public health, the protection of water quality, or the protection of the receiving environment. Waiver requests should be based on acceptable engineering practice and standards.

R317-5-3. General Standards, Prohibitions, Requirements, and Enforcement.

3.1. Failure to Comply With Rules.

Any person failing to comply with this rule shall be subject to enforcement action as specified in Sections 19-5-115 and 26A-1-123.

3.2. Feasibility.

LUWD systems are not feasible in some areas and situations. If property characteristics indicate conditions that may fail in any way to meet the requirements specified herein, the use of a LUWD system shall be prohibited.

3.3. Prohibited Flows.

No ground water drainage, drainage from roofs, roads, yards, or other similar sources shall discharge into any portion of a LUWD system, but shall be disposed of so they will in no way affect the system. Non-domestic wastes such as chemicals, paints, or other substances that are detrimental to the proper functioning of a LUWD system may not be disposed of in such systems.

3.4. Increased Flows Prohibited.

Wastewater flow may not exceed the design flow of a LUWD system.

3.5. Property Lines Crossed.

Privately owned LUWD systems, including replacement areas, shall be located on the same lot as the building served unless, when approved by the division, a perpetual utility easement and right-of-way is established and recorded on an adjacent or nearby lot for the construction, operation, and continued maintenance, repair, alteration, inspection, relocation, and replacement of a LUWD system, including all rights to ingress and egress necessary or convenient for the full or complete use, occupation, and enjoyment of the granted easement. The easement shall be large enough to accommodate the proposed LUWD system and replacement area. The easement shall meet the setbacks specified in Section R317-4-13 Table 2.

3.6. Initial Absorption Area and Replacement Area.

A. All properties that utilize LUWD systems shall be required to have a replacement area.

B. The absorption area, including installed system and replacement area, may not be subject to activity that is likely to adversely affect the soil or the functioning of the system. This may include vehicular traffic, covering the area with asphalt, concrete, or structures, filling, cutting or other soil modifications.

3.7. Operation and Maintenance.

Owners of a LUWD systems shall operate, maintain, and service their systems according to the standards of this rule.

3.8. No Discharge to Surface Waters or Ground Surface.

Effluent from any LUWD system may not be discharged to surface waters or upon the surface of the ground. Wastewater may not be discharged into any abandoned or unused well, or into any crevice, sinkhole, or similar opening, either natural or artificial.

3.9. Repair of a Malfunctioning or Unapproved System.

Upon determination by the regulatory authority that a malfunctioning or unapproved LUWD wastewater system creates or contributes to any dangerous or unsanitary condition that may involve a public health hazard, or noncompliance with this rule, the regulatory authority shall order the owner to take the necessary action to cause the condition to be corrected, eliminated or otherwise come into compliance.

A. For malfunctioning systems, the regulatory authority shall require and order:

1. all necessary steps, such as maintenance, servicing, repairs, and replacement of system components to correct the malfunctioning system, to meet all rule requirements to the extent possible and may not create any new risk to the environment or public health;

2. effluent quality testing as required by Subsection R317-5-9.2.D;

3. evaluation of the system design including non-approved changes to the system, the wastewater flow, and biological and chemical loading to the system;

4. additional tests or samples to troubleshoot the system malfunction.

3.10. Procedure for Wastewater System Abandonment. Whenever the use of a LUWD system has been abandoned or discontinued, the owner of the real property on which such wastewater system is located shall render it safe by having the septic tank, any other tanks, hollow seepage pit, or cesspool wastes pumped out or otherwise disposed of in an approved manner. Within 30 days the tanks shall be:

A. crushed in place and the void filled;

B. completely filled with earth, sand, or gravel; or

C. removed and backfilled.

3.11. Septage Management.

A person shall only dispose of septage, or sewage contaminated materials in a location or manner in accordance with the requirements of the division and any local agencies having jurisdiction.

3.12. Multiple Units Under Separate Ownership (except condominiums).

The common components of the LUWD system, including the reserve absorption area, shall be under the sponsorship of a body politic.

A. The subsurface absorption system shall be designed and constructed to provide duplicate capacity, meaning two independent systems. Each system shall be designed to accommodate the total anticipated maximum daily flow. The duplicate system shall be designed with appropriate valving, etc., to allow for periodic alternation of the use of each system.

B. Sufficient land area with suitable characteristics shall be planned and available to provide for a third absorption system capable of handling the total maximum daily wastewater flow. This area shall be kept free of permanent structures, traffic or soil modification.

3.13. Underground Injection Control.

Large underground wastewater disposal (LUWD) systems with design flow rates of 5,000 gallons per day or more are co-regulated by the Utah 1422 Underground Injection Control (UIC) Program in Rule R317-7. LUWD systems are authorized-by-rule under the UIC program provided they remain in compliance with the construction and operating permits issued according to Rule R317-5. However, if any noncompliance with these permits results in the potential for or demonstration of actual exceedance of any Utah Maximum Contaminant Levels (MCLs) in a receiving ground water, the noncompliance may also be a violation of the Utah UIC administrative rules and therefore be subject to enforcement action. Owners and operators of a large underground wastewater disposal system are required to submit UIC inventory information according to Subsection R317-7-6.4(C) using the approved form for a LUWD system.

R317-5-4. Feasibility Determination and Approval-in-Concept.

4.1. General Criteria for Determining LUWD System

Feasibility.

The division shall determine the feasibility of using a LUWD system. Upon favorable determination for feasibility an approval-in-concept will be granted by the division.

A. General Information. The required information shall include:

1. situs address if available;

2. name and address of the property owner and person requesting feasibility;

3. the location, type, and depth of all existing and proposed private and public drinking water wells, and other water supply sources within 1500 feet of the proposed LUWD system;

4. the location of all drinking water source protection zones delineated on the project site;

5. the location of all existing creeks, drainages, irrigation ditches, canals, and other surface and subsurface water conveyances within 1500 feet of the proposed LUWD system;

6. the location and distance to nearest sewer, owner of sewer, whether property is located within service boundary, and size of sewer; and

7. statement of proposed use if other than a single-family dwelling.

B. If the proposed LUWD system is located in aquifer recharge areas or areas of other particular geologic concern, the division may require such additional information relative to ground water movement, or possible subsurface wastewater flow.

C. Soil and Site Evaluation.

1. Soil Exploration Pit and Percolation Test.

a. A minimum of five soil exploration pits shall be excavated to allow the evaluation of the soils. The soil exploration pits shall be constructed and soil logs recorded as detailed in Section R317-4-14 Appendix C.

b. The division may require percolation tests in addition to the soil exploration pits.

c. The division may require additional pits, tests, or both where:

i. soil structure varies;

ii. limiting geologic conditions are encountered; or

iii. the division deems it necessary.

d. The percolation test shall be conducted as detailed in Section R317-4-14 Appendix D.

e. Soil exploration pits and percolation tests shall be conducted as closely as possible to the proposed absorption system site. The division shall have the option of inspecting the open soil exploration pits and monitoring the percolation test procedure. All soil logs and percolation test results shall be submitted to the division.

f. When there is a substantial discrepancy between the percolation rate and the soil classification, it shall be resolved through additional soil exploration pits, percolation tests, or both.

g. Absorption system feasibility and sizing shall be based on Section R317-4-13 Table 5 or 6.

2. Wind-Blown Sand.

The extremely fine grained wind-blown sand found in some parts of Utah shall be deemed not feasible for LUWD systems unless pretreatment is provided, as percolation test results in wind-blown sand will generally be rapid, but experience has shown that this soil has a tendency to become sealed with minute organic particles within a short period of time.

3. Suitable Soil Depth.

For conventional systems, effective suitable soil depth shall extend at least 48 inches or more below the bottom of the dispersal system to bedrock formations, impervious strata, or excessively permeable soil. Some alternative LUWD systems may have other requirements.

4. Ground Water Requirements.

The elevation of the anticipated maximum ground water table shall meet the separation requirements of the anticipated absorption systems.

a. Maximum Ground Water.

Maximum ground water table shall be determined where the anticipated maximum ground water table, including irrigation induced water table, might be expected to rise closer than 48 inches to the elevation of the bottom of a LUWD system. Maximum ground water table shall be determined where alternative LUWD wastewater systems may be considered based on groundwater elevations. The maximum ground water table shall be determined by the following.

i. Regular monitoring of the ground water table, or ground water table, perched, in an observation well for a period of one year, or for the period of the maximum groundwater table.

(1) Previous ground water records and climatological or other information may be consulted for each site proposed for a LUWDS system and may be used to adjust the observed maximum ground water table elevation.

ii. Direct visual observation of the maximum ground water table in a soil exploration pit for:

(1) evidence of crystals of salt left by the maximum ground water table; or

(2) chemically reduced iron in the soil, reflected by redoximorphoric features i.e., a mottled coloring.

(3) Previous ground water records and climatological or other information may be consulted for each site proposed for a LUWD system and may be used to adjust the observed maximum ground water table elevation in determining the anticipated maximum ground water table elevation.

iii. In cases where the anticipated maximum ground water table is expected to rise to closer than 34 inches from the original ground surface and an alternative LUWD system would be considered, previous ground water records and climatological or other information shall be used to adjust the observed maximum ground water table in determining the anticipated maximum ground water table.

b. Curtain Drains.

A curtain drain or other effective ground water interceptor may be allowed as an attempt to lower the groundwater table to meet the requirements of this rule. The division shall require that the effectiveness of such devices in lowering the ground water table be demonstrated during the season of maximum ground water table.

5. Ground Slope.

Absorption systems may not be placed on slopes where the addition of fluids is judged to create an unstable slope.

a. Absorption systems may be placed on slopes between 0% and 25%, inclusive.

b. Absorption systems may be placed on slopes greater than 25% but not exceeding 35% if:

i. all other requirements of this rule can be met;

ii. effluent from the proposed system will not contaminate ground water or surface water, and will not surface or move off site before it is adequately treated to protect public health and the environment;

iii. no slope will fail, and there will be no other landslide or structural failure if the system is constructed and operated adequately, even if all properties in the vicinity are developed with a LUWD system; and

iv. a report is submitted by a professional engineer or professional geologist that is licensed to practice in Utah. The report shall be imprinted with the engineer's or geologist's registration seal and signature and shall include the following.

(1) Predictions and supporting information of ground water transport from the proposed system and of expected areas of ground water mounding.

(2) A slope stability analysis that shall include information about the geology of the site and surrounding area, soil

exploration and testing, and the effects of adding effluent.

(3) The cumulative effect on slope stability of added effluent if all properties in the vicinity were developed with LUWD systems.

c. Absorption systems may not be placed on slopes greater than 35%.

6. Other Factors Affecting a LUWD System Feasibility.

a. The locations of all rivers, streams, creeks, dry or ephemeral washes, lakes, canals, marshes, subsurface drains, natural storm water drains, lagoons, artificial impoundments, either existing or proposed, that will affect building sites, shall be provided.

b. Areas proposed for LUWD wastewater systems shall comply with the setbacks in Section R317-4-13 Table 2.

c. If any part of a property lies within or abuts a flood plain area, the flood plain shall be shown within a contour line and shall be clearly labeled on the plan with the words "flood plain area".

7. Unsuitable.

Where soil and other site conditions are clearly unsuitable for the placement of a LUWD system, there is no need for conducting soil exploration pits or percolation tests.

R317-5-5. Engineering Reports, Plans and Construction Permits.

All engineering reports, plans and specifications shall be prepared by a registered professional engineer licensed to practice in the State of Utah and certified Level 3 in accordance with Rule R317-11.

5.1 Engineering Report.

An engineering report shall be submitted which shall contain design criteria along with all other information necessary to clearly describe the proposed project and demonstrate project feasibility as described in feasibility determination and approval-in-concept of Section R317-5-4.

5.2. Plan Review.

Submission of plans for review. Plans for new, alterations, repairs and replacements of large underground wastewater disposal systems shall be submitted to the division for review as required by Rule R317-1 and include the following:

A. Local Health Departments Requirements.

It is the applicant's responsibility to ensure that a LUWD System application to the division is in compliance with local health department requirements regarding the location, design, construction and maintenance of a LUWD system prior to the applicant submitting a request for a construction permit to the division. Where the petition has been approved by the director, the applicant is required to submit documentation that the local health department has approved the proposed LUWD system before a construction permit may be issued.

B. Information Required.

Plans submitted for review shall be drawn to scale, 1" = 10', 20' or 30', or other scale as approved by the division. Plans shall be prepared in such a manner that the contractor can read and follow them in order to install the system properly. Depending on the individual site and circumstances, or as determined by the division, some or all of the following information may be required.

1. Applicant Information.

a. The name, current address, and telephone number of the applicant.

b. Complete address, legal description of the property, or both to be served by this LUWD system.

2. LUWD System Site Plan.

a. Submittal date of plan.

b. North arrow.

c. Lot size and dimensions.

d. Legal description of property.

e. Ground surface contours, preferably at 2 foot intervals, of both the original and proposed final grades of the property, or relative elevations using an established bench mark.

f. Location and explanation of type of dwelling(s) or structure(s) to be served by a LUWD system.

g. Location and dimensions of paved and unpaved driveways, roadways and parking areas.

h. Location and dimensions of the essential components of the wastewater system including the replacement area for the absorption system.

i. Location of all soil exploration pits and all percolation test holes.

j. Location of building sewer and water service line to serve the building.

k. Location of sewer mains, manholes, clean-outs, and other appurtenances.

l. Location of easements or drainage right-of-ways affecting the property.

m. Location of all intermittent or year-round streams, ditches, watercourses, ponds, subsurface drains, etc. within 100 feet of proposed LUWD system.

n. The location, type, and depth of all existing and proposed water supply sources

o. Delineation of all drinking water source protection zones located on the project site.

p. Distance to nearest public water main and size of main.

q. Distance to nearest public sewer, size of sewer, and whether accessible by gravity.

3. Statement with Site Plan.

Statement indicating the source of culinary water supply, whether a well, spring, non-public or public system, its location and distances from all LUWD systems.

4. Soil Evaluation.

a. Soil Logs, Percolation Test Certificates, or both.

b. Statement with supporting evidence indicating the maximum anticipated ground water table and the flooding potential for LUWD system sites.

5. Relative Elevations.

Show relative elevations of the following, using an established bench mark.

a. Building drain outlet.

b. The inlet and outlet inverts of any septic tanks.

c. Septic tank access cover, including height and diameter of riser, if used.

d. Pump tank inlet, if used, including height and diameter of riser.

e. The outlet invert of the distribution box, if provided, and the ends or corners of each distribution pipe lateral in the absorption system.

f. The final ground surface over the absorption system.

6. System Design.

Details for said site, plans, and specifications are listed in Design in Section R317-4-6.

a. Schedule or grade, material, diameter, and minimum slope of building sewer and effluent sewer.

b. Septic tank and pump tank capacity, design, cross sections, etc., materials, and dimensions. If tank is commercially manufactured, state the name and address of manufacturer.

c. Absorption system details, including the following:

i. details of drop boxes or distribution boxes, if provided;

ii. schedule or grade, material, and diameter of distribution pipes;

iii. length, slope, and spacing of each absorption system component;

iv. maximum slope across ground surface of absorption system area;

v. distance of absorption system from trees, cut banks, fills, or subsurface drains; and cross section of absorption system showing the:

(1) depth and width of absorption system excavation;
(2) depth of distribution pipe;
(3) depth of filter material;
(4) barrier material, i.e., synthetic filter fabric, straw, etc., used to separate filter material from cover; and
(5) depth of cover.

d. Pump, if provided, details as referenced in Section R317-4-14 Appendix B.

e. If an alternative LUWD system is designed, include all pertinent information to allow plan review and permitting for compliance with this rule.

C. Plans Submitted.

1. All applicants requesting plan approval for a LUWD shall submit two copies of the above required information to enable the division to retain one copy as a permanent record.

2. Applications may be rejected if proper information is not submitted.

5.3. Construction Permit Required.

No person shall make or construct any device for treatment or discharge of wastewater without first receiving a permit to do so from the director.

R317-5-6. Design Requirements.

6.1. Shall meet the requirements of Section R317-4-6, with these exceptions:

A. When a LUWD serves multiple single family dwellings the wastewater flow shall be estimated at 400 gpd per dwelling.

B. Minimum separation distance from the bottom of the absorption trenches to the anticipated maximum ground water table is 48 inches. If a mound, sand lined trench, or packed bed pretreatment unit is designed and installed on the LUWD system, the horizontal separation distance may be reduced to 24 inches.

6.2. Components Required in a LUWD System:

A. A septic tank;

B. An effluent filter;

C. A pressurized subsurface disposal system.

1. This may be an absorption field, deep wall trenches, absorption beds, or, for packed bed media applications, drip irrigation dispersal, depending on location, topography, soil conditions and maximum ground water level.

2. Pressurized systems require cleanouts at the end of pressurized laterals and typically require a dosing chamber or dosing tank.

3. The Utah Guidance for Performance, Application, Design, Operation and Maintenance: Pressure Distribution Systems document shall be used for design requirements, along with the following:

a. Dosing pumps, controls and alarms shall comply with Section R317-4-14 Appendix B.

b. Pressure distribution piping.

i. All pressure transport, manifold, lateral piping, and fittings shall meet PVC Schedule 40 standards or equivalent.

ii. The ends of lateral piping shall be constructed with sweep elbows or an equivalent method to bring the end of the pipe to the final grade. The ends of the pipe shall be provided with threaded plugs, caps, or other devices acceptable to the division to allow for access and flushing of the lateral.

D. Accessibility components to insure proper maintenance and servicing. These include that all tanks shall have access risers to the surface of the ground; and absorption field inspection ports.

E. Additional components may also be required depending on the waste stream characteristics and the need to provide adequate protection to groundwater. These components may include pretreatment devices such as grease traps, or may involve secondary treatment using packed bed media systems.

R317-5-7. Construction and Installation.

Shall meet the requirements of Section R317-4-7.

R317-5-8. Final Inspection and Authorization to Use.

8.1. Final inspection.

Upon completion of construction, but before backfilling, the system designer must notify the division of completion and schedule a final inspection with the division. Where the local health department has the authority to issue operating permits they shall be included in the final inspection. The final inspection shall meet the requirements of Section R317-4-8. No wastewater may be introduced into a LUWD system until an authorization to use has been issued by the division.

8.2. Authorization to Use

The following documents, sealed by the engineer, must be provided to the division in order to receive authorization to use:

A. Written certification that the system was installed in accordance with the construction permit and any approved change orders.

B. Two record drawings of the completed system.

C. Two Operation and Maintenance Manuals. Manuals must include details of:

1. individuals of contact for the installed system;
2. list of all key components of the system;
3. maintenance and service instructions of each component;
4. schedule of maintenance inspections and servicing.

D. Written recommendation to the owner to place the facilities into service, pending issuance of the authorization to use by the division.

R317-5-9. Operation and Maintenance.

9.1. Operation and maintenance shall be provided by the owner to ensure the disposal system is functioning properly at all times.

9.2. The owner is responsible for maintaining a LUWD system and for performing periodic inspections, servicing and monitoring of its system as detailed in the issued operating permit, including the following:

A. Any new system installed after April 2009 must have a written operation and maintenance manual document describing the treatment and disposal system and outlining routine maintenance procedures, including checklists and maintenance logs needed for proper operation of the system.

B. Each LUWD Conventional System shall be assessed after the first year of operation and annually thereafter.

C. Each LUWD Pressure Distribution System shall be inspected as outlined in Section R317-4-23 Tables 7.1 and 7.2.

D. LUWD Alternative Systems.

1. Each alternative system shall be inspected as outlined in Section R317-4-13 Tables 7.1 and 7.2.

2. Each packed bed media system shall be sampled a minimum of every six months as outlined in Section R317-4-13 Table 7.3.

a. The grab sample shall be taken before discharge to an absorption system.

b. Effluent not meeting the standards of Section R317-4-13 Table 7.3, shall be followed with two successive weekly tests of the same type within a 30 day period from the first exceedance.

3. If two successive samples exceed the minimum standards, the system shall be deemed to be malfunctioning, and shall require further evaluation and a corrective action plan, see Subsection R317-5-3.9.

R317-5-10. Operating Permits and Annual Inspection Reports.

10.1. Operating Permit required.

An operating permit is required for all LUWD systems to monitor that proper operation and maintenance is occurring for

the protection of the environment and public health. The operating permit shall be issued by the director or, by delegated authority, the local health department having jurisdiction, and shall be effective for a period not to exceed 5 years from the date of issuance.

10.2. Local Health Department Authority to Issue Operating Permits.

Local health departments may request delegated authority to administer the operating permit program. The request must include an agreement to implement and enforce inspection, servicing, monitoring, and reporting requirements of this rule. The local health department must submit an annual report on or before September 1 of each calendar year, to the division containing:

A. A list of LUWD systems under delegation.

B. A summary listing the compliance status of each system, showing those systems that are currently failing, and those systems that have been repaired.

C. A summary of any enforcement actions taken, identifying those actions that are still pending, and those that been resolved.

10.3. Annual Inspection Report.

The owner of a LUWD system shall summit an annual inspection report covering the period of July 1 to June 30, the "reporting year", to the permitting agency no later than August 1 of each year. In this report, the owner shall report on all requirements listed in the operating permit. As a minimum, the report shall include the following items:

A. Facility name and address; owner name, address, and phone number;

B. List of facility components, e.g., septic tank, pump tank, gravel drainfield trench, gravelless chambers, pressure drainfield, etc.;

C. Design flow in gallons per day and number and type of connections;

D. Type of waste treated and disposed, i.e., residential, restaurant, other commercial establishment, etc.;

E. Checklist of inspections performed including the date of the inspection and a list of findings. The report must include, where pertinent:

1. measured sludge and scum levels;

2. date tanks were last pumped;

3. verify pumps, floats; and control panel are operating as designed;

4. date pump filter last cleaned;

5. date pressure laterals last cleaned and flushed and squirt height recorded;

6. any surfacing in absorption field; and

7. any observed or suspected system malfunction;

F. Packed Bed media system sampling results, where pertinent;

G. Name of the certified individual per Rule R317-11 conducting the inspection;

H. Signature of owner or certified operator, and date.

KEY: water pollution, large underground wastewater, sewerage, engineering
March 26, 2014 19-5
Notice of Continuation April 25, 2017

R317. Environmental Quality, Water Quality.
R317-550. Rules for Liquid Waste Operations.
R317-550-1. Definitions.

The following definitions shall apply in the interpretation and enforcement of this rule. The word "shall" as used herein indicates a mandatory requirement. The term "should" is intended to mean a recommended or desirable standard.

"Chemical Toilet" means a nonflush device wherein the waste is deposited directly into a receptacle containing a solution of water and chemical. It may be housed in a permanent or portable structure.

"Collection Vehicle" means any vehicle, tank, trailer, or combination thereof, which provides commercial collection, transportation, storage, or disposal of any waste defined as liquid waste.

"Division" means the Utah Division of Water Quality.

"Liquid Waste Operation" means any business activity or solicitation by which liquid wastes are collected, transported, stored, or disposed of by a collection vehicle. This shall include, but not be limited to, the cleaning out of septic tanks, wastewater holding tanks, chemical toilets, and vault privies.

"Liquid Waste Operator" means any person who conducts the business of a liquid waste operation.

"Liquid Waste" means, for the purpose of this rule, domestic wastewater or sewage.

"Local Health Department" means a county or multicounty local health department established under Title 26A.

"Person" means an individual, trust, firm, estate, company, corporation, partnership, association, state, state or federal agency or entity, municipality, commission, or political subdivision of a state as defined in Section 19-1-103.

"Public Health Hazard" means, for the purpose of this rule, a condition whereby there are sufficient types and amounts of biological, chemical, or physical agents relating to wastes that are likely to cause human illness, disorders, or disability. These include, but are not limited to, pathogenic viruses and bacteria, parasites, and toxic chemicals.

"Regulatory Authority" means either the Utah Division of Water Quality or the local health department having jurisdiction.

"Septic Tank" means a watertight receptacle which receives the discharge of a drainage system or part thereof, designed and constructed so as to retain solids, digest organic matter through a period of detention, and allow the liquids to discharge into soil outside of the tank through an underground absorption system.

"Tank" means any container that when placed on a vehicle is used to transport wastes removed from a septic tank, wastewater holding tank, chemical toilet. or vault privy.

"Vault Privy" means any facility wherein the waste is deposited without flushing, into a permanently-installed, watertight, vault or receptacle, which is usually installed below ground.

"Wastewater Holding Tank" means a watertight receptacle designed to receive and store liquid wastes to facilitate treatment at another location.

R317-550-2. Authority, Purpose and Scope of Rule.

2.1. These rules are administered by the division authorized by Title 19 Chapter 5.

2.2. The collection, storage, transportation, and disposal of all liquid wastes by liquid waste operators shall be accomplished in a sanitary manner which does not create a public health hazard or nuisance, or adversely affect the quality of the waters of the State.

2.3. A liquid waste operator shall have a current permit issued by the local health department having jurisdiction prior to initiating a liquid waste operation.

R317-550-3. Permitting Requirements.

3.1. Prior to initiating a liquid waste operation, the liquid waste operator shall make application to the local health department having jurisdiction for a permit to operate. The application shall include:

A. Name, address, and telephone number of applicant. If applicant is a partnership, the names and addresses of the partners; and if a corporation, the name and address of the corporation.

B. Name and address of the places of business if different from above.

C. Applicant shall state the number of collection vehicles to be used, description of vehicles (make, model, year, and license number), tank capacity, and any other related information required by the local health department.

D. A list of all sites shall be provided that are used for disposal of wastes resulting from the liquid waste operation. Applicants may be required by the regulatory authority to provide proof of permission to dispose of wastes at such sites.

3.2. To protect all persons damaged by faulty workmanship resulting from liquid waste operations, and to guarantee payment of monies owing incident to these regulations, the regulatory authority may require a surety bond and proof of general liability insurance as part of the application.

3.3. The operating permit shall be renewed at least every 3 years.

R317-550-4. Inspection of Liquid Waste Operations.

4.1. The regulatory authority may inspect all equipment and, if necessary, disposal sites to be used in connection with the liquid waste operation.

R317-550-5. Collection Vehicle Requirements.

5.1. Collection vehicle identification requirements shall be determined by the local health department having jurisdiction.

5.2. Each collection vehicle shall conform to the following minimum specification:

A. Tanks shall be of watertight construction, fully enclosed, durable, and shall be provided with suitable covers to prevent spillage during transport. The capacity of the tank in U.S. gallons shall be determined accurately by calculation, metering, or as specified by the manufacturer, and shall be plainly, legibly, and permanently marked or stamped on the exterior of the tank.

B. The collection vehicle shall be equipped with either a positive displacement pump or other type of pump which will not allow any spillage and will be self-priming.

C. The discharge connection of the tank shall be provided with a valve and with a threaded screw cap or other acceptable sealing device. When not in use, the valve shall be closed and the threaded screw cap or sealing device shall be in place to prevent accidental leakage or discharge.

5.3. When in use, pumping equipment shall be so operated that a public health hazard or nuisance will not be created. Each collection vehicle should at all times be supplied with a pressurized wash water tank, disinfectant, and implements needed for cleanup purposes in the event of accidental spillage of waste on the ground. The operator shall ensure that such spills are cleaned and disinfected in such a manner to render them harmless to human and animals.

5.4. Sewage hoses on collection vehicles shall be thoroughly drained, capped, and stored in such a manner that they will not create a public health hazard or nuisance.

5.5. Tanks used for collection, transportation, and storage of wastes shall be so constructed that the exterior can be easily cleaned.

5.6. All collection vehicles, when parked and not in use, shall be protected and maintained in such a manner that they will not promote an odor nuisance, the breeding of insects, the attraction of rodents, or create any other public health hazard or

nuisance.

R317-550-6. Conduct of Liquid Waste Operations, Including Submission of Reports.

6.1. All services rendered by the liquid waste operation shall be conducted in a sanitary manner that does not create a public health hazard or nuisance. After the services are rendered, the liquid waste operator shall furnish the customer with a written receipt that carries the business name and address of the liquid waste operation.

6.2. All wastewater components, consisting of scum, sludge, and liquid waste, shall be removed from septic tanks, wastewater holding tanks, chemical toilets, and vault privies. See Subsection R317-4-14 Appendix E for septic tank operation and maintenance.

6.3. The liquid waste operation shall submit summary data of their business activity to the regulatory authority as often as required by that agency. Summary data information shall include:

A. Source of all waste pumped on each occurrence, including name and address of source. If necessary, this information may be provided in code and made available for inspection at the business address of the liquid waste operation.

B. Specific type of waste disposal; system services on each occurrence.

C. Quantity of wastes pumped on each occurrence.

D. Name and location of authorized disposal site where liquid wastes were deposited for disposal.

R317-550-7. Disposal of Wastes at Approved Locations.

7.1. All wastes collected shall be disposed in accordance with the rules and regulations of the Division and the local health department having jurisdiction. Disposal shall be accomplished by one of the following methods:

A. Into a public sewer system at the place and point in the system designated and approved by the appropriate authority.

B. Into a landfill which has been approved by the Director of the Division of Solid and Hazardous Waste for disposal of such wastes and in accordance with Rules R315-301 through R315-320, and with concurrence by the local health department.

C. Land disposal, in accordance with the provisions of Subsection R317-8-1.10(10), if approved by the Director and with the concurrence of the local health department.

7.2. No waste shall be deposited into a sewerage system or treatment works that will have a detrimental effect on the overall operation.

7.3. Under no circumstances shall dumping of wastes be permitted into any public or private lake, pond, stream, river, watercourse, or any other body of water, or onto any public or private land which has not been designated as an approved disposal site.

7.4. It shall be unlawful for any liquid waste operation to transport, treat, store, or dispose of hazardous wastes as defined by 19-6-102(7) without complying with all provisions of Rules R315-1 through R315-301.

R317-550-8. Failure to Comply With Rules.

Any person failing to comply with these rules shall be subject to action as specified in Section 19-5-115.

KEY: dumping of wastes, liquid waste, pollution
July 30, 2014 19-5-104
Notice of Continuation April 25, 2017

R317. Environmental Quality, Water Quality.
R317-560. Rules for the Design, Construction, and Maintenance of Vault Privies and Earthen Pit Privies.
R317-560-1. Definitions.

The following definitions shall apply in the interpretation and enforcement of these rules. The word "shall" as used herein means a mandatory requirement. The term "should" is intended to mean a recommended or desirable standard.

1.1 "Division" - means the Utah Division of Water Quality

1.2 "Earthen Pit Privy" - means a toilet facility consisting of a pit in the earth covered with a privy building affording privacy and shelter and containing 1 or more stools with an opening into the pit.

1.3 "Health Officer" - means the Director of a local health department or his authorized representative.

1.4 "Local Health Department" - means a city-county or multi-county local health department established under Title 26A.

1.5 "Vault Privy" - means a toilet facility wherein the waste is deposited without flushing into a permanently-installed, watertight vault or receptacle. Vault wastes must be periodically removed and disposed of in accordance with these rules.

R317-560-2. General Requirements.

2.1 Vault privies and earthen pit privies are permitted as a substitute for water closets, for temporary or limited use in remote locations where provisions for water supply or wastewater disposal pose a significant problem. The intended primary use of vault and pit privies in this rule is for facilities such as labor camps, semi-developed and semi-primitive recreational camps, temporary mass gatherings, and other approved uses. Potable water under pressure may or may not be available.

2.2 Requests for the use of vault privies or earthen pit privies shall be evaluated on a case-by-case basis by the local health department having jurisdiction and must receive the written approval of the local health officer or his designated representative prior to the installation of such devices.

2.3 Vault privies and earthen pit privies shall be located and constructed in such a manner to prevent the entrance of precipitation or surface water into the vault or pit, either as runoff or as flood water.

2.4 All vault privies shall comply with the following:

A. They shall be located a minimum of:

(1) 10 feet from property lines and water distribution pipes.

(2) 15 feet and not more than 500 feet from any living or camping spaces served.

(3) 50 feet from any nonpublic culinary water source and from any lake, stream, river, or watercourse, measured from the high water line.

B. They shall be located at least 100 feet from "deep" public water supply wells. It is recommended that vault privies be located at least 1500 feet from "shallow" wells and springs used as public water sources. Any proposal to locate closer than 1500 feet must be reviewed and approved on a case-by-case basis by the health authority, taking into account geology, hydrology, topography, existing land use agreements, and potential for pollution of water source. Any person proposing to locate a vault privy closer than 1500 feet to a public "shallow" well or spring must submit a report to the health authority which considers the above items. The minimum required isolation distance where optimum conditions exist and with the approval of the health authority may be 100 feet. R309-106 requires a protective zone, established by the public water supply owner, before a new source is approved. Public water sources which existed prior to the requirement for a protective zone requirement may not have acquired one. Such circumstances must be reviewed on a case-by-case basis by the health authority. "Deep" wells and "shallow" public water supply sources are as defined in R309-106.

C. The maximum high water table shall be at least 2' below the maximum depth of the vault.

2.5 All earthen pit privies shall comply with the following:

A. They shall be located a minimum of:

(1) 25 feet from property lines and water distribution pipes.

(2) 25 feet and not more than 500 feet from any living or camping spaces served.

(3) 100 feet from any lake, stream, river, or watercourse, measured from the high water line.

B. They shall be located at least 100 feet from "deep" wells that are nonpublic water supply sources. They shall be located at least 200 feet from "shallow" wells and springs that are nonpublic water supply sources. Although this latter separation distance shall be generally adhered to as the minimum required separation distance for "shallow" nonpublic water supply sources, exceptions may be approved on a case-by-case basis by the health authority, taking into account geology, hydrology, topography, existing land use agreements, and potential for pollution of water source. Any person proposing to locate an earthen pit privy closer than 200 feet to an individual or nonpublic "shallow" well or spring must submit a report to the health authority which considers the above items. In no case shall the health authority grant approval for an earthen pit privy to be closer than 100 feet from a "shallow" well or spring. "Deep" wells and "shallow" nonpublic water supply sources shall be defined as for public water sources in R309-106.

C. They shall be isolated from public water supply sources as specified for vault privies in R317-560-2.4.B.

D. The maximum high water table shall be at least 4' below the maximum depth of the pit.

R317-560-3. Design and Construction Requirements.

3.1 All vault privies shall have vaults or receptacles which are watertight and shall be constructed of reinforced concrete, metal or other material of equal durability which has been approved by the local health department. Inside and outside surfaces of metal vaults shall be thoroughly coated with a good quality asphalt-base material.

3.2 For all earthen pit privies, pit cribbing shall be installed in the pit to prevent caving of soil into the pit and to insure a firm foundation for the building. The pit cribbing shall fit firmly, be in uniform contact with the earth walls on all sides, and shall descend to the full depth of the pit and rise flush with the ground surface.

3.3 All vault privies and earthen pit privies shall comply with the following:

A. A sill or foundation constructed of concrete or treated lumber shall be placed on the ground surface around the vault or pit so as to underlie the floor area of the privy building.

B. A floor and riser of impervious material shall be placed over the sill and vault or pit in such a manner to prevent access of rodents and insects into the vault or pit.

C. The privy building shall be firmly anchored, rigidly constructed, free from hostile surface features such as sharp edges and exposed nail points, and shall afford complete privacy and protection from the elements. The building shall be of fly-tight construction. The door(s) shall be self-closing and provided with an inside latch. Interior floors, walls, ceilings, partitions, and doors shall be finished with readily cleanable materials resistant to wastes and cleaners.

D. The building shall be ventilated by leaving approximately 4-inch openings at (1) the top of two opposite walls just beneath the roof, and (2) at the bottom of two opposite walls just above the floor, all of which are screened with 16-mesh screen or smaller of durable material. Hardware

mesh with 1/4" openings may be placed on the inside and outside of the screened openings to protect the smaller mesh screen. Direct line of sight into the building through the bottom ventilation openings shall be effectively obstructed with a louver or other suitable means.

E. Each vault or pit shall be vented to atmosphere with a minimum of 100 square inches of vent area for each seat connected to the vault. (One hundred square inches is equivalent to two 8-inch pipes, or one 12-inch pipe.) Roof vents must extend at least 12 inches above the highest point of the roof and shall be provided with a rain cap and screened with 16-mesh screen or smaller of durable material. Venting to an attic vent may be provided for by utilizing the space between an inside and outside wall if that space provides sufficient area.

F. The seat should be so spaced as to provide a minimum clear space of 24 inches between each seat opening in multiple unit installations, and should provide 12 inches clear space from the seat opening to the sidewall in single and multiple units. In multiple unit installations, partitions should be provided between risers to afford user privacy.

G. The seat riser should have an inside clearance of not less than 21 inches from the front wall and not less than 24 inches from the rear wall of the privy building.

H. The seat top should be not less than 12 inches nor more than 16 inches above the floor.

I. The seat opening shall be covered with an attached, movable toilet seat and lid of easily cleanable, impervious material that can be raised to allow sanitary use as a urinal and can be closed when not in use. Privy buildings for public use shall be provided with open-front seats.

J. Commercially preconstructed vault privy buildings not incorporating all of the requirements of these rules may be evaluated for approval on a case-by-case basis by local health departments.

R317-560-4. Maintenance Requirements.

4.1 Odor-control chemicals or disinfectants may be added to the vault or pit at frequent intervals to prevent bacterial decomposition and resulting odors. Extreme caution should be exercised to insure that these chemicals are not spilled on or allowed to remain on the seat. Garbage, ashes, oil, hazardous or toxic wastes, or other wastes not normally deposited in vault privies or earthen pit privies shall not be disposed of therein.

4.2 All vault privies and earthen pit privies shall be maintained in a satisfactory manner to prevent the occurrence of a public health nuisance or hazard or to preclude any adverse affect upon the quality of any waters of the State.

4.3 Toilet paper with a holder should be provided for every seat. An adequate supply of toilet paper should be maintained at all times.

4.4 All vault privies shall comply with the following:

A. The vault or receptacle is not permitted to be filled to a point higher than 12 inches below the floor surface of the privy building.

B. Vault wastes shall be periodically emptied at sufficiently frequent intervals to prevent creation of an insanitary condition, and shall be transported in an acceptable manner to a disposal site approved by the Division. Where disposal in a public sewer system is not possible, vault wastes must be deposited in approved sanitary landfills.

4.5 All earthen pit privies shall comply with the following:

A. When the pit becomes filled to within 18 inches of the ground surface, a new pit shall be excavated and the old one shall be backfilled with approximately 2 feet of compacted earth and mounded slightly to allow for settlement and to prevent depressions for surface ponding of water.

TABLE

Type of Camp	Source	Storage
Modern camps with full facilities	60 gal/day/person	30 gal/person
Semi-developed camps, and day-use areas with limited facilities (With flush type toilets)	Minimum 5 gal/ day/person 20 gal/day/person	Minimum 2.5 gal/person 10 gal/person

KEY: waste water, waste disposal, sewerage, toilets
1993 19-5-104
Notice of Continuation April 25, 2017

R380. Health, Administration.
R380-1. Petitions for Department Declaratory Orders.
R380-1-1. Authority.

As required by Section 63G-4-503, and as authorized by Sections 26-1-5(3) and 26-1-17, this rule provides the procedures for the submission, review, and disposition of petitions for agency declaratory orders on the applicability of statutes administered by the Department, rules promulgated by the Department or any of its committees having statutory authority to make rules, and orders issued by the Department. R380-5 governs petitions for declaratory orders concerning orders issued by committees having statutory authority to issue orders.

R380-1-2. Petition Procedure.

(1) Any person or government agency directly affected by a statute administered by the Department, a rule promulgated by the Department or any of its committees having statutory authority to make rules, or an order issued by the Department may petition for a declaratory order.

(a) For petitions seeking a declaratory order determining the applicability of statutes administered by the Department, the petitioner shall file the petition with the Executive Director.

(b) For petitions seeking a declaratory order determining the applicability of rules promulgated by the Department or any of its committees, the petitioner shall file the petition with the Department division that administers the program to which the rule pertains.

(c) For petitions seeking a declaratory order determining the applicability of orders promulgated by the Department, and not by a committee given statutory authority to issue orders, the petitioner shall file the petition with the Department division that administers the program associated with the subject matter of the order.

R380-1-3. Petition Form.

The petition shall:

(1) be clearly designated as a request for a declaratory order;

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

(3) describe the situation or circumstances giving rise to the need for the declaratory order or in which applicability of the statute, rule, or order is to be reviewed;

(4) describe the reason or need for the applicability review;

(5) identify the person or agency directly affected by the statute, rule, or order;

(6) include an address and telephone where the petitioner can be reached during regular work days; and

(7) be signed by the petitioner.

R380-1-4. Petition Review and Recommendation.

(1) The Executive Director may determine the applicability of a statute, rule or order or may refer the request to the particular committee having statutory authority to make rules if such a committee exists for the statute, or may refer the request to a division or other administrative unit within the Department that more closely administers the statute.

(2) The committee to which a petition has been referred shall, without undue delay, make a written recommendation on the disposition of the petition to the Executive Director.

R380-1-5. Petition Disposition.

(1) The committee or administrative unit within the department making the recommendation to the Executive Director under this rule shall:

(a) review and consider the petition;

(b) prepare a recommended declaratory order stating:

(i) the applicability or non-applicability of the statute, rule, or order at issue;

(ii) the reasons for the applicability or non-applicability of the statute, rule, or order; and

(iii) any requirements imposed on the agency, the petitioner, or any person as a result of the declaratory order.

(2) The person or committee making the recommendation under this rule may:

(i) interview the petitioner;

(ii) hold an informal adjudicative hearing to gather information prior to making its determination;

(iii) hold a public information-gathering hearing on the petition;

(iv) consult with other Department staff, committee members, the Attorney General's Office, other government agencies, or the public; and

(v) take any other action necessary to provide the petition adequate review and due consideration.

(3) The Executive Director may modify the recommendation, refer the recommendation back for modification, or reject the recommendation. The Executive Director shall prepare the final declaratory order without undue delay and send the petitioner a copy of the order when completed.

KEY: administrative procedures, rules and procedures, declaratory orders

1992	**63G-4-503**
Notice of Continuation April 3, 2017	**26-1-5(3)**
	26-1-17

R380. Health, Administration.
R380-5. Petitions for Declaratory Orders on Orders Issued by Committees.
R380-5-1. Authority.

As required by Section 63G-4-503, and as authorized by Sections 26-1-5(3) and 26-1-17, this rule provides the procedures for the submission, review, and disposition of petitions for agency declaratory orders concerning orders issued by committees having statutory authority to issue orders. R380-1 governs petitions for declaratory orders concerning the applicability of statutes administered by the Department, rules promulgated by the Department or any of its committees having statutory authority to make rules, and orders issued by the Department.

R380-5-2. Petition Procedure.

Any person or government agency directly affected by an order issued by a committee having statutory authority to issue orders may petition for a declaratory order concerning the order issued by the committee. The petitioner shall file the petition with the Department division that administers the program over which the committee has statutory authority to issue orders.

R380-5-3. Petition Form.

The petition shall:

(1) be clearly designated as a request for a declaratory order;

(2) identify the order to be reviewed;

(3) describe the situation or circumstances giving rise to the need for the declaratory order or in which applicability of the order is to be reviewed;

(4) describe the reason or need for the applicability review;

(5) identify the person or agency directly affected by the order;

(6) include an address and telephone where the petitioner can be reached during regular work days; and

(7) be signed by the petitioner.

R380-5-4. Petition Review and Recommendation.

(1) The statutory committee may determine the applicability of the order, may refer the request to the division or other administrative unit within the Department that administers the program over which the committee has statutory authority to issue orders for a recommended decision, or may refer the request to the division or other administrative unit within the Department that administers the program over which the committee has statutory authority to issue orders for a final decision.

(2) The division or other administrative unit within the Department that administers the program to which a petition has been referred shall, without undue delay, make a written recommendation on the disposition of the petition to the committee, or make a decision on the petition, depending on the delegation from the committee.

R380-5-5. Petition Disposition.

(1) The committee or administrative unit within the department shall:

(a) review and consider the petition;

(b) prepare a recommended declaratory order stating:

(i) the applicability or non-applicability of the order at issue;

(ii) the reasons for the applicability or non-applicability of the order; and

(iii) any requirements imposed on the agency, the petitioner, or any person as a result of the declaratory order.

(2) The committee or the administrative unit within the Department may:

(i) interview the petitioner;

(ii) hold an informal adjudicative hearing to gather information prior to making its determination;

(iii) hold a public information-gathering hearing on the petition;

(iv) consult with other Department staff, committee members, the Attorney General's Office, other government agencies, or the public; and

(v) take any other action necessary to provide the petition adequate review and due consideration.

(3) For petitions which a committee has referred to an administrative unit within the Department that administers the program for a recommended decision, the committee may modify the recommendation, refer the recommendation back for modification, or reject the recommendation. The committee shall prepare the final declaratory order without undue delay and send the petitioner a copy of the order when completed.

KEY: administrative procedures, rules and procedures, declaratory orders

1992	**63G-4-503**
Notice of Continuation April 3, 2017	**26-1-5(3)**
	26-1-17

R380. Health, Administration.
R380-10. Informal Adjudicative Proceedings.
R380-10-1. Authority and Purpose.

This rule sets forth informal adjudicative procedures for the Department of Health and committees created within the Department under Section 26-1-7. Utah Code Sections 26-1-5, 26-1-17, and 26-1-24, and Title 63G, Chapter 4 authorize it.

R380-10-2. Definitions.

For purposes of this rule, the definitions in Section 63G-4-103 of the Utah Administrative Procedures Act apply, in addition:

(1) "Agency" means the Department of Health bureau, office, or division that most closely administers the program under which the agency action is taken or which is responsible to administer the program that deals with the request for agency action.

(2) "Agency action" means an agency determination after conducting adjudicative proceedings by agency staff of the legal rights, duties, privileges, immunities, or other legal interests of one or more identifiable persons, including all determinations to grant, deny, revoke, suspend, modify, annul, withdraw, or amend an authority, right, or license, all as limited by Subsection 63G-4-102(2).

(3) "Initial agency determination" means a decision without conducting adjudicative proceedings by agency staff of the legal rights, duties, privileges, immunities, or other legal interests of one or more identifiable persons, including all determinations to grant, deny, revoke, suspend, modify, annul, withdraw, or amend an authority, right, or license, all as limited by Subsection 63G-4-102(2).

(4) "Notice of agency action" means the formal notice that meets the requirements of Subsection 63G-4-201(2) which an agency or policy making committee issues to commence an adjudicative proceeding.

(5) "Presiding officer" means the individual designated by the Department or by a policy making committee in accordance with R380-10-5 or by statute to conduct an adjudicative proceeding.

(6) "Policy making committee" means a committee that is created under Section 26-1-7 and to which a statute delegates authority to make rules.

(7) "Request for agency action" means the formal written request that meets the requirements of Subsection 63G-4-201(3) and that clearly expresses a request that the agency commence adjudicative proceedings.

R380-10-3. Form of Proceeding and Applicability.

(1) The Department of Health prefers to resolve disputes at the lowest level. This rule does not foreclose simple resolution through discussion and negotiation between an agency and any person affected by an agency action.

(2) Except as provided in this rule or as otherwise designated by rule or statute or converted pursuant to Subsection 63G-4-202(3), all Department of Health adjudicative proceedings are informal proceedings.

(3) Unless otherwise designated by rule or statute or converted pursuant to Subsection 63G-4-202(3), all adjudicative proceedings before any policy making committee and all appeals to the Executive Director are designated as formal proceedings.

(4) The provisions of this rule do not govern actions or proceedings which a federal statute or regulation requires to be conducted solely in accordance with federal procedures. If federal statute or regulation requires a modification to these procedures, the federal procedures prevail.

(5) To the extent that this rule conflicts with a similar rule adopted by an agency within the Department that governs adjudicative proceedings, the conflicting provisions of the other rule govern.

R380-10-4. Adjudicative Authority.

(1) An agency's or policy making committee's authority to decide an adjudicative matter is limited to the specific subject matter of the program that it administers.

(2) If an adjudicative matter is not solely within the program administration of a single agency or policy making committee, the executive director may appoint a presiding officer for the matter.

(3) A committee that is not a policy making committee has no adjudicative authority, except as it may be designated to serve as a presiding officer or to otherwise render a recommended decision.

R380-10-5. Presiding Officer.

The agency head shall serve as the presiding officer for all informal proceedings, except that the agency head may designate a presiding officer as approved by the executive director. A policy making committee may designate as a presiding officer:

(1) an individual from the committee;

(2) an individual from Department staff as approved by the executive director;

(3) some other qualified and experienced person approved by the executive director.

R380-10-6. Commencement of Proceedings, Response.

(1) If a person is aggrieved by an initial agency determination, he may file with the agency a request for agency action within the shorter of 30 calendar days of either receiving the initial agency determination or the agency's mailing of the initial agency determination.

(2) If the informal adjudicative proceeding is commenced by a notice of agency action, all parties in the action, except the agency or policy making committee that initiates the agency action, shall file an answer or other pleading responsive to the allegations contained in the notice of agency action.

(3) If the informal adjudicative proceeding is commenced by a request for agency action, the agency or policy making committee that performed the agency action need not file an answer or other responsive pleading. However, the particular agency or policy making committee must consider the request and grant or deny it or set the request for further proceedings as required by Section 63G-4-201(d).

R380-10-7. Adjudicative Hearings.

(1) The agency or policy making committee before which the matter resides shall hold a hearing if:

(a) a statute or other rule requires it; or

(b) another rule permits it and a party requests it with the request for agency action or within 25 calendar days of the mailing of the notice of agency action, or within 25 days of notice of the agency's setting a matter for informal adjudicative proceedings, or within another period as prescribed by rule.

(2) If any party requests a hearing and if there is a disputed issue of fact, the presiding officer shall conduct an evidentiary hearing. In any evidentiary hearing, the parties named in the notice of agency action or in the request for agency action may testify, present evidence, and comment on the issues. If there is no disputed issue of fact, the presiding officer may determine all issues in the adjudicative proceeding based on oral or written argument.

(3) Hearings may be held only after timely notice to all parties.

(4) All hearings are open to all parties, but the hearing officer may take appropriate measures to preserve the integrity of the hearing, exclude witnesses if requested by a party, and protect the confidentiality of records or other information protected by law.

(5) Discovery is prohibited, but the agency may issue

subpoenas or other orders to compel production of necessary evidence.

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

(7) Intervention is prohibited, except that the agency may enact rules permitting intervention where a federal statute or regulation requires that a state permit intervention.

(8) All parties to the proceedings are responsible to assure the appearance of witnesses and for the costs of appearance of witnesses.

(9) Within a reasonable time after the close of the hearing, the presiding officer shall issue a signed order in writing that states the following:

(a) the decision;

(b) the reasons for the decision;

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

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

(10) 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.

(11) The agency shall promptly mail a copy of the presiding officer's order to each party. (12) All hearings shall be tape recorded or recorded by a shorthand reporter at the agency's expense.

(a) If all parties agree, the hearing may be recorded by a certified shorthand reporter at the requesting party's expense. The certified short hand reporter's transcript is the official transcript of the hearing and is the property of the agency.

(b) Any party, at its own expense, may have a reporter who is approved by the agency prepare a transcript from the agency's record of the hearing; however, the agency's or policy making committee's record of the hearing is the official record of the hearing.

R380-10-8. Presiding Officer's Decision.

In all instances where an agency head has designated a person to serve as presiding officer in an adjudicative proceeding, the presiding officer's decision is a recommended decision to the agency head and the agency head may accept, reverse, or modify the presiding officer's order and may remand the order to the presiding officer for further proceedings. If the agency head reverses or modifies the presiding officer's order, the agency head's order shall contain revised findings of fact and conclusions of law as needed, based on the record before the presiding officer and as may be supplemented before the agency head.

R380-10-9. Agency Review.

Any party may seek review of an agency action by filing a written request as provided in Section 63G-4-301. For decisions that are appealable to a policy making committee, the party must file the request with the agency that administers the program that deals with the matter. For all other appeals, the party must file the request with the Executive Director.

KEY: administrative procedures, health administration

1993	**26-1-5**
Notice of Continuation April 21, 2017	**26-1-17**
	26-1-24
	63G-4

R380. Health, Administration.
R380-20. Government Records Access and Management.
R380-20-1. Purpose.

This rule establishes procedures that implement the Government Records Access and Management Act, Chapter 2, Title 63G, within the Department of Health. It is authorized by Sections 26-1-5, 26-1-17, 63G-2-204(2), and 63A-12-104(2).

R380-20-2. Requests for Access.

All public requests for a record under Section 63G-2-204 shall be directed to the GRAMA Records Officer in the Office of the Executive Director, with the exception of records created by or held by the entities listed below within the Department. For records created or held by the entities listed, the request must be made to the specific entity listed.

Office of the Medical Examiner
Bureau of Human Resource Management
Employee Assistance Section
Bureau of Vital Records and Health Statistics

R380-20-3. Research Requests for Access.

Notwithstanding R380-20-2, all requests for records for research purposes pursuant to Section 63G-2-202(8) shall be directed to the GRAMA Records Officer in the Office of the Executive Director.

KEY: public records, government documents, GRAMA
1992 **63G-2-202(8)**
Notice of Continuation April 3, 2017 **63G-2-204**
63A-12-104
26-1-5
26-1-17

R380. Health, Administration.
R380-100. Americans with Disabilities Act Grievance Procedures.
R380-100-1. Authority and Purpose.

(1) This rule is made under authority of Section 26-1-17 and Subsection 63G-3-201(3). As required by 28 CFR 35.107, the Utah Department of Health, as a public entity that employs more than 50 persons, adopts and publishes the grievance procedures within this rule for the prompt and equitable resolution of complaints alleging any action prohibited by Title II of the Americans with Disabilities Act, as amended.

(2) The purpose of this rule is to implement the provisions of 28 CFR 35 which in turn implements Title II of the Americans with Disabilities Act, which provides that no individual shall be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by the department because of a disability.

R380-100-2. Definitions.

(1) "ADA Coordinator" means the employee assigned by the executive director to investigate and facilitate the prompt and equitable resolution of complaints filed by qualified persons with disabilities. The ADA Coordinator may be a representative of the Department of Human Resource Management assigned to the Department.

(2) "Department" means the Department of Health created by Section 26-1-4.

(3) "Designee" means an individual appointed by the executive director or a director to investigate allegations of ADA non-compliance in the event the ADA Coordinator is unable or unwilling to conduct an investigation for any reason, including a conflict of interest. A designee does not have to be an employee of the department; however, the designee must have a working knowledge of the responsibilities and obligations required of employers and employees by the ADA.

(4) "Director" means the head of the division of the Department affected by a complaint filed under this rule.

(5) "Disability" means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

(6) "Executive Director" means the executive director of the department.

(7) "Major life activities" include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, and working. A major life activity also includes the operation of a major bodily function, such as functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

(8) "Qualified Individual" means an individual who meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the Department. A "qualified individual" is also an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that individual holds or desires.

R380-100-3. Filing of Complaints.

(1) Any qualified individual may file a complaint alleging noncompliance with Title II of the Americans with Disabilities Act, as amended, or the federal regulations promulgated thereunder.

(2) Qualified individuals shall file their complaints with the Department's ADA Coordinator, unless the complaint alleges that the ADA Coordinator was non-compliant, in which case qualified individuals shall file their complaints with the Department's designee.

(3) Qualified individuals shall file their complaints within 90 days after the date of the alleged noncompliance to facilitate the prompt and effective consideration of pertinent facts and appropriate remedies; however, the Executive Director has the discretion to direct that the grievance process be utilized to address legitimate complaints filed more than 90 days after alleged noncompliance.

(4) Each complaint shall:

(a) include the complainant's name and address;

(b) include the nature and extent of the individual's disability;

(c) describe the department's alleged discriminatory action in sufficient detail to inform the department of the nature and date of the alleged violation;

(d) describe the action and accommodation desired; and

(e) be signed by the complainant or by his legal representative.

(5) Complaints filed on behalf of classes or third parties shall describe or identify by name, if possible, the alleged victims of discrimination.

(6) If the complaint is not in writing, the ADA coordinator or designee shall transcribe or otherwise reduce the complaint to writing upon receipt of the complaint.

(7) By the filing of a complaint or a subsequent appeal, the complainant authorizes necessary parties to conduct a confidential review all relevant information, including records classified as private or controlled under the Government Records Access and Management Act, Utah Code, Subsection 63G-2-302(1)(b) and Section 63G-2-304,consistent with 42 U.S.C. 12112(d)(4)(A), (B), and (C) and 42 U.S.C. Section 12112(d)(3)(B) and (C), and relevant information otherwise protected by statute, rule, regulation, or other law.

R380-100-4. Investigation of Complaints.

(1) The ADA coordinator or designee shall investigate complaints to the extent necessary to assure all relevant facts are collected and documented. This may include gathering all information listed in Subsection R380-100-3(4) and (7) of this rule if it is not made available by the complainant.

(2) The ADA coordinator or designee may seek assistance from the Attorney General's staff, and the department's human resource and budget staff in determining what action, if any, should be taken on the complaint. The ADA coordinator or designee may also consult with the director of the affected division in making a recommendation.

(3) The ADA coordinator or designee shall consult with representatives from other state agencies that may be affected by the decision, including the Office of Planning and Budget, the Department of Human Resource Management, the Division of Risk Management, the Division of Facilities Construction Management, and the Office of the Attorney General before making any recommendation that would:

(a) involve an expenditure of funds beyond what is reasonably able to be accommodated within the applicable line item so that it would require a separate appropriation;

(b) require facility modifications; or

(c) require reassignment to a different position.

R380-100-5. Recommendation and Decision.

(1) Within 15 working days after receiving the complaint, the ADA coordinator or designee shall recommend to the director what action, if any, should be taken on the complaint. The recommendation shall be in writing or in another accessible format suitable to the complainant.

(2) If the ADA coordinator or designee is unable to make a recommendation within the 15 working day period, the complainant shall be notified in writing, or in another accessible

format suitable to the complainant, stating why the recommendation is delayed and what additional time is needed.

(3) The director may confer with the ADA coordinator or designee and the complainant and may accept or modify the recommendation to resolve the complaint. The director shall render a decision within 15 working days after the director's receipt of the recommendation from the ADA coordinator or designee. The director shall take all reasonable steps to implement the decision. The director's decision shall be in writing, or in another accessible format suitable to the complainant, and shall be promptly delivered to the complainant.

R380-100-6. Appeals.

(1) The complainant may appeal the director's decision to the executive director within ten working days after the complainant's receipt of the director's decision.

(2) The appeal shall be in writing or in another accessible format reasonably suited to the complainant's ability.

(3) The executive director may name a designee to assist on the appeal. The ADA coordinator and the director's designee may not also be the executive director's designee for the appeal.

(4) In the appeal the complainant shall describe in sufficient detail why the decision does not effectively address the complainant's needs.

(5) The executive director or designee shall review the ADA coordinator's recommendation, the director's decision, and the points raised on appeal prior to reaching a decision. The executive director may direct additional investigation as necessary. The executive director shall consult with representatives from other state agencies that would be affected by the decision, including the Office of Planning and Budget, the Department of Human Resource Management, the Division of Risk Management, the Division of Facilities Construction Management, and the Office of the Attorney General before making any decision that would:

(a) involve an expenditure of funds beyond what is reasonably able to be accommodated within the applicable line item so that it would require a separate appropriation;

(b) require facility modifications; or

(c) require reassignment to a different position.

(6) The executive director shall issue a final decision within 15 working days after receiving the complainant's appeal. The decision shall be in writing, or in another accessible format suitable to the complainant, and shall be promptly delivered to the complainant.

(7) If the executive director or designee is unable to reach a final decision within the 15 working day period, the complainant shall be notified in writing, or by another accessible format suitable to the complainant, why the final decision is being delayed and the additional time needed to reach a final decision.

R380-100-7. Record Classification.

(1) Records created in administering this rule are classified as "protected" under Subsections 63G-2-305(9), (22), (24), and (25).

(2) After issuing a decision under Section R380-100-5 or a final decision upon appeal under Section R380-100-6, portions of the record pertaining to the complainant's medical condition shall be classified as "private" under Subsection 63G-2-302(1)(b) or "controlled" under Section 63G-2-304, consistent with 42 U.S.C. 12112(d)(4)(A), (B), and (C) and 42 U.S.C. 12112(d)(3)(B) and (C), at the option of the ADA coordinator.

(a) The written decision of the division director or executive director shall be classified as "public," and all other records, except controlled records under Subsection R380-100-7(2), classified as "private."

R380-100-8. Relationship to Other Laws.

This rule does not prohibit or limit the use of remedies available to individuals under:

(a) the state Anti-Discrimination Complaint Procedures, Section 34A-5-107, and Section 67-19-32;

(b) the Federal ADA Complaint Procedures, 28 CFR 35.170 through 28 CFR 35.178; or

(c) any other Utah State or federal law that provides equal or greater protection for the rights of individuals with disabilities.

KEY: grievance procedures, disabled persons
August 22, 2011 26-1-17
Notice of Continuation April 24, 2017 63G-3-102(2)

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-60. Medicaid Policy for Pharmacy Program.
R414-60-1. Introduction.

The Medicaid Pharmacy program reimburses for covered outpatient drugs dispensed to eligible Medicaid clients by a pharmacy enrolled with Utah Medicaid pursuant to a prescription from an enrolled prescriber operating within the scope of the prescriber's license.

R414-60-2. Definitions.

(1) "Covered outpatient drug" means a drug that meets all of the following criteria:

(a) Requires a prescription for dispensing;

(b) Has a National Drug Code number;

(c) Is eligible for Federal Medical Assistance Percentages funds;

(d) Has been approved by the Food and Drug Administration; and

(e) Is listed in the Medi-Span drug file.

(2) "Full-benefit dual eligible beneficiary" means an individual who has Medicare and Medicaid benefits.

(3) "Rural pharmacy" means a pharmacy located in the state of Utah, which is outside of Weber County, Davis County, Utah County, and Salt Lake County.

(4) "Urban pharmacy" means a pharmacy located in Weber County, Davis County, Utah County, Salt Lake County, or in another state.

(5) "Usual and customary charge" is the lowest amount a pharmacy charges the general public for a covered outpatient drug, which reflects all advertised savings, discounts, special promotions, or any other program available to the general public.

R414-60-3. Client Eligibility Requirements.

(1) Medicaid covers prescription drugs for individuals who are categorically and medically needy under the Medicaid program.

(2) Outpatient drugs included in the Medicare Prescription Drug Benefit-Part D for full-benefit dual eligible beneficiaries will not be covered under Medicaid in accordance with Subsection 1935(a) of the Social Security Act. Certain limited drugs provided in accordance with Subsection 1927(d)(2) of the Social Security Act to all Medicaid recipients, but not included in the Medicare Prescription Drug Benefit-Part D, are payable by Medicaid.

(3) Outpatient drugs included in contracts with the Accountable Care Organization (ACO) must be obtained through the ACO for clients enrolled in an ACO.[

R414-60-4. Program Coverage.

(1) Covered outpatient drugs eligible for Federal Medical Assistance Percentages funds are included in the pharmacy benefit; however, covered outpatient drugs may be subject to limitations and restrictions.

(2) In accordance with Subsection 58-17b-606(4), when a multi-source A-rated legend drug is available in the generic form, Medicaid will only reimburse for the generic form of the drug unless:

(a) reimbursing for the non-generic brand-name legend drug will result in a financial benefit to the State; or

(b) the treating physician demonstrates a medical necessity for dispensing the non-generic, brand-name legend drug.

(3) Prescriptions that are not executed electronically must be written on tamper-resistant prescription forms. Tamper-resistant prescription forms must include all of the following:

(a) One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;

(b) One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; and

(c) One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

(d) Documentation by the pharmacy of verbal confirmation of a prescription not written on a tamper resistant prescription form by the prescriber or the prescriber's agent satisfies the tamper-resistant requirement. Documentation of the verbal confirmation must include the date, time, and name of the individual who verified the validity of the prescription.

(e) Pharmacies must maintain documentation of receipt of a prescription by a Medicaid client or the client's authorized representative. The documentation must clearly identify the covered outpatient drug received by the client, the date the covered outpatient drug was received, and who received the covered outpatient drug.

(f) Claims for covered outpatient drugs not dispensed to a Medicaid client or the client's authorized representative within 10 days must be reversed and any payment from Medicaid must be returned.

R414-60-5. Limitations.

(1) Limitations may be placed on drugs in accordance with 42 U.S.C. 1396r-8 or in consultation with the Drug Utilization Review (DUR) Board. Limitations are included in the Pharmacy Services Provider Manual and attachments, incorporated by reference in Section R414-1-5, and may include:

(a) Quantity limits or cumulative limits for a drug or drug class for a specified period of time;

(b) Therapeutic duplication limits may be placed on drugs within the same or similar therapeutic categories;

(c) Step therapy, including documentation of therapeutic failure with one drug before another drug may be used; or

(d) Prior authorization.

(2) A covered outpatient drug that requires prior authorization may be dispensed for up to a 72-hour supply without obtaining prior authorization during a medical emergency.

(3) Drugs listed as non-preferred on the Preferred Drug List may require prior authorization as authorized by Section 26-18-2.4.

(4) Drugs may be restricted and are reimbursable only when dispensed by an individual pharmacy or pharmacies.

(5) Medicaid does not cover drugs not eligible for Federal Medical Assistance Percentages funds.

(6) Medicaid does not cover outpatient drugs included in the Medicare Prescription Drug Benefit-Part D for full-benefit dual eligible beneficiaries.

(7) Drugs provided to clients during inpatient hospital stays are not covered as an outpatient pharmacy benefit nor separately payable from the Medicaid payment for the inpatient hospital services.

(8) Medicaid covers only the following prescription cough and cold preparations meeting the definition of a covered outpatient drug:

(a) Guaifenesin with Dextromethorphan (DM) 600mg/30mg tablets;

(b) Guaifenesin with Hydrocodone 100mg/5mL liquid;

(c) Promethazine with Codeine liquid;

(d) Guaifenesin with Codeine 100mg/10mg/5mL liquid;

(e) Carbinoxamine with Pseudoephedrine 1mg/15mg/5mL liquid; and

(f) Carbinoxamine/Pseudoephedrine/DM 15mg/1mg/4mg/5mL liquid.

(9) Medicaid will pay for no more than a one-month supply of a covered outpatient drug per dispensing, except for the following:

(a) Medications included on the Utah Medicaid Generic Medication Three-Month Supply Medication List attachment to the Pharmacy Services Provider Manual may be covered for up to a three-month supply per dispensing. Medicaid clients eligible for Primary Care Network services under Rule R414-100 are not eligible to receive more than a one-month supply per dispensing.

(b) Prenatal vitamins for pregnant women, multiple vitamins with or without fluoride for children through five years of age, and fluoride supplements may be covered for up to a 90-day supply per dispensing.

(c) Medicaid may cover contraceptives for up to a three-month supply per dispensing.

(10) Medicaid will pay for a prescription refill only when 80% of the previous prescription has been exhausted, with the exception of narcotic analgesics. Medicaid will pay for a prescription refill for narcotic analgesics after 100% of the previous prescription has been exhausted.

(11) Medicaid does not cover the following drugs:

(a) Drugs not eligible for Federal Medical Assistance Percentages funds;

(b) Drugs for anorexia, weight loss or weight gain;

(c) Drugs to promote fertility;

(d) Drugs for the treatment of sexual or erectile dysfunction;

(e) Drugs for cosmetic purposes or hair growth;

(f) Vitamins; except for prenatal vitamins for pregnant women, vitamin drops for children through five years of age, and fluoride supplements;

(g) Over-the-counter drugs not included in the Utah Medicaid Over-the-Counter Drug List attachment to the Pharmacy Services Provider Manual;

(h) Drugs for which the manufacturer requires, as a condition of sale, that associated tests and monitoring services are purchased exclusively from the manufacturer or its designee;

(i) Drugs given by a hospital to a patient at discharge;

(j) Breast milk, breast milk substitutes, baby food, or medical foods, except for prescription metabolic products for congenital errors of metabolism;

(k) Drugs available only through single-source distribution programs, unless the distributor is enrolled with Medicaid as a pharmacy provider.

(12) Medicaid may only cover hemophilia clotting factor when it is dispensed by a single-contracted provider in accordance with the Utah Medicaid State Plan.

R414-60-6. Copayment Policy.

Medicaid clients are to pay any applicable copayment amount that complies with the requirements of the Utah Medicaid State Plan and Rule R414-1.

R414-60-7. Reimbursement.

(1) A pharmacy may not submit a charge to Medicaid that exceeds the pharmacy's usual and customary charge.

(2) Covered-outpatient drugs are reimbursed at the lesser of the following:

(a) The Wholesale Acquisition Cost;

(b) The Federal Upper Limit assigned by the Centers for Medicare and Medicaid Services;

(c) The Utah Maximum Allowable Cost; and

(d) The submitted ingredient cost.

(e) If a prescriber obtains prior authorization for a brand-name version of a multi-source drug in accordance with 42 CFR 447.512 or if a brand-name drug is covered because a financial benefit will accrue to the State in accordance with Section 58-17b-606, then Medicaid will not apply the Utah Maximum Allowable Cost or Federal Upper Limit to the claim.

(f) Pharmacies participating in the 340B program and using medications obtained through the 340B program to bill Medicaid must submit the actual acquisition cost of the medication on the claim.

(g) Pharmacies that participate in the Federal Supply Schedule and use medications obtained through the schedule to bill Utah Medicaid, must submit the actual acquisition cost of the medication on the claim unless the claim is reimbursed as a bundled charge or All Inclusive Rate.

(h) Pharmacies that obtain and use medications at a nominal price must submit the actual acquisition cost of the medication on the claim.

(i) The Utah Maximum Allowable Cost (UMAC) for drugs for which the Centers for Medicare and Medicaid Services (CMS) publishes a National Average Drug Acquisition Cost (NADAC), is the NADAC itself. The UMAC for which CMS does not publish a NADAC is calculated by the Department.

(3) Dispensing fees are as follows:

(a) $9.99 for urban pharmacies in Utah;

(b) $10.15 for rural pharmacies in Utah;

(c) $7.66 for pharmacies located in a state other than Utah;

(d) $716.54 for hemophilia clotting factor dispensed by the contracted provider.

(e) Medicaid will pay the lesser of the assigned dispensing fee or the submitted dispensing fee;

(f) Medicaid will only pay one dispensing fee per 24 days per covered outpatient drug per pharmacy.

(4) Medicaid will pay the lesser of the sum of the allowed amount for the covered outpatient drug and dispensing fee or the billed charges.

(5) Immunizations provided to Medicaid clients who are at least 19 years of age will be paid for the cost of the immunization plus a dispensing fee. Medicaid will pay the lesser of the allowed or submitted charges.

(6) Immunizations provided to Medicaid clients who are 18 years old or younger will only be eligible for a dispensing fee with no reimbursement for the immunization. Immunizations for Medicaid clients who are 18 years old or younger must be obtained through the Vaccines for Children program.

(7) Blood glucose test strips listed as preferred on the Utah Medicaid Preferred Drug List will be reimbursed at the lesser of the Wholesale Acquisition Cost with no dispensing fee or the billed charges.

(8) In accordance with the Utah Medicaid State Plan, the Department may only reimburse a single-contracted provider for the purchase of hemophilia clotting factor.

R414-60-8. Mandatory Patient Counseling.

(1) Medicaid clients, or their representatives, must receive counseling that fulfills the requirements of 42 U.S.C. 1396r-8 each time a covered outpatient medication is dispensed.

(2) Counseling is not required if a Medicaid client, or their representative, refuses the offer to counsel.

(3) The offer to counsel must be documented and producible upon request.

R414-60-9. New Drug Products.

A new drug product, including a new size or strength of an existing approved product, may be reviewed by the DUR Board to determine whether the drug should be subject to restrictions or limitations. New drugs may be withheld from coverage for no more than twelve weeks while restrictions or limitations are being evaluated.

R414-60-10. Over-the-Counter Drugs.

Medicaid covers over-the-counter drugs when the drug is listed on the Utah Medicaid Over-the-Counter Drug List attachment to the Pharmacy Services Provider Manual, incorporated by reference in Section R414-1-5.

R414-60-11. Compounds.

(1) Compounded non-sterile prescriptions are a covered benefit if at least one ingredient is a covered-outpatient drug that would otherwise qualify for coverage.

(2) Compounded sterile prescriptions are a covered benefit if at least one ingredient is a covered-outpatient drug that would otherwise qualify for coverage, and is prepared by a pharmacy that has certified to Utah Medicaid that it adheres to the United States Pharmacopeia/National Formulary chapter <797> standard, and tests the final product for sterility, potency and purity.

KEY: Medicaid
April 1, 2017 26-18-3
Notice of Continuation April 28, 2017 26-1-5

R414. Health, Health Care Financing, Coverage and Reimbursement Policy.
R414-61. Home and Community-Based Services Waivers.
R414-61-1. Introduction and Authority.

(1) This rule establishes authority for the Department of Health to administer all Section 1915(c) waivers.

(2) The rule is authorized by Section 26-18-3 and Section 1915(c) of the Social Security Act.

R414-61-2. Incorporation by Reference.

The Department incorporates by reference the following home and community-based services waivers:

(1) Waiver for Technology Dependent/Medically Fragile Individuals, effective July 1, 2013;

(2) Waiver for Individuals Age 65 or Older, effective July 1, 2015;

(3) Waiver for Individuals with Acquired Brain Injuries, effective July 1, 2014;

(4) Waiver for Individuals with Physical Disabilities, effective July 1, 2016;

(5) Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions, effective July 1, 2015;

(6) New Choices Waiver, effective July 1, 2015;

(7) Medicaid Autism Waiver, effective October 1, 2015; and

(8) Medically Complex Children's Waiver, effective October 1, 2015.

These documents are available for public inspection during business hours at the Utah Department of Health, Division of Medicaid and Health Financing, located at 288 North 1460 West, Salt Lake City, UT, 84114-3102.

KEY: Medicaid
April 20, 2017 26-18-3
Notice of Continuation October 30, 2014

R426. Health, Family Health and Preparedness, Emergency Medical Services.
R426-5. Emergency Medical Services Training and Certification Standards.
R426-5-100. Authority and Purpose.

(1) This rule is established under Title 26, Chapter 8a to provide uniform minimum standards to be met by those providing emergency medical services in the State of Utah; and for the training, certification, and recertification of individuals who provide emergency medical service and for those providing instructions and training to pre-hospital emergency medical care providers.

(2) The definitions in Title 26, Chapter 8a are adopted and incorporated by reference into this rule.

R426-5-200. Scope of Practice.

(1) The Department may certify as an EMR, EMT, AEMT, EMT-IA Paramedic, or EMD an individual who meets the initial certification requirements in this rule.

(2) The Committee adopts as the standard for EMR, EMT, AEMT, EMT-IA, or Paramedic training and competency in the state, the following United States Department of Transportation's National Emergency Medical Services Education Standards.

(3) An EMR, EMT, AEMT, or Paramedic may perform the skills as described in the EMS National Education Standards, to their level of certification, as adopted in this section.

(4) Per Utah Code section 41-6a-523 persons authorized to draw blood/immunity from liability and section 53-10-405 DNA specimen analysis -- Saliva sample to be obtained -- Blood sample to be drawn by a professional. Acting at the request of a peace officer a paramedic may draw field blood samples to determine alcohol or drug content and for DNA analysis. Acting at the request of a peace officer an AEMT may draw field blood samples to determine alcohol or drug content and for DNA analysis if they have received certification pursuant to administrative rule R438-12. A person authorized by this section to draw blood samples may not be held criminally or civilly liable if drawn in a medically acceptable manner.

R426-5-300. Certification.

(1) The Department may certify an EMR, EMT, EMT-IA, AEMT, Paramedic, or EMD for a four-year period.

(2) An individual who wishes to become certified as a EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD shall:

(a) successfully complete a Department-approved EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD course as described in this rule;

(b) be able to perform the functions listed in the National EMS Education Standards adopted in this rule as verified by personal attestation and successful accomplishment by certified EMS Instructors during the course;

(c) achieve a favorable recommendation from the course coordinator and course medical director stating technical competence during field and clinical training and successful completion of all training requirements for an EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD certification;

(d) submit the applicable fees and a completed application, including social security number and signature, to the Department;

(e) submit to and pass a background investigation, including an FBI background investigation if the applicant has not resided in Utah for the past consecutive five years;

(f) maintain and submit documentation of having completed a Department approved CPR course within the prior two years that is consistent with the most current version of the American Heart Association Guidelines for the level of Healthcare Provider Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC); and

(g) submit TB test results as per R426-5-700.

(3) Age requirements:

(a) EMR may certify at 16 years of age or older; and

(b) EMT, AEMT, EMT-IA and Paramedic may certify at 18 years of age or older.

(4) Within 120 days after the official course end date the applicant shall successfully complete the Department written and practical EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD examinations, or reexaminations, if necessary.

(5) Test development, the Department shall:

(a) develop or approve written and practical tests for each certification;

(b) establish the passing score for certification and recertification written and practical tests;

(c) the Department may administer the tests or delegate the administration of any test to another entity; and

(d) the Department may release only to the individual who took the test and to persons who have a signed release from the individual who took the test:

(i) whether the individual passed or failed a written or practical test; and

(ii) the subject areas where items were missed on a written or practical test.

(6) An individual who fails any part of the EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD certification or recertification written or practical examination may retake the examination twice without further course work.

(7) If the individual fails both re-examinations, they shall take a complete EMR, EMT, AEMT, Paramedic, or EMD training course respective to the certification level sought to be eligible for further examination.

(8) The individual may retake the course as many times as they desire, but may only take the examinations three times for each completed course. If an individual retakes the course because of failure to pass the examinations, the individual shall pass both the practical and written test administered after completion of the new course.

(9) An individual who wishes to enroll in an AEMT, EMT-IA, or Paramedic course shall have as a minimum a Utah EMT certification. This Certification shall remain current until new certification level is obtained.

(10) The Department may extend the time limits for an individual who demonstrates that the inability to meet the requirements within the 120 days was due to circumstances beyond the applicant's control, such as for documented medical circumstances that prevent completion of testing, military deployment out of the state, extreme illness in the immediate family, or the like.

R426-5-400. Certification at a Lower Level.

(1) An individual who has taken a Paramedic course, but has not been recommended for certification, may request to become certified at the AEMT levels if:

(a) the paramedic course coordinator submits to the Department a favorable letter of recommendation stating that the individual has successfully obtained the knowledge and skills of the AEMT level as required by this rule; and

(b) the individual successfully completes all requirements for an AEMT.

R426-5-500. Certification Challenges.

(1) The Department may certify as an EMT or AEMT; a registered nurse licensed in Utah, a nurse practitioner licensed in Utah, a physician assistant licensed in Utah, or a physician licensed in Utah who:

(a) is able to demonstrate knowledge, proficiency and competency to perform all the functions listed in the National EMS Education Standards as verified by personal attestation and successful demonstration to a currently certified course

coordinator and an off-line medical director of all cognitive, affective, and psychomotor skills listed in the National EMS Education Standards;

(b) has a knowledge of:

(i) medical control protocols;

(ii) state and local protocols; and

(iii) the role and responsibilities of an EMT or AEMT respectively.

(c) maintain and submit documentation of having completed a CPR course within the prior two years that is consistent with the most current version of the American Heart Association Guidelines for adult and pediatric healthcare provider CPR and ECC; and

(d) is 18 years of age or older.

(e) each level shall be challenged sequentially and individually

(2) To become certified, the applicant shall:

(a) submit three letters of recommendation from health care providers attesting to the applicant's patient care skills and abilities;

(b) submit a favorable recommendation from a currently certified course coordinator attesting to competency of all knowledge and skills contained within the National EMS Education Standards;

(c) submit the applicable fees and a completed application, including social security number, signature, and, proof of current Utah license as a Registered Nurse, a Physician Assistant, or a Medical Doctor;

(d) within 120 days after submitting the challenge application, successfully complete the Department written and practical EMT examinations, or reexaminations, if necessary;

(e) the Department may extend the time limit for an individual who demonstrates the inability to meet the requirements within 120 days was due to circumstances beyond the applicant's control;

(f) submit to and pass a background screening clearance as per R426-5-2700; and

(g) submit a statement from a physician, confirming the applicant's results of a TB examination conducted within one year prior to submitting the application.

R426-5-600. Recertification Requirements.

(1) The Department may recertify an individual for a four-year period or for a shorter period as modified by the Department to standardize recertification cycles.

(2) An individual seeking recertification shall:

(a) submit the applicable fees and a completed application, including social security number and signature, to the Department;

(b) submit to and pass a background screening clearance as per R426-5-2700;

(c) maintain and submit documentation of having completed a CPR course within the prior two years that is consistent with the most current version of the American Heart Association Guidelines for the level of Adult and Pediatric Healthcare Provider CPR and ECC. CPR shall be kept current during certification;

(d) submit TB test results as per R426-5-700;

(e) successfully complete the Department applicable written and practical recertification examinations, or reexaminations if necessary, within one year prior to expiration; and

(f) provide documentation of completion of Department-approved CME requirements.

(3) The EMR, EMT, AEMT, EMT-IA and Paramedic shall complete the required CME hours, as outlined in the department's Recertification Protocol for EMS Personnel manual and in accordance with the National EMS Education Standards. The hours shall be completed throughout the prior four years.

(4) As well as requirements in (2)(c) The following course completion documentation is required for the specific certification level and may be included in the CME required hours:

(a) EMR 52 hours of CME.

(b) EMT 98 hours of CME.

(c) AEMT 108 hours of CME.

(d) EMT-IA 108 hours of CME.

(e) Paramedic 144 hours of CME; and,

(f) EMD 48 hours of CME.

(5) An EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD may complete CME hours through various methodologies, but 30 percent of the CME hours shall be practical hands-on training.

(6) All CME shall be related to the required skills and knowledge of the EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD's level of certification.

(7) The CME Instructors need not be certified EMS instructors, but shall be knowledgeable in the subject matter.

(8) The EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD shall complete and provide documentation of demonstrating the psychomotor skills listed in the current National EMS Education Standards at their level of certification.

(9) An EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD who is affiliated with an EMS organization should have the organization's designated training officer submit a letter verifying the completion of the recertification requirements. An EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD who is not affiliated with a licensed or designated EMS provider shall submit verification of all recertification requirements directly to the Department.

(10) An AEMT, EMT-IA or Paramedic shall submit a letter from a certified off-line medical director recommending the individual for recertification and verifying the individual has demonstrated proficiency in the psychomotor skills listed in the current National EMS Education Standards at their level of certification.

(11) Each EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD is individually responsible to complete and submit all required recertification material to the Department at one time, no later than 30 days and no earlier than one year prior to the individual's current certification expiration date. If the Department receives incomplete or late recertification materials, the Department may not be able to process the recertification before the certification expires. The Department processes recertification material in the order received.

(12) A licensed or designated EMS provider, or a Department approved entity who provides CME may compile and submit recertification materials on behalf of an EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD; however, the individual EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD remains responsible for a timely and complete submission.

(13) The Department may shorten recertification periods. An EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD whose recertification period is shortened shall meet the CME requirements in each of the required and elective subdivisions on a prorated basis by the expiration of the shortened period.

(14) The Department may not lengthen certification periods more than the four-year certification, unless the individual is a member of the National Guard or reserve component of the armed forces and is on active duty when certification expired. If this happens, the individual shall recertify in accordance with Utah Code 39-1-64.

R426-5-700. TB Test Requirements.

(1) All levels of certification and recertification except EMD shall submit a statement from a physician or other health

care provider, confirming the applicant's negative results of a Tuberculin Skin Test or equivalent (TB test) examination conducted within the prior year, or complete the following requirements:

(a) if the test is positive, and there is no documented history of prior Latent TB Infection (LTBI) treatment, the applicant shall see his primary care physician for a chest x-ray (CXR) in accordance with current Center for Disease Control and Prevention (CDC) guidelines and further evaluation; and

(b) Results of CXR and medical history shall be submitted to the Department.

(2) If the CXR is negative, the applicant's medical history will be reviewed by the State EMS Medical Director. For individuals at high risk for developing active TB, treatment will be strongly recommended.

(3) If the CXR is positive, the applicant is considered to be suspect Active TB. Should the diagnosis be confirmed:

(a) Completion of treatment or release by an appropriate physician will be required prior to certification; and

(b) each such case will be reviewed by the State EMS Medical Director.

(4) If an applicant who is required to get treatment refuses the treatment, the Department may deny certification.

(5) A TB test should not be performed on a person who has a documented history of either a prior positive TB test or prior treatment for tuberculosis. The applicant shall instead have a CXR in accordance with current CDC guidelines and provide documentation of negative CXR results to the department.

(6) If the applicant has had prior treatment for active TB or LTBI, the applicant shall provide documentation of this treatment prior to certification. Documentation of this treatment will be maintained by the Department, and needs only to be provided once.

(7) Each such case will be reviewed by the State EMS Medical Director.

R426-5-800. Reciprocity.

(1) The Department may certify an individual as an EMR, EMT, AEMT, Paramedic, or EMD an individual certified outside of the State of Utah if the applicant can demonstrate the applicant's out-of-state training and experience requirements are equivalent to or greater than what is required in Utah.

(2) An individual seeking reciprocity for certification in Utah based on out-of-state training and experience shall:

(a) Submit the applicable fees and a completed application, including social security number and signature, to the Department and complete all of the following within 120 days of submitting the application;

(b) submit to and pass a background screening clearance as per R426-5-2700;

(c) maintain and submit documentation of having completed a CPR course within the prior two years that is consistent with the most current version of the American Heart Association Guidelines for the level of Healthcare Provider CPR and ECC;

(d) submit TB test results as per R426-5-700;

(e) successfully complete the Department written and practical EMR, EMT, AEMT, Paramedic, or EMD examinations, or reexaminations, if necessary;

(f) submit a current certification from one of the states of the United States or its possessions, or current registration and the name of the training institution if registered with the National Registry of EMTs; and

(g) provide documentation of completion of 25 hours of continuing medical education (CME) within the prior year. EMDs shall provide documentation of completion of 12 hours of CME within the prior year

(3) The Department may certify as an EMD an individual certified by the National Academy of Emergency Medical Dispatch (NAEMD) or equivalent. An individual seeking reciprocity for certification in Utah based on NAEMD or equivalent certification shall:

(a) Submit documentation of current NAEMD or equivalent certification.

(b) maintain and submit documentation of having completed within the prior two years;

(i) a Department approved CPR course that is consistent with the most current version of the American Heart Association Guidelines for CPR and ECC; and

(ii) a minimum of a two-hour course in critical incident stress management (CISM).

(4) An individual who fails the written or practical EMR, EMT, or AEMT examination three times will be required to complete a Department approved EMR, EMT, or AEMT, course respective to the certification level sought.

(5) A candidate for paramedic reciprocity who fails the written or practical examinations three times can request further consideration of reciprocity after five years if the candidate has worked for an out of state EMS provider and can verify steady employment as a paramedic for at least three of the five years.

R426-5-900. Lapsed Certification.

(1) An individual whose EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD certification has expired for less than one year may, within one year after expiration, complete all recertification requirements, pay a late recertification fee, and successfully pass the written certification examination to become certified. The individual's new expiration date will be four years from the previous expiration date.

(2) An individual whose certification has expired for more than one year shall:

(a) submit a letter of recommendation including results of an oral examination, from a certified off-line medical director, verifying proficiency in patient care skills at the certification level;

(b) successfully complete the applicable Department written and practical examinations;

(c) complete all recertification requirements; and

(d) the individual's new expiration date will be four years from the completion of all recertification materials.

(3) An individual whose certification has lapsed, is not authorized to provide care as an EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD until the individual completes the recertification process.

R426-5-1000. Transition to 2009 National EMS Education Standards.

(1) The Department adopts the 2009 National Education Standards as noted in this rule resulting in a need for specific dates for a transition period. These dates shall be as follows:

(a) EMT Basic to EMT January 1, 2012 to January 1, 2016; and

(b) EMT Intermediate to Advanced EMT, October 1, 2011 to September 30, 2013.

(2) Transition for EMT-B to EMT will be accomplished through the Department's written examination as part of the Individual's recertification process during the transition period.

(3) Transition for EMT-I and EMT-IA to AEMT will be accomplished through the Department's written AEMT transition examination during the transition period.

(4) Transition will not change the Individual's recertification date.

(5) During the transition period:

(a) EMT-I and EMT-IA will be deemed equivalent to AEMT certification, in accordance with the respective licensed or designated EMS provider's waivers; and

(b) EMT-B will be deemed equivalent to EMT

certification.

(c) EMT-IA may maintain level of certification as long as employed by a licensed EMT-IA provider.

(6) After the deadline of September 31, 2013 of the AEMT transition period:

(a) an EMT-I who has not yet transitioned will be deemed an EMT, and;

(b) an EMT-IA who is not working for a licensed EMT-IA provider shall be deemed an AEMT.

R426-5-1100. Emergency Medical Care During Clinical Training.

A student enrolled in a Department-approved training program may, under the direct supervision of the course coordinator, an instructor in the course, or a preceptor for the course, perform activities delineated within the training curriculum that otherwise require certification to perform.

R426-5-1200. Instructor Requirements.

(1) The Department may certify as an EMS Instructor an individual who:

(a) meets the initial certification requirements in R426-5-1300; and

(b) is currently certified in Utah as an EMR, EMT, AEMT,EMT-IA, Paramedic, or EMD.

(2) The Committee adopts the United States Department of Transportation's "EMS Instructor Training Program as the standard for EMS Instructor training and competency in the state, which is adopted and incorporated by reference.

(3) An EMS instructor may only teach up to the certification level to which the instructor is certified. An EMS instructor who is only certified as an EMD may only teach EMD courses.

(4) An EMS instructor shall comply with the teaching standards and procedures in the EMS Instructor Manual.

(5) An EMS instructor shall maintain the EMS certification for the level the instructor is certified to teach. If an individual's EMS certification lapses, the instructor certification is invalid until EMS certification is renewed.

(6) The Department may waive a particular instructor certification requirement if the applicant can demonstrate the applicant's training and experience requirements are equivalent or greater to what are required in Utah.

R426-5-1300. Instructor Certification.

(1) The Department may certify an individual who is an EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD as an EMS Instructor for a two-year period.

(2) An individual who wishes to become certified as an EMS Instructor shall:

(a) Submit an application and pay all applicable fees;

(b) submit three letters of recommendation regarding EMS skills and teaching abilities;

(c) submit documentation of 15 hours of teaching experience;

(d) successfully complete all required examinations; and

(e) successfully complete the Department-sponsored initial EMS instructor training course.

(3) An individual who wishes to become certified as an EMS Instructor to teach EMR, EMT, AEMT, or paramedic courses shall also:

(a) Provide documentation of 30 hours of patient care within the prior year.

(4) The Department may waive portions of the initial EMS instructor training courses for previously completed Department-approved instructor programs.

R426-5-1400. Instructor Recertification.

(1) An EMS instructor who wishes to recertify as an instructor shall:

(a) maintain current EMS certification; and

(b) attend the required Department-approved recertification training at least once in the two year recertification cycle;

(2) Submit an application and pay all applicable fees.

R426-5-1500. Instructor Lapsed Certification.

(1) An EMS instructor whose instructor certification has expired for less than two years may again become certified by completing the recertification requirements.

(2) An EMS instructor whose instructor certification has expired for more than two years shall complete all initial instructor certification requirements and reapply as if there were no prior certification.

R426-5-1600. Training Officer Certification.

(1) The Department may certify an individual who is a certified EMS instructor as a training officer for a two-year period.

(2) An individual who wishes to become certified as an EMS Training officer shall:

(a) Be currently certified as an EMS instructor;

(b) successfully complete the Department's course for new training officers;

(c) submit an application and pay all applicable fees; and

(d) submit biennially a completed and signed "Training Officer Contract" to the Department agreeing to abide by the standards and procedures in the then current Training Officer Manual.

(3) A training officer shall maintain EMS instructor certification to retain training officer certification.

(4) An EMS training officer shall abide by the terms of the Training Officer Contract, and comply with the standards and procedures in the Training Officer Manual as incorporated into the respective Training Officer Contract.

R426-5-1700. Training Officer Recertification.

(1) A training officer who wishes to recertify as a training officer shall:

(a) Attend a training officer seminar at least once in the two year recertification cycle;

(b) maintain current EMS instructor and EMS certification;

(c) submit an application and pay all applicable fees;

(d) successfully complete any Department-examination requirements; and

(e) submit biennially a completed and signed new "Training Officer Contract" to the Department agreeing to abide by the standards and procedures in the current training officer manual.

R426-5-1800. Training Officer Lapsed Certification.

(1) An individual whose training officer certification has expired for less than two years may again become certified by completing the recertification requirements. The individual's new expiration date will be two years from the old expiration date.

(2) An individual whose training officer certification has expired for more than two year shall complete all initial training officer certification requirements and reapply as if there were no prior certification.

R426-5-1900. Course Coordinator Certification.

(1) The Department may certify an individual as an EMS course coordinator for a two-year period.

(2) An individual who wishes to certify as a course coordinator shall:

(a) Be certified as an EMS instructor;

(b) be a co-coordinator of record for one Department-approved course with a certified course coordinator;

(c) submit a written evaluation and recommendation from the course coordinator in the co-coordinated course;

(d) complete certification requirements within one year of completion of the Department's course for new course coordinators;

(e) submit an application and pay all applicable fees;

(f) complete the Department's course for new course coordinators;

(g) sign and submit annually the "Course Coordinator Contract" to the Department agreeing to abide to the standards and procedures in the then current Course Coordinator Manual; and

(h) maintain EMS instructor certification.

(3) A Course Coordinator may only coordinate courses up to the certification level to which the course coordinator is certified. A course coordinator, who is only certified as an EMD, may only coordinate EMD courses.

(4) A course coordinator shall abide by the terms of the "Course Coordinator Contract" and comply with the standards and procedures in the Course Coordinator Manual as incorporated into the "Course Coordinator Contract."

(5) A Course Coordinator shall maintain an EMS Instructor certification and the EMS certification for the level that the course coordinator is certified to coordinate. If an individual's EMS certification lapses, the Course Coordinator certification is invalid until EMS certification is renewed.

R426-5-2000. Course Coordinator Recertification.

(1) A course coordinator who wishes to recertify as a course coordinator shall:

(a) Maintain current EMS instructor and EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD certification;

(b) coordinate or co-coordinate at least one Department-approved course every two years;

(c) attend a course coordinator seminar at least once in the two year recertification cycle;

(d) submit an application and pay all applicable fees; and

(e) sign and submit biannually a Course Coordinator Contract to the Department agreeing to abide by the policies and procedures in the then current Course Coordinator Manual.

R426-5-2100. Course Coordinator Lapsed Certification.

(1) An individual whose course coordinator certification has expired for less than two year may again become certified by completing the recertification requirements. The individual's new expiration date will be two years from the recertification date.

(2) An individual whose course coordinator certification has expired for more than two year

must complete all initial course coordinator certification requirements and reapply as if there were no prior certification.

R426-5-2200. Course Approvals.

(1) A course coordinator offering EMS training to individuals who wish to become certified as an EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD shall obtain Department approval prior to initiating an EMS training course. The Department shall approve a course if:

(a) The applicant submits the course application and fees no earlier than 90 days and no later than 30 days prior to commencing the course;

(b) the applicant has sufficient equipment available for the training or if the equipment is available for rental from the Department;

(c) the Department finds the course meets all the Department rules and contracts governing training;

(d) the course coordinators and instructors hold current respective course coordinator and EMS instructor certifications; and

(e) the Department has the capacity to offer the applicable examinations in a timely manner after the conclusion of the course.

R426-5-2300. Paramedic Training Institutions Standards Compliance.

(1) A person shall be authorized by the Department to provide training leading to the certification of a paramedic.

(2) To become authorized and maintain authorization to provide paramedic training, a person shall:

(a) Enter into the Department's standard paramedic training contract; and

(b) adhere to the terms of the contract, including the requirement to provide training in compliance with the Course Coordinator Manual and the Utah Paramedic Training Program Accreditation Standards Manual.

R426-5-2400. Off-line Medical Director Requirements.

(1) The Department may certify an off-line medical director for a four-year period.

(2) An off-line medical director shall be:

(a) a physician actively engaged in the provision of emergency medical care;

(b) familiar with the Utah EMS Systems Act, Title 26, Chapter 8a, and applicable state rules; and

(c) familiar with medical equipment and medications required.

R426-5-2500. Off-line Medical Director Certification.

(1) An individual who wishes to certify as an off-line medical director shall:

(a) have completed an American College of Emergency Physicians or National Association of Emergency Medical Services Physicians medical director training course or the Department's medical director training course within twelve months of becoming a medical director;

(b) submit an application and;

(c) pay all applicable fees.

(2) An individual who wishes to recertify as an off-line medical director shall:

(a) attend the medical directors annual workshop at least once every four years

(b) submit an application; and

(c) pay all applicable fees.

R426-5-2600. Epinephrine Auto-Injector Use.

(1) Any qualified entities or qualified adults as defined in 26-41-102 in accordance with 26-41-107 shall receive training approved by the Department.

(a) The training shall include:

(i) recognition of life threatening symptoms of anaphylaxis;

(ii) appropriate administration of an epinephrine auto-injector;

(iii) proper storage of an epinephrine auto-injector;

(iv) disposal of an epinephrine auto-injector; and

(v) an initial and annual refresher course.

(2) The annual refresher course requirement may be waived if:

(a) The qualified entities or qualified adults are currently licensed or certified at the EMR or higher level by the State of Utah, or

(b) The approved trainings are the Red Cross and American Heart Association epinephrine auto-injector modules.

(3) Training in the school setting shall be based on approved Department trainings found on http://www.choosehealth.utah.gov/prek-12/school-nurses.php

and provided in accordance with 26-41-104.

(4) All epinephrine auto injectors shall be stored and disposed of following the manufacturer's specifications.

R426-5-2700. Law Enforcement Blood Draws Authorized Individual Qualifications.

Individuals who are not authorized to draw blood pursuant to Utah Code Title 41-6a-523(1)(b), or individuals who are not certified by the Department such as EMTs, AEMTs, EMT-IAs, or Paramedics pursuant to Utah Code Title 26-8a-302 shall meet one of the following requirements as a prerequisite for authorization to withdraw blood for the purpose of determining its alcoholic or drug content when requested to do so by a peace officer:

(1) training in blood withdrawal procedures obtained as a defined part of a successfully completed college or university course taken for credit, or

(2) training in blood withdrawal procedures obtained as a defined part of a successfully completed training course which prepares individuals to function in routine clinical or emergency medical situations, or

(3) training of no less than three weeks duration in blood withdrawal procedures under the guidance of a licensed physician.

R426-5-2800. Permits for Blood Draws.

(1) Pursuant Utah Code Title 41-6a-523(1)(b), the Department may issue permits to withdraw blood for the purpose of determining the alcoholic or drug content therein, when requested by a peace officer, to qualified applicants, as determined by the Department. Individuals described in R426-5-2700 are exempt from permit requirements.

(2) The permit shall be of a size suitable for framing and a wallet-sized permit card shall be issued with the permit. Permits for blood draws are not required for people.

(3) Application to obtain a permit shall be made to the Director, Division of Epidemiology and Laboratory Services on forms provided by the Department.

(4) The permit shall be prominently displayed in the facility where the permit holder is employed. When the permit holder is requested to withdraw blood for the above stated purpose at a location other than the facility indicated above, he must have a valid permit card on his person.

(5) The effective date of a permit shall be the date the application is approved by the Department, which date shall appear on the permit and on the wallet-sized permit card. Permits shall be valid for a three year period on a calendar year basis. The date the permit expires shall appear on the permit and on the wallet-sized permit card. Permits shall be subject to termination or revocation pursuant to R426-5-2900.

(6) Application to renew permits shall be made to the Director, Division of Epidemiology and Laboratory Services before the end of each three year permit period. Such application shall be made on forms provided by the Department. The permit holder shall either certify that he has been engaged in performing blood withdrawal procedures during the current permit period or submit a certificate signed by a physician attesting to his competence to perform blood withdrawal procedures.

(7) Permit holders must notify the Director, Division of Epidemiology and Laboratory Services within 15 days of a change in name or mailing address. Permits or permit cards that are destroyed or lost may be replaced upon written request from the permit holder.

R426-5-2900. Cause for Blood Draw Permit Termination or Revocation.

Violation of this rule is a class B misdemeanor under Utah Code Title 26-23-6 and is cause to cancel any permit issued under this rule.

Permits shall be subject to termination or revocation under any one of the following:

(1) The permit holder has made any misrepresentation of a material fact in his application, or any other communication to the Department or its representatives, which misrepresentation was material to the eligibility of the permit holder;

(2) The permit holder is not qualified under R426-5-2700 to hold a permit;

(3) The permit holder after having received a permit has been convicted of a felony or of a misdemeanor which misdemeanor involves moral turpitude; or

(4) The permit holder does not comply with the display or possession requirements stated in R426-5-2800(3).

R426-5-3000. Published List of Authorized Individuals Permitted to Draw Blood.

The Department shall publish annually, a list of individuals authorized to withdraw blood for determination of its alcoholic or drug content, when requested to do so by a peace officer. This list shall include the individual's name, mailing address, and permit number. The list shall be made available to all state and local law enforcement agencies, all local health departments, and any other person or agency requesting the information. The Department may publish amended lists when deemed necessary.

R426-5-3100. Background Screening Clearance for EMS Certification.

(1) The Department shall conduct a background screening on each individual who seeks to certify or recertify as an EMR, EMT, AEMT, EMT-IA, Paramedic, or EMD. The Department shall approve EMS certification or recertification upon successful completion of a background screening. Background clearance indicates the individual does not pose an unacceptable risk to public health and safety.

(2) The Department may review relevant information obtained from the following sources:

(a) Department of Public Safety arrest, conviction, and disposition records described in Title 53, Chapter 10, Criminal Investigations and Technical Services Act, including information in state, regional, and national records files;

(b) juvenile court arrest, adjudication, and disposition records, as allowed under Section 78A-6- 209;

(c) federal criminal background databases available to the state;

(d) the Department of Human Services' Division of Child and Family Services Licensing Information System described in Section 62A-4a-1006;

(e) child abuse or neglect findings described in Section 78A-6-323;

(f) the Department of Human Services' Division of Aging and Adult Services vulnerable adult abuse, neglect, or exploitation database described in Section 62A-3-311.1; and

(g) licensing and certification records of individuals licensed or certified by the Division of Occupational and Professional Licensing under Title 58, Occupations and Professions.

(3) If the Department determines an individual is not eligible for certification or recertification based upon the criminal background screening and the individual disagrees with the information provided by the Criminal Investigations and Technical Services Division or court record, the individual may challenge the information as provided in Utah Code Annotated Sections 77-18a.

(4) If the Department determines an individual is not eligible for certification or recertification based upon the non-criminal background screening and the individual disagrees with the information provided, the individual may challenge the

information through the appropriate agency.

(5) The individual seeking certification or recertification shall submit the completed application, including fees, prior to submission of finger prints.

(6) Exclusion from certification or recertification.

(a) Criminal Convictions or Pending Charges:

(i) If an individual has been convicted, has pleaded no contest, is subject to a plea in abeyance, or a diversion agreement, for the following offenses within the past 15 years, they shall not be approved for certification or recertification:

(A) any felony or class A under Title 76, Chapter 5 Offenses Against the Person, Utah Criminal Code;

(B) any felony or class A under Title 76, Chapter 9, Offenses Against Public Order and Decency, Utah Criminal Code excluding sections 103 and 108;

(C) any felony or class A or B under the following Utah Criminal Codes:

(I) 76-9-301.8, Bestiality;

(II) 76-9-702.1, Sexual Battery; and

(III) 76-9-702.5, Lewdness Involving Child.

(ii) If an individual has been convicted or has pleaded no contest for the following offenses, 15 years have passed since the last conviction and the offense cannot be expunged they shall be considered for certification or recertification:

(A) any felony or class A under Title 76, Chapter 5 Offenses Against the Person, Utah Criminal Code;

(B) any felony or class A under Title 76, Chapter 9, Offenses Against Public Order and Decency, Utah Criminal Code excluding sections 103 and 108;

(C) any felony or class A or B under the following Utah Criminal Codes:

(I) 76-9-301.8, Bestiality;

(II) 76-9-702.1, Sexual Battery; and

(III) 76-9-702.5, Lewdness Involving Child.

(iii) If an individual has been convicted, has pleaded no contest, is subject to a plea in abeyance, or a diversion agreement, for the following offenses, they shall be considered for certification or recertification:

(A) any felony or class A under Utah Criminal Code not listed in R426-5-3100(6)(a)(i).

(B) any class B or C under Title 76, Chapter 5 Offenses Against the Person, Utah Criminal Code;

(C) any felony, class A under Title 76, Chapter 6, Offenses Against Property, Utah Criminal Code;

(D) any felony or class A under Title 76, Chapter 6a, Pyramid Schemes, Utah Criminal Code;

(E) any felony or class A under Title 76, Chapter 8, Offenses Against the Administration of Government, Utah Criminal Code;

(F) any felony, class A under Title 76, Chapter 10, Offenses Against Public Health, Welfare, Safety and Morals, Utah Criminal Code;

(G) any felony, class A, B or C under the following Utah Criminal Codes:

(I) 76-10-1201 to 1229.5, Pornographic and Harmful Materials and Performances; and

(II) 76-10-1301 to 1314, Prostitution;

(III) any felony or class A under Utah Criminal Code 76-10-2301, Contributing to the Delinquency of a Minor;

(H) any felony or class A or B under Utah Motor Vehicles Traffic Code 41-6a-502 and 517.

(I) any felony or class A or B under Utah Occupations and Professions Utah Controlled Substances Act 58-37.

(J) any felony or class A or B under Alcoholic Beverage Control Act 32B-4-409.

(K) any criminal conviction or pattern of convictions that may represent an unacceptable risk to public health and safety.

(iv) An individual seeking certification who has been convicted or has pleaded no contest, is subject to a plea in abeyance, a diversion agreement, a warrant for arrest, arrested or charged for any of the identified offenses in R426-5-3100(6)(a)(iii), shall be considered for certification.

(v) A certified EMS individual who is subject to a warrant of arrest, arrested or charged for any of the identified offenses in R426-5-3100(6)(a)(iii), and after an investigation and Peer Review Board process as established in R426-5-3300, the Department may issue recertification, or suspend or revoke a certification, or place a certification on probation.

(vi) A certified EMS individual who is subject to a warrant of arrest, arrested or charged for any of the identified offenses in R426-5-3100(6)(a)(i), shall immediately have the individuals EMS certification placed on restriction pending the outcome of a CCEU investigation as per the process established in R426-5-3300.

(b) Juvenile Records.

(i) As required by Utah Code Subsection 26-8a-310(5)(b), juvenile court records shall be reviewed if an individual is:

(A) under the age of 28; or

(B) over the age of 28 and has convictions or pending charges identified in R426-5-3100(6)(a).

(ii) Adjudications by a juvenile court may exclude the individual from certification or recertification if the adjudications refer to an act that, if committed by an adult, would be a felony or a misdemeanor any of the identified offenses in R426-5-2700(6)(a).

(c) Non-Criminal Records.

(i) The Department may deny certification or recertification based on a supported finding from:

(A) the Department of Human Services' Division of Child and Family Services Licensing Information System described in Section 62A-4a-1006;

(B) child abuse or neglect findings described in Section 78A-6-323;

(C) the Department of Human Services' Division of Aging and Adult Services vulnerable adult abuse, neglect, or exploitation database described in Section 62A-3-311.1;

(ii) The Department may deny certification or recertification based on a finding from licensing records of individuals licensed by the Division of Occupational and Professional Licensing under Title 58, Occupations and Professions.

(d) Review of Relevant Information.

(i) Results of background screening review, as listed above in R426-5-3100(6)(a)(ii)-(iii), (b) or (c) may be reviewed to determine under what circumstance, if any, the individual may be granted certification or recertification. The following factors may be considered:

(A) types and number;

(B) passage of time;

(C) surrounding circumstances;

(D) intervening circumstances; and

(E) steps taken to correct or improve.

(ii) The Department shall rely on relevant information identified in R426-5-3100(2) as conclusive evidence and may deny certification or recertification based on that information.

(e) Appeal of Department certification decision.

(i) A certified EMS individual may appeal a Department certification decision as listed in R426-5-3100(6)(d)(i)to the CCEU as per the process established in R426-5-3300.

(7) A certified EMS individual who has been arrested, charged, or convicted shall notify the Department CCEU and all employers or affiliated entities who utilize the EMS individual's certification within 7 business days. The certified EMS individual shall also notify the Department of all entities they work for or are affiliated with.

(8) All licensed or designated EMS providers who are notified or become aware of a certified EMS individual arrest, charge or conviction shall notify the Department CCEU within

7 business days.

R426-5-3200. Review and Investigation by the Complaint, Compliance and Enforcement Unit (CCEU).

(1) The CCEU shall review all complaints filed against an EMS provider and a certified EMS individual.

(a) Complaints shall be in writing and submitted on an approved CCEU complaint form.

(b) Every complaint shall have the complainants contact information and be signed by the complainant.

(2) Designated or licensed provider complaints will be investigated by the CCEU.

(a) The CCEU may conduct interviews with the provider.

(b) The CCEU will allow the provider an opportunity to respond to the allegations and to provide supporting witnesses and documentation.

(c) Based on the investigation, the CCEU will make recommendations to the Department's Bureau Director.

(d) If the CCEU recommendation is that the provider is to be placed on probation or suspension, the CCEU shall recommend terms and conditions.

(e) The Department may take action against a designated or licensed provider's license or designation based on the investigative findings.

(f) The Department shall notify the provider in writing of the Department's decision within 30 days of completion of the investigation.

(3) Certified EMS individual complaints will be investigated either by the CCEU or by the Primary Affiliated Provider (PAP).

(a) The CCEU shall investigate the following complaints against a certified EMS individual.

(i) If the CCEU determines that:

(A) the certified EMS individual demonstrates a threat to him or herself or to a coworker,

(B) the certified EMS individual demonstrates a threat to the public health,

(C) the certified EMS individual demonstrates a threat to the safety or welfare of the public,

(D) the certified EMS individual potentially violated R426-5-2800(4), or

(E) the CCEU determines the risk cannot be reasonably mitigated.

(ii) The Department may place the certified EMS individual on a restricted certification while and investigation is pending until terms are reached for a provisional certification using the process outlined in R426-5-3200(5)(e).

(iii) The CCEU may conduct interviews with all parties necessary. The CCEU will gather information and evidence, which may include requiring the certified EMS individual to submit to a drug or alcohol screening or any other appropriate evaluation.

(iv) The certified EMS individual shall have an opportunity to respond to the allegations and to provide supporting witnesses and documentation.

(v) Once the CCEU has completed its investigation it shall submit the report with all findings and recommendations to the Peer Review Board per R426-5-3300 and the Bureau Director for review.

(vi) While waiting for the Peer Review Board process, the Department shall notify the certified EMS individual in writing of the CCEU's recommendation within 30 days of the completion of the investigation.

(b) The Primary Affiliated Provider shall investigate a complaint against the certified EMS individual who the CCEU refers to the PAP.

(i) The PAP investigation shall:

(A) be investigated by the licensed or designated EMS provider's EMS certified medical training officer or designee;

(B) be completed and findings submitted to the CCEU within 30 calendar days from receipt of complaint from the CCEU;

(ii) If the CCEU determines that the PAP actions are insufficient, the CCEU may initiate an investigation of the certified EMS individual which follows the CCEU and the Peer Review Board process.

(4) The Department shall investigate a certified EMS individual's certification or a provider's license or designation for any of the following:

(a) refusal to submit to a drug test requested by the EMS provider or the Department;

(b) failure to report by an individual or any affiliated provider pursuant to R426-5-3100(7)and(8);

(c) non-prescribed use of or addiction to narcotics or drugs;

(d) use of alcoholic beverages or being under the influence of alcoholic beverages at any level while on call or on duty as an EMS personnel or while driving any EMS vehicle;

(e) being under the influence of a prescribed or non-prescribed medication or drug(legal or illegal) while on call or on duty as a certified EMS individual who affects the person's ability to operate or function safely.

(f) failure to comply with the training, licensing, or relicensing requirements for the license or certification;

(g) failure to comply with a contractual agreement as an EMS instructor, a training officer, or a course coordinator. Action taken by the Department on this item shall only be against the individual's ability to perform this particular function and would not affect their base certification;

(h) fraud or deceit in applying for or obtaining a certification;

(i) fraud, deceit, lack of professional competency, patient abuse, or theft in the performance of the duties as a certified EMS individual;

(j) false or misleading information or failure to disclose criminal background information during an investigation or an EMS Personnel Peer Review Board proceeding;

(k) unauthorized use or removal of narcotics, medications, supplies or equipment from a provider, emergency vehicle or health care facility;

(l) performing procedures or skills beyond the level of certification or providers licensure;

(m) violation of laws pertaining to medical practice, drugs, or controlled substances;

(n) mental incompetence as determined by a court of competent jurisdiction;

(o) demonstrated inability and failure to perform adequate patient care;

(p) inability to provide emergency medical services with reasonable skill and safety because of illness, or as a result of any other mental or physical condition, when the individual's condition demonstrates a clear and unjustifiable threat or potential threat to oneself, coworkers, or the public health, safety, or welfare that cannot be reasonably mitigated;

(q) misrepresentation of an individual's level of certification;

(r) failure of a certified EMS individual to display a clearly identifiable level of medical certification during an EMS response;

(s) unsafe, unnecessary or improper operation of an emergency vehicle that would likely cause concern or create a danger to the general public; or

(t) improper or unnecessary use of emergency equipment.

(5) Background screening referrals may be submitted to the CCEU.

(a) The CCEU shall review any case referred under R426-5-3100.

(b) The CCEU may require the certified EMS individual

to provide the proper criminal background documentation.

(c) The certified EMS individual shall notify the CCEU of all entities they work for or are affiliated with or that they may become affiliated with in connection to their EMS certification.

(d) Failure to comply with any CCEU requirements may result in disciplinary action against the certified EMS individual's certification.

(e) The CCEU may negotiate with the certified EMS individual and their primary affiliated provider to determine terms and conditions of the EMS individual's provisional certification.

(i) When the Department determines a certified EMS individual's certification will be restricted, the CCEU shall notify both the certified EMS individual and all providers they are affiliated with.

(ii) Within 2 business days of receiving the complaint or referral, the CCEU will attempt to contact and begin negotiations with the primary affiliated provider and the certified EMS individual. All parties will attempt to determine reasonable terms and conditions to the certified EMS individual's certification that would mitigate the concerns alleged in the complaint or referral.

(iii) If terms and conditions are agreed upon between the parties, the certified EMS individual and all affiliated providers shall be notified immediately. This notification will include that the certified EMS individual is under a provisional certification with terms and conditions until the resolution of any criminal charge or the completion of an investigation.

(iv) If the certified EMS individual is not employed or affiliated with a provider or if terms and conditions are not agreed upon, the CCEU will take action necessary to protect the public's best interest.

(v) The CCEU, the certified EMS individual and the provider, if applicable shall sign the terms of the provisional certification and licensure agreement. Non-licensed providers shall be notified of the provisional certification and its terms and conditions.

(vi) Once the provisional certification has been signed, all known EMS providers who the certified EMS individual is affiliated with will be notified immediately by the CCEU.

(vii) If any affiliated EMS provider or the certified EMS individual fail to abide by the terms and conditions of a provisional certification, both may be subject to sanctions by the Department.

(6) Appeal process;

(a) If a provider chooses to appeal an action by the Department, they may appeal to the EMS Committee or pursue a remedy under the Utah Administrative Procedures Act, 63G-4-201.

(i) If the Department action is appealed to the EMS Committee, then the recommendation shall be given to the Department Executive Director for a final decision.

(b) If a certified EMS individual chooses to appeal an action by the Department, they may appeal to the Executive Director, or pursue a remedy under the Utah Administrative Procedures Act, 63G-4-201.

R426-5-3300. Peer Review Board.

The EMS Personnel Peer Review Board is created under section 26-8a-105(4).

(1) Membership of the EMS Personnel Peer Review Board. The EMS Personnel Peer Review Board shall be composed of the following 15 members appointed by the Executive Director of the Department of Health:

(a) One EMS administrative officer representing a licensed provider from a county of the first or second class;

(b) One EMS administrative officer representing a licensed provider from a county of the third through sixth class;

(c) One educational representative from an accredited EMS training program;

(d) One physician certified and practicing as an EMS Medical Director;

(e) One certified EMD;

(f) Two representatives from professional employee groups, one fire based, and one non-fire based;

(g) Two certified quality assurance/medical training officers;

(h) Two non-supervisory certified EMT's;

(i) Two non-supervisory certified AEMT's;

(j) Two non-supervisory certified Paramedics;

(2) EMS Personnel Peer Review Board member terms of office:

(a) Except as provided in subsection (2)(b) members shall be appointed for a six year term beginning no later than October 1, 2015.

(b) The Department shall adjust the length of terms to ensure the terms of members of the board are staggered so approximately one third of the board is appointed every two years.

(c) No member shall serve consecutive full terms.

(d) When a vacancy occurs in the membership of the board for any reason, the Executive Director of the Department shall appoint the replacement for the balance of the unexpired term. If the balance of the term is greater than 50% of the initial term, then the term shall be considered a full term.

(e) The EMS Personnel Peer Review Board shall organize and select one of its members as Chair and one of its members as Vice Chair to serve no more than two years in each position.

(f) If a board member becomes ineligible for the EMS Personnel Peer Review Board membership position through promotion, an increase in level of certification or transfer out of the employment position which qualified them for the appointment, they shall be replaced at the next two year interval.

(g) An equitable mix of urban and rural members is preferred.

(3) EMS Personnel Peer Review Board Meetings.

(a) Regular meetings of the Peer Review Board shall be scheduled quarterly.

(i) Regular meetings shall be noticed and posted to employers and posted in accordance with the Utah Open and Public Meetings Act, Section 52-4-202.

(ii) Failure to attend three or more consecutive meetings by any member may be grounds for removal of that member and replacement in accordance with subsection (2)(d).

(iii) A member may not receive compensation or benefits from the Department for the member's service. The member may receive per diem and travel expensed in accordance with Department rules and policies.

(4) Once a complaint against a certified EMS individual is investigated, the CCEU shall refer the case and provide a report with all findings and recommendations to the EMS Personnel Peer Review Board.

(5) If the EMS Personnel Peer Review Board chooses to recommend any action that deviates from the CCEU recommendation, the board shall provide written justification for that recommendation.

(6) The EMS Personnel Peer Review Board may make recommendations to the Bureau Director, of:

(a) no Department action, or

(b) a letter of notice, or

(c) probation of the certified EMS individual's certification with specific terms and conditions for a period of time, or

(d) suspension of the certified EMS individual's certification for a defined period of time, or

(e) permanent revocation of the certified EMS individual's certification.

(7) If the Department's Bureau Director modifies the recommended action of the EMS Personnel Peer Review Board,

the Director shall attach a written letter of dissent noting the reasoning for the decision. The Bureau Director shall then notify the EMS Personnel Peer Review Board of the dissent and action taken.

(8) The certified EMS individual shall be notified by the Department of any action taken within 15 days of the decision by mail.

(9) An action to restrict, place on probation, suspend, or revoke the certified EMS individual's certification shall be done in accordance with Title 63G, Chapter 4, Administrative Procedures Act.

R426-5-3400. EMS Rules Task Force.

The EMS Rules Task Force is created under section 26-8a-105(3).

(1) Membership of the EMS Rules Task Force. The EMS Rules Task Force shall be composed of the following members appointed by the Executive Director of the Department of Health:

(a) a representative from the Utah Fire Chiefs' Association;

(b) a representative from the EMS Directors' Association;

(c) a EMS medical director;

(d) a privately owned EMS representative;

(e) a rural EMS medical dispatch representative;

(f) a paramedic licensed provider representative;

(g) an urban EMS medical dispatch representative;

(h) an Emergency Nurses Association representative;

(i) a course coordinator from an accredited EMS training program;

(j) an EMS training officer;

(k) a representative from the State EMS Committee;

(l) a trauma center representative.

(2) EMS Rules Task Force member terms of office:

(a) Except as provided in subsection (2)(b) members shall be appointed for a three year term.

(b) The Department shall adjust the length of terms to ensure the terms of members of the EMS Rules Task Force are staggered so approximately one third of the EMS Rules Task Force is appointed every two years.

(c) Members may serve two consecutive full terms.

(d) When a vacancy occurs in the membership for any reason, the Department shall solicit applications for replacement for the balance of the unexpired term. If the balance of the term is greater than 50% of the initial term, then the term shall be considered a full term.

(e) The EMS Rules Task Force may organize and select one of its members as Chair and one of its members as Vice Chair to serve no more than two years in each position.

(f) If a EMS Rules Task Force member becomes ineligible for the EMS Task Force membership position through promotion, an increase in level of certification or transfer out of the employment position which qualified them for the appointment, they shall be replaced at the next two year interval.

(g) An equitable mix of urban and rural members is preferred.

(3) EMS Rules Task Force Meetings.

(a) Regular meetings of the EMS Rules Task Force shall be scheduled as determined by the membership and the Department.

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R477. Human Resource Management, Administration.
R477-1. Definitions.
R477-1-1. Definitions.

The following definitions apply throughout these rules unless otherwise indicated within the text of each rule.

(1) Abandonment of Position: An act of resignation resulting when an employee is absent from work for three consecutive working days without approval.

(2) Actual FTE: The total number of full time equivalents based on actual hours paid in the state payroll system.

(3) Actual Hours Worked: Time spent performing duties and responsibilities associated with the employee's job assignments.

(4) Actual Wage: The employee's assigned wage rate in the central personnel record maintained by the Department of Human Resource Management.

(5) Administrative Leave: Leave with pay granted to an employee at management discretion that is not charged against the employee's leave accounts.

(6) Administrative Adjustment: An adjustment to a salary range approved by DHRM that is not a Market Comparability Adjustment, a Structure Adjustment, or a Reclassification. It is for administrative purposes only. An Administrative Adjustment will result in an increase to incumbent pay only when necessary to bring salaries to the minimum of the salary range.

(7) Administrative Salary Decrease: A decrease in the current actual wage based on non-disciplinary administrative reasons determined by an agency head.

(8) Administrative Salary Increase: An increase in the current actual wage based on special circumstances determined by an agency head.

(9) Agency: An entity of state government that is:

(a) directed by an executive director, elected official or commissioner defined in Title 67, Chapter 22 or in other sections of the code;

(b) authorized to employ personnel; and

(c) subject to Title 67, Chapter 19, Utah State Personnel Management Act.

(10) Agency Head: The executive director or commissioner of each agency or a designated appointee.

(11) Agency Human Resource Field Office: An office of the Department of Human Resource Management located at another agency's facility.

(12) Agency Management: The agency head and all other officers or employees who have responsibility and authority to establish, implement, and manage agency policies and programs.

(13) Alternative State Application Program (ASAP): A program designed to appoint a qualified person with a disability through an on the job examination period.

(14) Appeal: A formal request to a higher level for reconsideration of a grievance decision.

(15) Appointing Authority: The officer, board, commission, person or group of persons authorized to make appointments in their agencies.

(16) Break in Service: A point at which an individual has an official separation date and is no longer employed by the State of Utah.

(17) Budgeted FTE: The total number of full time equivalents budgeted by the Legislature and approved by the Governor.

(18) Bumping: A procedure that may be applied prior to a reduction in force action (RIF). It allows employees with higher retention points to bump other employees with lower retention points as identified in the work force adjustment plan, as long as employees meet the eligibility criteria outlined in interchangeability of skills.

(19) Career Mobility: A temporary assignment of an employee to a different position for purposes of professional growth or fulfillment of specific organizational needs.

(20) Career Service Employee: An employee who has successfully completed a probationary period in a career service position.

(21) Career Service Exempt Employee: An employee appointed to work for a period of time, serving at the pleasure of the appointing authority, who may be separated from state employment at any time without just cause.

(22) Career Service Exempt Position: A position in state service exempted by law from provisions of career service under Section 67-19-15.

(23) Career Service Status: Status granted to employees who successfully complete a probationary period for career service positions.

(24) Category of Work: A job series within an agency designated by the agency head as having positions to be eliminated agency wide through a reduction in force. Category of work may be further reduced as follows:

(a) a unit smaller than the agency upon providing justification and rationale for approval, including:

(i) unit number;

(ii) cost centers;

(iii) geographic locations;

(iv) agency programs.

(b) positions identified by a set of essential functions, including:

(i) position analysis data;

(ii) certificates;

(iii) licenses;

(iv) special qualifications;

(v) degrees that are required or directly related to the position.

(25) Change of Workload: A change in position responsibilities and duties or a need to eliminate or create particular positions in an agency caused by legislative action, financial circumstances, or administrative reorganization.

(26) Classification Grievance: The approved procedure by which an agency or a career service employee may grieve a formal classification decision regarding the classification of a position.

(27) Classified Service: Positions that are subject to the classification and compensation provisions stipulated in Section 67-19-12.

(28) Classification Study: A Classification review conducted by DHRM under Section R477-3-4. A study may include single or multiple job or position reviews.

(29) Compensatory Time: Time off that is provided to an employee in lieu of monetary overtime compensation.

(30) Contractor: An individual who is contracted for service, is not supervised by a state supervisor, but is responsible for providing a specified service for a designated fee within a specified time. The contractor shall be responsible for paying all taxes and FICA payments, and may not accrue benefits.

(31) Critical Incident Drug or Alcohol Test: A drug or alcohol test conducted on an employee as a result of the behavior, action, or inaction of an employee that is of such seriousness it requires an immediate intervention on the part of management.

(32) Demotion: A disciplinary action resulting in a reduction of an employee's current actual wage.

(33) Detailed Position Record Management Report: A document that lists an agency's authorized positions, incumbent's name and hourly rate, job identification number, salary range, and schedule.

(34) DHRM: The Department of Human Resource Management.

(35) DHRM Approved Recruitment and Selection System: The state's recruitment and selection system, which is a

centralized and automated computer system administered by the Department of Human Resource Management.

(36) Disability: Disability shall have the same definition found in the Americans With Disabilities Act (ADA) of 1990, 42 USC 12101 (2008); Equal Employment Opportunity Commission regulation, 29 CFR 1630 (2008); including exclusions and modifications.

(37) Disciplinary Action: Action taken by management under Rule R477-11.

(38) Dismissal: A separation from state employment for cause under Section R477-11-2.

(39) Dual State Employment: Employees who work for more than one agency and meet the employee criteria which is located in the Division of Finance accounting policy 11-18.00.

(40) Drug-Free Workplace Act: A 1988 congressional act, 34 CFR 84 (2008), requiring a drug-free workplace certification by state agencies that receive federal grants or contracts.

(41) Employee Personnel Files: For purposes of Title 67, Chapters 18 and 19, the files or records maintained by DHRM and agencies as required by Section R477-2-5. This does not include employee information maintained by supervisors.

(42) Employment Eligibility Verification: A requirement of the Immigration Reform and Control Act of 1986, 8 USC 1324 (1988) that employers verify the identity and eligibility of individuals for employment in the United States.

(43) "Escalator" Principle: Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), returning veterans are entitled to return back onto their seniority escalator at the point they would have occupied had they not left state employment.

(44) Excess Hours: A category of compensable hours separate and apart from compensatory or overtime hours that accrue at straight time only when an employee's actual hours worked, plus additional hours paid, exceed an employee's normal work period.

(45) Fitness For Duty Evaluation: Evaluation, assessment or study by a licensed professional to determine if an individual is able to meet the performance or conduct standards required by the position held, or is a direct threat to the safety of self or others.

(46) FLSA Exempt: Employees who are exempt from the overtime and minimum wage provisions of the Fair Labor Standards Act.

(47) FLSA Nonexempt: Employees who are not exempt from the overtime and minimum wage provisions of the Fair Labor Standards Act.

(48) Follow Up Drug or Alcohol Test: Unannounced drug or alcohol tests conducted for up to five years on an employee who has previously tested positive or who has successfully completed a voluntary or required substance abuse treatment program.

(49) Furlough: A temporary leave of absence from duty without pay for budgetary reasons or lack of work.

(50) GOMB: Governor's Office of Management and Budget.

(51) Grievance: A career service employee's claim or charge of the existence of injustice or oppression, including dismissal from employment resulting from an act, occurrence, omission, condition, discriminatory practice or unfair employment practice not including position classification or schedule assignment, or a complaint by a reporting employee as defined in Section 67-19a-101(4)(c).

(52) Grievance Procedures: The statutory process of grievances and appeals as set forth in Sections 67-19a-101 through 67-19a-406 and the rules promulgated by the Career Service Review Office.

(53) Gross Compensation: Employee's total earnings, taxable and nontaxable, as shown on the employee's pay statement.

(54) Highly Sensitive Position: A position approved by DHRM that includes the performance of:

(a) safety sensitive functions:

(i) requiring an employee to operate a commercial motor vehicle under 49 CFR 383 (January 18, 2006);

(ii) directly related to law enforcement;

(iii) involving direct access or having control over direct access to controlled substances;

(iv) directly impacting the safety or welfare of the general public;

(v) requiring an employee to carry or have access to firearms; or

(b) data sensitive functions permitting or requiring an employee to access an individual's highly sensitive, personally identifiable, private information, including:

(i) financial assets, liabilities, and account information;

(ii) social security numbers;

(iii) wage information;

(iv) medical history;

(v) public assistance benefits; or

(vi) driver license

(55) Hiring List: A list of qualified and interested applicants who are eligible to be considered for appointment or conditional appointment to a specific position created in the DHRM approved recruitment and selection system.

(56) HRE: Human Resource Enterprise; the state human resource management information system.

(57) Incompetence: Inadequacy or unsuitability in performance of assigned duties and responsibilities.

(58) Inefficiency: Wastefulness of government resources including time, energy, money, or staff resources or failure to maintain the required level of performance.

(59) Interchangeability of Skills: Employees are considered to have interchangeable skills only for those positions they have previously held successfully in Utah state government executive branch employment or for those positions which they have successfully supervised and for which they satisfy job requirements.

(60) Intern: An individual in a college degree or certification program assigned to work in an activity where on-the-job training or community service experience is accepted.

(61) Job: A group of positions similar in duties performed, in degree of supervision exercised or required, in requirements of training, experience, or skill and other characteristics. The same salary range is applied to each position in the group.

(62) Job Description: A document containing the duties, distinguishing characteristics, knowledge, skills, and other requirements for a job.

(63) Job Family: A group of jobs that have related or common work content, that require common skills, qualifications, licenses, etc., and that normally represents a general occupation area.

(64) Job Requirements: Skill requirements defined at the job level.

(65) Job Series: Two or more jobs in the same functional area having the same job title, but distinguished and defined by increasingly difficult levels of skills, responsibilities, knowledge and requirements; or two or more jobs with different titles working in the same functional area that have licensure, certification or other requirements with increasingly difficult levels of skills, responsibilities, knowledge and requirements.

(66) Leave Benefit: A benefit provided to an employee that includes: Annual leave, sick leave, converted sick leave, and holiday leave. These benefits are not provided to non-benefited employess.

(67) Legislative Salary Adjustment: A legislatively approved salary increase for a specific category of employees based on criteria determined by the Legislature.

(68) Malfeasance: Intentional wrongdoing, deliberate violation of law or standard, or mismanagement of responsibilities.

(69) Market Based Bonus: One time lump sum monies given to a new hire or a current employee to encourage employment with the state.

(70) Market Comparability Adjustment: An adjustment to a salary range approved by the legislature that is based upon salary data and other relevant information from comparable jobs in the market that is collected by DHRM or from DHRM approved justifiable sources. The Market Comparability Adjustment may also change incumbent pay resulting in a budgetary impact for an agency.

(71) Merit Increase: A legislatively approved and funded salary increase for employees to recognize and reward successful performance.

(72) Misconduct: Wrongful, improper, unacceptable, or unlawful conduct or behavior that is inconsistent with prevailing agency practices or the best interest of the agency.

(73) Misfeasance: The improper or unlawful performance of an act that is lawful or proper.

(74) Nonfeasance: Failure to perform either an official duty or legal requirement.

(75) Pay for Performance Award: A type of cash incentive award where an employee or group of employees may receive a cash award for meeting or exceeding well-defined annual production or performance standards, targets and measurements.

(76) Pay for Performance: A plan for incentivizing employees for meeting or exceeding production or performance goals, in which the plan is well-defined before work begins, eligible work groups are defined, specific goals and targets are determined, measurement procedures are in place, and specific incentives are provided when goals and targets are met.

(77) Performance Evaluation: A formal, periodic evaluation of an employee's work performance.

(78) Performance Improvement Plan: A documented administrative action to address substandard performance of an employee under Section R477-10-2.

(79) Performance Management: The ongoing process of communication between the supervisor and the employee which defines work standards and expectations, and assesses performance leading to a formal annual performance evaluation.

(80) Performance Plan: A written summary of the standards and expectations required for the successful performance of each job duty or task. These standards normally include completion dates and qualitative and quantitative levels of performance expectations.

(81) Performance Standard: Specific, measurable, observable and attainable objectives that represent the level of performance to which an employee and supervisor are committed during an evaluation period.

(82) Personnel Adjudicatory Proceedings: The informal appeals procedure contained in Section 63G-4-101 et seq. for all human resource policies and practices not covered by the state employees grievance procedure promulgated by the Career Service Review Office, or the classification appeals procedure.

(83) Phased Retirement: Employment on a half-time basis of a retiree with the same participating employer immediately following the retiree's retirement date. During phased retirement retiree will receive a reduced retirement allowance.

(84) Position: A unique set of duties and responsibilities identified by DHRM authorized job and position management numbers.

(85) Position Description: A document that describes the detailed tasks performed, as well as the knowledge, skills, abilities, and other requirements of a specific position.

(86) Position Identification Number: A unique number assigned to a position for FTE management.

(87) Post Accident Drug or Alcohol Test: A Drug or alcohol test conducted on an employee who is involved in a vehicle accident while on duty or driving a state vehicle:

(a) where a fatality occurs;

(b) where there is sufficient information to conclude that the employee was a contributing cause to an accident that results in bodily injury or property damage; or

(c) where there is reasonable suspicion that the employee had been driving while under the influence of alcohol or a controlled substance.

(88) Preemployment Drug Test: A drug test conducted on:

(a) final applicants who are not current employees;

(b) final candidates for a highly sensitive position;

(c) employees who are final candidates for transfer or promotion from a non-highly sensitive position to a highly sensitive position; or

(d) employees who transfer or are promoted from one highly sensitive position to another highly sensitive position.

(89) Probationary Employee: An employee hired into a career service position who has not completed the required probationary period for that position.

(90) Probationary Period: A period of time considered part of the selection process, identified at the job level, the purpose of which is to allow management to evaluate an employee's ability to perform assigned duties and responsibilities and to determine if career service status should be granted.

(91) Proficiency: An employee's overall quality of work, productivity, skills demonstrated through work performance and other factors that relate to employee performance or conduct.

(92) Promotion: An action moving an employee from a position in one job to a position in another job having a higher salary range maximum.

(93) Protected Activity: Opposition to discrimination or participation in proceedings covered by the antidiscrimination statutes or the Utah State Grievance and Appeal Procedure. Harassment based on protected activity can constitute unlawful retaliation.

(94) Random Drug or Alcohol Test: Unannounced drug or alcohol testing of a sample of highly sensitive employees done in accordance with federal regulations or state rules, policies, and procedures, and conducted in a manner such that each highly sensitive employee has an equal chance of being selected for testing.

(95) Reappointment: Return to work of an individual from the reappointment register after separation from employment.

(96) Reappointment Register: A register of individuals who have prior to March 2, 2009:

(a) held career service status and been separated in a reduction in force;

(b) held career service status and accepted career service exempt positions without a break in service and were not retained, unless discharged for cause; or

(c) by Career Service Review Board decision been placed on the reappointment register.

(97) Reasonable Suspicion Drug or Alcohol Test: A drug or alcohol test conducted on an employee based on specific, contemporaneous, articulated observations concerning the appearance, behavior, speech or body odors of the employee.

(98) Reassignment: An action mandated by management moving an employee from one job or position to a different job or position with an equal or lesser salary range maximum for administrative reasons. A reassignment may not include a decrease in actual wage except as provided in federal or state law.

(99) Reclassification: A DHRM reallocation of a single position or multiple positions from one job to another job to reflect management initiated changes in duties and responsibilities.

(100) Reduction in Force: (RIF) Abolishment of positions resulting in the termination of career service staff. RIFs can occur due to inadequate funds, a change of workload, or a lack of work.

(101) Reemployment: Return to work of an employee who resigned or took military leave of absence from state employment to serve in the uniformed services covered under USERRA.

(102) Requisition: An electronic document used for HRE Online recruitment, selection and tracking purposes that includes specific information for a particular position, job seekers' applications, and a hiring list.

(103) Salary Range: Established minimum and maximum rates assigned to a job.

(104) Schedule: The determination of whether a position meets criteria stipulated in the Utah Code Annotated to be career service (schedule B) or career service exempt (schedule A).

(105) Separation: An employee's voluntary or involuntary departure from state employment.

(106) Settling Period: A sufficient amount of time, determined by agency management, for an employee to fully assume new or higher level duties required of a position.

(107) Structure Adjustment: An adjustment to a salary range approved by DHRM that is based upon salary data and other relevant information from comparable jobs in the market that is collected by DHRM or from DHRM approved justifiable sources. The salary range adjustment cannot have a budgetary impact on an agency unless additional approval is received from the Governor's Office.

(108) Tangible Employment Action: A significant change in employment status, such as firing, demotion, failure to promote, work reassignment, or a decision which changes benefits.

(109) Transfer: An action not mandated by management moving an employee from one job or position to another job or position with an equal or lesser salary range maximum for which the employee qualifies. A transfer may include a decrease in actual wage.

(110) Uniformed Services: The United States Army, Navy, Marine Corps, Air Force, Coast Guard; Reserve units of the Army, Navy, Marine Corps, Air Force, or Coast Guard; Army National Guard or Air National Guard; Commissioned Corps of Public Health Service, National Oceanic and Atmospheric Administration (NOAA), National Disaster Medical Systems (NDMS) and any other category of persons designated by the President in time of war or emergency. Service in Uniformed Services includes: voluntary or involuntary duty, including active duty; active duty for training; initial active duty for training; inactive duty training; full-time National Guard duty; or absence from work for an examination to determine fitness for any of the above types of duty.

(111) Unlawful Discrimination: An action against an employee or applicant based on race, religion, national origin, color, sex, age, disability, pregnancy, sexual orientation, gender identity, protected activity under the anti-discrimination statutes, political affiliation, military status or affiliation, or any other factor, as prohibited by law.

(112) USERRA: Uniformed Services Employment and Reemployment Rights Act of 1994 (P.L. 103-353), requires state governments to re-employ eligible veterans who resigned or took a military leave of absence from state employment to serve in the uniformed services and who return to work within a specified time period after military discharge.

(113) Veteran: An individual who has served on active duty in the armed forces for more than 180 consecutive days, or was a member of a reserve component who served in a campaign or expedition for which a campaign medal has been authorized. Individuals must have been separated or retired under honorable conditions.

(114) Volunteer: Any person who donates services to the state or its subdivisions without pay or other compensation except actual and reasonable expenses incurred, as approved by the supervising agency.

(115) Wage: The fixed hourly rate paid to an employee.

(116) Work Period: The maximum number of hours an employee may work prior to accruing overtime or compensatory hours based on variable payroll cycles outlined in 67-19-6.7 and 29 CFR 553.230.

KEY: personnel management, rules and procedures, definitions

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Notice of Continuation April 27, 2017	**67-19-18**

R477. Human Resource Management, Administration.
R477-2. Administration.
R477-2-1. Rules Applicability.

These rules apply to the executive branch of Utah State Government and its career and career service exempt employees. Other entities may be covered in specific sections as determined by statute. Any inclusions or exceptions to these rules are specifically noted in applicable sections. Entities which are not bound by mandatory compliance with these rules include:

(1) members of the Legislature and legislative employees;

(2) members of the judiciary and judicial employees;

(3) officers, faculty, and other employees of state institutions of higher education;

(4) officers, faculty, and other employees of the public education system, other than those directly employed by the State Office of Education;

(5) employees of the Office of the Attorney General;

(6) elected members of the executive branch and their employees;

(7) employees of independent entities, quasi-governmental agencies and special service districts;

(8) employees in any position that is determined by statute to be exempt from these rules.

R477-2-2. Compliance Responsibility.

Agencies shall comply with these rules.

(1) The Executive Director, DHRM, may authorize exceptions to these rules where allowed when:

(a) applying the rule prevents the achievement of legitimate government objectives; or

(b) applying the rule infringes on the legal rights of an employee.

(2) Agency personnel records, practices, policies and procedures, employment and actions, shall comply with these rules and are subject to compliance audits by DHRM.

(3) In cases of noncompliance with Title 67, Chapter 19, and these rules, the Executive Director, DHRM, may find the responsible agency official to be subject to the penalties under Subsection 67-19-18(1) pertaining to misfeasance, malfeasance or nonfeasance in office.

R477-2-3. Fair Employment Practice and Discrimination.

All state personnel actions shall provide equal employment opportunity for all individuals.

(1) Employment actions including appointment, tenure or term, condition or privilege of employment shall be based on the ability to perform the essential duties, functions, and responsibilities assigned to a particular position.

(2) Employment actions may not be based on race, religion, national origin, color, sex, age, disability, pregnancy, sexual orientation, gender identity, or protected activity under the anti-discrimination statutes, political affiliation, military status or affiliation or any other non-job related factor, except as provided under Subsection 67-19-15(2)(b)(ii).

(3) An employee who alleges unlawful discrimination may:

(a) submit a complaint to the agency head; and

(b) file a charge with the Utah Labor Commission Anti-Discrimination and Labor Division within 180 days of the alleged harm, or directly with the EEOC within 300 days of the alleged harm.

(4) A state official may not impede any employee from the timely filing of a discrimination complaint in accordance with state and federal requirements.

R477-2-4. Control of Personal Service Expenditures.

(1) Statewide control of personal service expenditures shall be the shared responsibility of the employing agency, the Governor's Office of Management and Budget, the Department of Human Resource Management and the Division of Finance.

(2) Changes in job identification numbers, salary ranges, or number of positions listed in the Detailed Position Record Management Report shall be approved by the Executive Director, DHRM or designee.

(3) No person shall be placed or retained on an agency payroll unless that person occupies a position listed in an agency's approved Detailed Position Record Management Report.

R477-2-5. Records.

Access to and privacy of personnel records maintained by DHRM are governed by Title 63G, Chapter 2, the Government Records Access and Management Act (GRAMA) and applicable federal laws. DHRM shall designate and classify the records and record series it maintains under the GRAMA statute and respond to GRAMA requests for employee records.

(1) DHRM shall maintain an electronic record for each employee that contains the following, as appropriate:

(a) Social Security number, date of birth, home address, and private phone number.

(i) This information is classified as private under GRAMA.

(ii) DHRM may grant agency access to this information for state business purposes. Agencies shall maintain the privacy of this information.

(b) performance ratings;

(c) records of actions affecting employee salary history, classification history, title and salary range, employment status and other personal data.

(2) DHRM shall maintain, on behalf of agencies, personnel files.

(3) DHRM shall maintain, on behalf of agencies, a confidential medical file. Confidentiality shall be maintained in accordance with applicable regulations. Information in the medical file is private, controlled, or exempt in accordance with Title 63G-2.

(4) An employee has the right to review the employee's personnel file, upon request, in the presence of a DHRM representative.

(a) An employee may request corrections, amendments to, or challenge any information in the DHRM electronic or hard copy personnel file, through the following process:

(i) The employee shall request in writing to the appropriate agency human resource field office that changes occur.

(ii) The employing agency shall be given an opportunity to respond.

(iii) Disputes over information that are not resolved between the employing agency and the employee shall be decided in writing by the Executive Director, DHRM. DHRM shall maintain a record of the employee's letter, the agency's response, and the DHRM Executive Director's decision.

(5) When a disciplinary action is rescinded or disapproved upon appeal, forms, documents and records pertaining to the case shall be removed from the personnel file.

(a) When the record in question is on microfilm, a seal will be placed on the record and a suitable notice placed on the carton or envelope. This notice shall indicate the limits of the sealed Title and the authority for the action.

(6) Upon employee separation, DHRM shall retain electronic records for thirty years. Agency hard copy records shall be retained at the agency for a minimum of two years, and then transferred to the State Record Center to be retained according to the record retention schedule.

(7) When an employee transfers from one agency to another, the former agency shall transfer the employee's personnel file, medical and I-9 records to the new agency.

(8) An employee who violates confidentiality is subject to disciplinary action and may be personally liable.

(9) Records related to conduct for which an employee may

be disciplined under R477-11-1(1) are classified as private records under Subsection 62G-2-302(2)(a).

(i) If disciplinary action under R477-11-1(4) has been sustained and completed and all time for appeal has been exhausted, the documents issued in the disciplinary process are classified as public records under Subsection 63G-2-301(3)(o).

R477-2-6. Release of Information in a Reference Inquiry.

Reference checks or inquiries made regarding current or former public employees, volunteers, independent contractors, and members of advisory boards or commissions can be released if the information is classified as public, or if the subject of the record has signed and provided a current reference release form for information authorized under Title 63G, Chapter 2, of the Government Records Access and Management Act.

(1) The employment record is the property of Utah State Government with all rights reserved to utilize, disseminate or dispose of in accordance with the Government Records Access and Management Act.

(2) Additional information may be provided if authorized by law.

R477-2-7. Employment Eligibility Verification (Immigration Reform and Control Act - 1986).

Employees newly hired, rehired, or placed through reciprocity with or assimilation from another career service jurisdiction shall provide verifiable documentation of their identity and eligibility for employment in the United States by completing all sections of the Employment Eligibility Verification Form I-9 as required under the Immigration Reform and Control Act of 1986.

R477-2-8. Disclosure by Public Officers Supervising a Relative.

It is unlawful for a public officer to appoint, directly supervise, or to make salary or performance recommendations for relatives except as prescribed under Section 52-3-1.

(1) A public officer supervising a relative shall make a complete written disclosure of the relationship to the agency head in accordance with Section 52-3-1.

R477-2-9. Employee Liability.

An employee who becomes aware of any occurrence which may give rise to a law suit, who receives notice of claim, or is sued because of an incident related to state employment, shall give immediate notice to his supervisor and to the Department of Administrative Services, Division of Risk Management.

(1) In most cases, under Title 63G, Chapter 7, the Governmental Immunity Act, an employee shall receive defense and indemnification unless the case involves fraud, malice or the use of alcohol or drugs by the employee.

(2) Before an agency may defend its employee against a claim, the employee shall make a written request for a defense to the agency head within ten calendar days, under Subsection 63G-7-902(2).

R477-2-10. Alternative Dispute Resolution.

Agency management may establish a voluntary alternative dispute resolution program under Chapter 63G, Chapter 5.

KEY: administrative responsibility, confidentiality of information, fair employment practices, public information

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R477. Human Resource Management, Administration.

R477-3. Classification.

R477-3-1. Job Classification Applicability.

(1) The Executive Director, DHRM, shall prescribe the procedures and methods for classifying all positions except for the following positions, which include:

(a) employees already exempted from DHRM rules in R477-2-1;

(b) all employees in:

(i) the office and residence of the governor;

(ii) the Utah Science Technology and Research Initiative (USTAR);

(iii) the Public Lands Policy Coordinating Council;

(iv) the Office of the Utah State Auditor; and

(v) the Utah State Treasurer's Office;

(c) employees of the State Board of Education, who are licensed by the State Board of Education;

(d) employees in any position that is determined by statute to be exempt from classified service;

(e) employees whose agency has authority to make rules regarding performance, compensation, and bonuses for its employees;

(f) other persons appointed by the governor under statute;

(g) temporary employees who work part time indefinite or work on a time limited basis;

(h) patients and inmates designated as schedule AU;

(i) members of state and local boards and councils and other employees designated as schedule AQ; and

(j) educational interpreters and educators as defined by Section 53A-25b-102 who are employed by the Utah Schools for the Deaf and the Blind.

(2) The Executive Director, DHRM, may designate specific job titles, job and position identification numbers, schedule codes, and other administrative information for all employees exempted in R477-2-1 and R477-3-1 for identification and reporting purposes only. These employees are not to be considered classified employees.

(3) Employees in schedule codes AD and AR are not considered classified employees but are subject to the Job Description and Assignment of Duties sections of this rule.

R477-3-2. Job Description.

DHRM shall maintain job descriptions, as appropriate.

(1) Job descriptions shall contain:

(a) job title;

(b) distinguishing characteristics;

(c) a description of tasks commonly associated with most positions in the job;

(d) statements of required knowledge, skills, and other requirements;

(e) FLSA status and other administrative information as approved by DHRM.

R477-3-3. Assignment of Duties.

(1) Management may assign, modify, or remove any position task or responsibility in order to accomplish reorganization, improve business practices or processes, or for any other reason deemed appropriate by agency management.

(2) Significant changes in the assigned duties may require a position classification review as described in R477-3-4.

R477-3-4. Position Classification Review.

(1) A formal classification review may be conducted under the following circumstances:

(a) as part of a classification study;

(b) at the request of agency management, with the approval of the Executive Director, DHRM or designee; or

(c) as part of a classification grievance review

(2) DHRM shall determine if there have been sufficient

significant changes in the duties of a position to warrant a formal review.

(3) When an agency is reorganized or positions are redesigned, no classification reviews shall be conducted until an appropriate settling period has occurred.

(4) The Executive Director, DHRM, or designee shall make final classification decisions unless overturned by a hearing officer or court.

R477-3-5. Position Classification Grievances.

(1) Under 67-19-31, an agency or a career service employee may grieve formal classification decisions regarding the classification of a position.

(a) This rule refers to grievances concerning the assignment of individual positions to appropriate jobs based on duties and responsibilities. The assignment of salary ranges is not included in this rule.

(b) An employee may only grieve a formal classification decision regarding the employee's own position.

(2) Formal service for classification grievance communication to employees shall be made by:

(a) certified mail to the employee's address of record, and

(b) email to the employee's state email account.

R477-3-6. Policy Exceptions.

The Executive Director, DHRM, may authorize exceptions to this rule consistent with Subsection R477-2-2(1).

KEY: administrative procedures, grievances, job descriptions, position classifications
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R477. Human Resource Management, Administration.
R477-4. Filling Positions.
R477-4-1. Authorized Recruitment System.

Agencies shall use the DHRM approved recruitment and selection system unless an alternate system has been pre-approved by DHRM.

R477-4-2. Career Service Exempt Positions.

(1) The Executive Director, DHRM, may approve the creation and filling of career service exempt positions, as defined in Section 67-19-15.

(2) Agencies may use any pre-approved process to select an employee for a career service exempt position. Appointments may be made without competitive examination, provided job requirements are met.

(3) Appointments to fill an employee's position who is on approved leave shall only be made temporarily.

(4) Appointments made on a temporary basis shall be career service exempt and:

(a) be Schedule IN, in which the employee:

(i) is hired to work part time indefinitely; and

(ii) shall work less than 30 hours per week.

(b) be Schedule TL, in which the employee:

(i) is hired to work on a time limited basis.

(c) may, at the discretion of management, be offered benefits if working a minimum of 40 hours per pay period.

(d) if the required work hours of the position meet or exceed 30 hours per week for Schedule IN or if the position exceeds anticipated time limits for Schedule TL, agency management shall consult with DHRM to review possible alternative options.

(5) Only Schedule A, IN or TL appointments made from a hiring list under Subsection R477-4-8 may be considered for conversion to career service.

(6) Disclosure statements shall be obtained and reference and background checks shall be conducted for all Schedule AB, AC, AD and AR new hire appointees.

R477-4-3. Career Service Positions.

(1) Selection of a career service employee shall be governed by the following:

(a) DHRM business practices;

(b) career service principles as outlined in R477-2-3 Fair Employment Practice emphasizing recruitment of qualified individuals based upon relative knowledge, skills and abilities;

(c) equal employment opportunity principles;

(d) Section 52-3-1, employment of relatives;

(e) reasonable accommodation for qualified applicants covered under the Americans With Disabilities Act.

R477-4-4. Recruitment and Selection for Career Service Positions.

(1) Prior to initiating recruitment, agencies may administer any of the following personnel actions:

(a) reemployment of a veteran eligible under USERRA;

(b) reassignment within an agency initiated by an employee's reasonable accommodation request under the ADA;

(c) fill a position as a result of return to work from long term disability or workers compensation at the same or lesser salary range;

(d) reassignment or transfer made in order to avoid a reduction in force, or for reorganization or bumping purposes;

(e) reassignment, transfer, or career mobility of qualified employees to better utilize skills or assist management in meeting the organization's mission;

(f) reclassification; or

(g) conversion from schedule A to schedule B as authorized by Subsection R477-5-1(3).

(2) Agencies shall use the DHRM approved recruitment

and selection system for all career service position vacancies. This includes recruitments open within an agency, across agency lines, or to the general public. Recruitment shall comply with federal and state laws and DHRM rules and procedures.

(a) All recruitment announcements shall include the following:

(i) Information about the DHRM approved recruitment and selection system; and

(ii) opening and closing dates.

(b) Recruitments for career service positions shall be posted for a minimum of three business days, excluding state holidays.

(3) Agencies may carry out all the following steps for recruitment and selection of vacant career service positions concurrently. Management may make appointments according to the following order:

(a) from the reappointment register created prior to March 2, 2009, provided the applicant applies for the position and meets minimum qualifications.

(b) from a hiring list of qualified applicants for the position, or from another process pre-approved by the Executive Director, DHRM.

R477-4-5. Transfer and Reassignment.

(1) Positions may be filled through a transfer or reassignment.

(a) The receiving agency shall verify the employee's career service status and that the employee meets the job requirements for the position.

(b) Agencies receiving a transfer or reassignment of an employee shall accept all of that employee's previously accrued sick, annual, and converted sick leave on the official leave records.

(d) A transfer may not include in increase but may include a decrease in actual wage.

(e) A reassignment may not include a decrease in actual wage except as provided in federal or state law.

(f) Except as provided in R477-4-5, an employee who is transferred or reassigned to a position where the employee's current actual wage is above the salary range maximum of the new position, is considered to be above maximum and may not be eligible for a longevity increase. Employees shall be eligible for a longevity increase only after they have been above the salary range maximum for 12 months and all other longevity criteria are met.

(g) An employee with a wage that is above the salary range maximum because of a longevity increase, who is transferred or reassigned and remains at or above the salary range maximum, shall receive their next longevity increase three years from the date they received the most recent increase if they receive a passing performance appraisal rating within the previous 12 months.

(2) A reassignment or transfer may include assignment to:

(a) a different job or position with an equal or lesser salary range maximum;

(b) a different work location; or

(c) a different organizational unit.

R477-4-6. Rehire.

(1) A former employee shall compete for career service positions through the DHRM approved recruitment and selection system and shall serve a new probationary period, as designated in the official job description.

(a) The annual leave accrual rate for an employee who is rehired to a position which receives leave benefits shall be based on all eligible employment in which the employee accrued leave.

(b) An employee rehired into a benefited position within one year of separation shall have forfeited sick leave reinstated as Program III sick leave.

(c) An employee rehired into a benefited position within one year of separation due to a reduction in force shall have forfeited sick leave reinstated to Program I, Program II, and Program III as accrued prior to the reduction in force.

(d) Except for employees rehired under the provisions of R477-4-6(2), a rehired employee may be offered any salary within the salary range for the position.

(2) Employees rehired under the Phased Retirement Program pursuant to Utah Code Section 49-11-13 shall be:

(a) Classified as time-limited (TL schedule) for the duration of a phased retirement employment period; and

(b) Placed at or below the employee's wage at the time of retirement. Employees cannot be placed below the minimum of the established salary range of the job.

R477-4-7. Examinations.

(1) Examinations shall be designed to measure and predict applicant job performance.

(2) Examinations shall include the following:

(a) a detailed position record (DPR) based upon a current job or position analysis;

(b) an initial, impartial screening of the individual's qualifications;

(c) impartial evaluation and results; and

(d) reasonable accommodation for qualified individuals with disabilities.

(3) Examinations and ratings shall remain confidential and secure.

R477-4-8. Hiring Lists.

(1) The hiring list shall include the names of applicants to be considered for appointment or conditional appointment to a specific job, job series or position.

(a) An individual shall be considered an applicant when the individual applies for a particular position identified through a specific recruitment.

(b) Hiring lists shall be constructed using a DHRM approved recruitment and selection system.

(c) Applicants for career service positions shall be evaluated and placed on a hiring list based on job, job series or position related criteria.

(d) All applicants included on a hiring list shall be examined with the same examination or examinations.

(2) An individual who falsifies any information in the job application, examination or evaluation processes may be disqualified from further consideration prior to hire, or disciplined if already hired.

(3) The appointing authority shall demonstrate and document that equal consideration was given to all applicants on a hiring list whose final score or rating is equal to or greater than that of the applicant hired.

(4) The appointing authority shall ensure that any employee hired meets the job requirements as outlined in the official job description.

R477-4-9. Job Sharing.

Agency management may establish a job sharing program as a means of increasing opportunities for part-time employment. In the absence of an agency program, individual employees may request approval for job sharing status through agency management.

R477-4-10. Internships.

Interns or students in a practicum program may be appointed with or without competitive selection. Intern appointments shall be to temporary career service exempt positions.

R477-4-11. Volunteer Experience Credit.

(1) Documented job related volunteer experience shall be given the same consideration as similar paid employment in satisfying the job requirements for career service positions.

(a) Volunteer experience may not be substituted for required licensure, POST certification, or other criteria for which there is no substitution in the job requirements in the job description.

(b) Court ordered community service experience may not be considered.

R477-4-12. Reorganization.

When an agency is reorganized, but an employee's position does not change substantially, the agency may not require the employee to compete for his current position.

R477-4-13. Career Mobility Programs.

Employees and agencies are encouraged to promote career mobility programs.

(1) A career mobility is a temporary assignment of an employee to a different position for purposes of professional growth or fulfillment of specific organizational needs. Career mobility assignments may be to any salary range.

(2) Agencies may provide career mobility assignments inside or outside state government in any position for which the employee qualifies.

(3) An eligible employee or agency may initiate a career mobility.

(a) Career mobility assignments may be made without going through the competitive process but shall remain temporary.

(b) Career mobility assignments shall only become permanent if:

(i) the position was originally filled through a competitive recruitment process; or

(ii) a competitive recruitment process is used at the time the agency determines a need for the assignment to become permanent.

(4) Agencies shall develop and use written career mobility contract agreements between the employee and the supervisor to outline all program provisions and requirements. The career mobility shall be both voluntary and mutually acceptable.

(5) A participating employee shall retain all rights, privileges, entitlements, tenure and benefits from the previous position while on career mobility.

(a) If a reduction in force affects a position vacated by a participating employee, the participating employee shall be treated the same as other RIF employees.

(b) If a career mobility assignment does not become permanent at its conclusion, the employee shall return to the previous position or a similar position at a salary rate described in R477-6-6(10).

(6) An employee who has not attained career service status prior to the career mobility program cannot permanently fill a career service position until the employee obtains career service status through a competitive process.

R477-4-14. Assimilation.

(1) An employee assimilated by the state from another government career service system to fill a Schedule B position shall receive career service status after completing a probationary period if originally selected through a competitive examination process judged by the Executive Director, DHRM, to be equivalent to the process prescribed in DHRM Rules.

(a) Assimilation agreements shall specify whether there are employees eligible for reemployment under USERRA in positions affected by the agreement.

(b) An assimilated employee shall accrue leave at the same rate as other career service employees with the same seniority.

R477-4-15. Policy Exceptions.

The Executive Director, DHRM, may authorize exceptions to this rule, consistent with Subsection R477-2-2(1).

KEY: employment, fair employment practices, hiring practices

January 1, 2017 67-19-6

Notice of Continuation April 27, 2017 67-20-8

R477. Human Resource Management, Administration.
R477-5. Employee Status and Probation.
R477-5-1. Career Service Status.

(1) Only an employee who is hired through a pre-approved process shall be eligible for appointment to a career service position.

(2) An employee shall complete a probationary period prior to receiving career service status.

(3) Management may convert a career service exempt employee to career service status, in a position with an equal or lower salary range to the previous career service position held, when:

(a) the employee previously held career service status with no break in service between the last career service position held and career service exempt status;

(b) the employee was hired from a hiring list to a schedule A, TL or IN position, in the same job title to which they would convert, as prescribed by Subsection R477-4-8; or

(c) the employee was hired through the Alternative State Application Program (ASAP) and successfully completed a six month on the job examination period.

R477-5-2. Probationary Period.

The probationary period allows agency management to evaluate an employee's ability to perform the duties, responsibilities, skills, and other related requirements of the assigned career service position. The probationary period shall be considered part of the selection process.

(1) An employee shall receive an opportunity to demonstrate competence in a career service position. A performance plan shall be established and the employee shall receive feedback on performance in relation to that plan.

(a) During the probationary period, an employee may be separated from state employment in accordance with Subsection R477-11-2(1).

(b) At the end of the probationary period, an employee shall receive a performance evaluation. Evaluations shall be entered into HRE as the performance evaluation that reflects successful or unsuccessful completion of probation.

(2) Each career service position shall be assigned a probationary period consistent with its job.

(a) The probationary period may not be extended except for periods of leave without pay, long-term disability, workers compensation leave, temporary transitional assignment, military leave under USERRA, or donated leave from an approved leave bank.

(b) The probationary period may not be reduced after appointment.

(c) An employee who has completed a probationary period and obtained career service status shall not be required to serve a new probationary period unless there is a break in service.

(3) An employee in a career service position who works at least 50% of the regular work schedule or more shall acquire career service status after working the same amount of elapsed time in hours as a full-time employee would work with the same probationary period.

(4) An employee serving probation in a career service position may be transferred, reassigned or promoted to another career service position. Each new appointment shall include a new probationary period unless the agency determines that the required duties or knowledge, skills, and abilities of the old and new position are similar enough not to warrant a new probationary period. The probationary period shall be the full probationary period defined in the job description of the new position.

R477-5-3. Policy Exceptions.

The Executive Director, DHRM, may authorize exceptions to this rule, consistent with Subsection R477-2-2(1).

KEY: employment, personnel management, state employees
July 1, 2013 67-19-6
Notice of Continuation April 27, 2017 67-19-16(5)(b)

R477. Human Resource Management, Administration.
R477-6. Compensation.
R477-6-1. Pay Plans.

(1) With approval of the Governor, the Executive Director, DHRM, shall develop salary ranges for pay plans for each job.

(a) Each job description shall include a salary range.

(b) Agency approved wage increases within salary ranges shall be:

(i) at least 1/2%, or

(ii) to the maximum wage within the salary range, if the difference between the current wage and the salary range maximum is less than 1/2%.

(c) Agency approved wage decreases within salary ranges shall be:

(i) at least 1/2%, or

(ii) to the minimum wage within the salary range, if the difference between the current wage and the salary range minimum is less than 1/2%.

(d) Salary increases and decreases shall not place an employee below the salary range minimum or above the salary range maximum unless the criteria for longevity increases has been met.

R477-6-2. Allocation to the Pay Plans for Classified Employees.

(1) Each job in classified service shall be:

(a) assigned to a salary range and job family.

(b) surveyed in the market in accordance with the benchmark job(s).

(c) included in a market comparability adjustment recommendation if warranted.

(2) Salary ranges can be adjusted through:

(a) an administrative adjustment determined appropriate by DHRM for administrative purposes that is not based on a change of duties and responsibilities, nor based on a comparison to salary data in the market;

(b) a structure adjustment that has no budgetary impact on all affected agencies; or

(c) a market comparability adjustment to a job's salary range based upon salary data and other relevant information for similar jobs in the market through an annual compensation benchmark survey or other sources.

(i) Market comparability adjustment recommendations shall be included in the annual compensation plan and are submitted to the Governor no later than October 31 of each year.

(ii) Funding for market comparability adjustments shall be legislatively approved if the adjustment would cause a budgetary impact.

(iii) If market comparability adjustments are funded and approved for benchmark jobs, salary ranges for other jobs in the same job family shall be adjusted by relative ranking with the benchmark job.

(3) Salary ranges cannot be adjusted more frequently than on an annual basis without an exception by the Executive Director, DHRM.

R477-6-3. Pay Plans for Unclassified Employees Designated as Schedule AD and AR.

(1) Each job in an AD/AR pay plan shall be assigned to a salary range that is no more than 40% above and below the salary range midpoint.

(2) Salary ranges may be adjusted through:

(a) An administrative adjustment determined appropriate by DHRM for administrative purposes.

(b) A structure adjustment.

(i) DHRM will consult with the Governor's Office of Management and Budget (GOMB) prior to making structure adjustments. GOMB approval is required for adjustments to the salary range of the Deputy Director or equivalent.

(ii) Funding for structure adjustments shall be legislatively approved unless the adjustment has no budgetary impact.

(iii) Structure adjustment recommendations that require funding may be included in the annual compensation plan.

(iv) Structure adjustments may take place on an annual basis. Limited exceptions addressing a critical need may be granted upon request and approval of the Executive Director, DHRM.

(v) Structure adjustments shall not be approved for cross agency jobs unless the adjustment has no budgetary impact on all affected agencies.

R477-6-4. Pay Plans for Unclassified Employees Designated as Schedule AC, AG, AH, AS,AN, AO, AP, IN,TL,AU and AQ.

(1) Each job exempted from classified service that are identified in positions under R477-3-1(1) shall have a salary range with a beginning and ending salary of any amount determined appropriate by the affected agency.

R477-6-5. Appointments.

(1) All appointments shall be placed on the DHRM approved salary range for the job.

(2) Qualifying military service members returning to work under USERRA shall be placed in their previous position or a similar position. Reemployment shall include the same seniority status, wage, including any cost of living adjustments, general increase, reclassification of the service member preservice position, or market comparability adjustments that would have affected the service member's preservice position during the time spent by the affected service member in the uniformed services. Performance related salary increases are not included.

R477-6-6. Salary.

(1) Promotions.

(a) An employee who is in designated schedules B, AD, AR, AT, or AW and is promoted to a job with a salary range maximum exceeding the employee's current salary range maximum shall receive a wage increase of at least 5%.

(b) An employee who is promoted may not be placed higher than the maximum or lower than the minimum in the new salary range except as provided in subsection R477-6-6(3), governing longevity salary increases.

(c) To be eligible for a promotion, an employee shall meet the requirements and skills specified in the job description and position specific criteria as determined by the agency for the position.

(2) Reclassifications.

(a) At agency management's discretion, an employee reclassified to a job with a salary range maximum exceeding the employee's current salary range maximum may receive a wage increase of at least 1/2% or up to the salary range maximum. An employee shall be placed within the new salary range. An employee's eligibility for a longevity salary increase shall be consistent with Subsection R477-6-6(3).

(b) An employee whose job is reclassified to a job with a lower salary range shall retain the current wage.

(3) Longevity Salary Increase.

(a) An employee shall receive an initial longevity salary increase of 2.75% when:

(i) the employee has been in state service for eight years or more. The employee may accrue years of service in more than one agency and such service is not required to be continuous; and

(ii) the employee has been at or above the maximum of the current salary range for at least one year and received a passing performance appraisal rating within the 12-month period preceding the longevity increase.

(b) An employee who has received the initial longevity increase is then eligible for an additional 2.75% increase every three years. To be eligible for these additional increases, an employee shall receive a passing performance appraisal rating within the 12-month period preceding the longevity increase.

(c) An employee with a wage that is above the maximum salary range because of a longevity salary increase:

(i) shall retain the current actual wage if receiving an administrative adjustment or is reassigned or reclassified to a job with a lower salary range maximum.

(ii) who is reclassified to a job with a higher salary range maximum shall only receive a wage increase if the current actual wage is less than the salary range maximum of the new job. At the discretion of agency management the salary increase shall be at least 1/2% or up to the salary range maximum of the new job.

(iii) who is promoted shall only receive a wage increase if the current actual wage is less than the salary range maximum of the new job. The wage increase shall be at least 5% or up to the salary range maximum of the new job.

(iv) who is promoted, reclassified, transferred, reassigned or receives an administrative adjustment and remains at or above the salary range maximum, shall receive their next longevity salary increase three years from the date they received the most recent increase if they receive a passing performance appraisal rating within the previous twelve months.

(d) An employee with a wage that is not at or above the salary range maximum who is reclassified, transferred, reassigned, or receiving an administrative adjustment and has a current actual wage that is above the salary range maximum of the new job is considered to be above maximum and may not be eligible for a longevity salary increase. Employees shall be eligible for a longevity salary increase when they have been above the salary range maximum for 12 months and all other longevity salary increase criteria are met.

(h) An employee in Schedules AB, IN, or TL is not eligible for the longevity salary increase program.

(4) Administrative Adjustment.

(a) An employee whose position has been allocated by DHRM from one job to another job or salary range for administrative purposes may not receive an adjustment in the current actual wage unless the employee is below the minimum of the new salary range.

(b) An employee whose position is changed by administrative adjustment to a job with a lower salary range shall retain the current wage even if the current wage exceeds the new salary range maximum.

(5) Reassignment.

An employee's current actual wage may not be decreased except as provided in federal or state law.

(6) Transfer.

Management may decrease the current actual wage of an employee who transfers to another job with the same or lower salary range maximum.

(7) Demotion.

An employee demoted consistent with Section R477-11-2 shall receive a reduction in the current actual wage of at least 1/2%, or down to the salary range minimum as determined by the agency head or designee. The agency head or designee may move an employee to a job with a lower salary range concurrent with the reduction in the current actual wage.

(8) Administrative Salary Increase.

The agency head authorizes and approves administrative salary increases under the following parameters:

(a) An employee shall receive an increase of at least 1/2% or up to the salary range maximum.

(b) Administrative salary increases shall only be granted when the agency has sufficient funding within their annualized base budgets for the fiscal year in which the adjustment is given.

(c) Justifications for administrative salary increases shall be:

(i) in writing;

(ii) approved by the agency head or designee;

(iii) supported by unique situations or considerations in the agency.

(d) The agency head or designee shall answer any challenge or grievance resulting from an administrative salary increase.

(e) Administrative salary increases may be given during the probationary period. Wage increases shall be at least 1/2% or up to the salary range maximum. These increases alone do not constitute successful completion of the probationary period or the granting of career service status.

(f) An employee at or above the salary range maximum may not be granted administrative salary increases.

(g) Increasing an employee's wage as part of a transfer or reassignment action must be justified as an administrative salary increase in a separate action.

(9) Administrative Salary Decrease.

The agency head authorizes and approves administrative salary decreases for nondisciplinary reasons according to the following:

(a) The final wage may not be less than the salary range minimum.

(b) Wage decreases shall be at least 1/2% or down to the salary range minimum.

(c) Justification for administrative salary decreases shall be:

(i) in writing;

(ii) approved by the agency head; and

(iii) supported by issues such as previous written agreements between the agency and the employee to include career mobility, reasonable accommodation, or other unique situations or considerations in the agency.

(d) The agency head or designee shall answer any challenge or grievance resulting from an administrative salary decrease.

(10) Career Mobility.

(a) Agencies may offer an employee on a career mobility assignment a wage increase or decrease of at least 1/2% within the new salary range.

(b) If a career mobility assignment does not become permanent at its conclusion, the employee shall return to the previous position or a similar position and shall receive, at a minimum, the same wage and the same or higher salary range that the employee would have received without the career mobility assignment.

(11) Exceptions.

The Executive Director, DHRM, may authorize exceptions for wage increases or decreases.

R477-6-7. Incentive Awards.

(1) Only agencies with written and published incentive award and bonus policies may reward employees with incentive awards or bonuses. Incentive awards and bonuses are discretionary, not an entitlement, and are subject to the availability of funds in the agency.

(a) Policies shall be approved annually by DHRM and be consistent with standards established in these rules and the Department of Administrative Services, Division of Finance, rules and procedures.

(b) Individual awards may not exceed $4,000 per pay period and $8,000 in a fiscal year, except when approved by DHRM and the governor.

(i) A request for a retirement incentive award shall be accompanied by documentation of the work units affected and any cost savings.

(ii) A single payment of up to $8,000 may be granted as a retirement incentive.

(c) All cash and cash equivalent incentive awards and bonuses shall be subject to payroll taxes.

(2) Performance Based Incentive Awards.

(a) Cash Incentive Awards

(i) An agency may grant a cash incentive award to an employee or group of employees that demonstrates exceptional effort or accomplishment beyond what is normally expected on the job for a unique event or over a sustained period of time.

(ii) Pay for Performance cash incentive award programs offered by an agency shall be included in the agency's incentive awards policy and reviewed annually by DHRM, in consultation with GOMB.

(A) The policy shall include information supporting the following:

(1) Sustainability of the funding for the cash incentive program;

(2) The positions eligible to participate in the Pay for Performance program;

(3) Goals of the program;

(4) Type of work to be incentivized; and

(5) Ability to track the effectiveness of the program.

(iii) All cash awards shall be approved by the agency head or designee. They shall be documented and a copy shall be maintained by the agency.

(b) Noncash Incentive Awards

(i) An agency may recognize an employee or group of employees with noncash incentive awards.

(ii) Individual noncash incentive awards may not exceed a value of $50 per occurrence and $200 for each fiscal year.

(iii) Noncash incentive awards may include cash equivalents such as gift certificates or tickets for admission. Cash equivalent incentive awards shall be subject to payroll taxes and shall follow standards and procedures established by the Department of Administrative Services, Division of Finance.

(3) Cost Savings Bonus

(a) An agency may establish a bonus policy to increase productivity, generate savings within the agency, or reward an employee who submits a cost savings proposal.

(i) The agency shall document the cost savings involved.

(4) Market Based Bonuses

An agency may award a cash bonus as an incentive to acquire or retain an employee with job skills that are critical to the state and difficult to recruit in the market.

(a) All market based bonuses shall be approved by DHRM.

(i) When requesting market based awards an agency shall submit documentation specifying how the agency will benefit by granting the bonus based on:

(A) budget;

(B) recruitment difficulties;

(C) a mission critical need to attract or retain unique or hard to find skills in the market; or

(D) other market based reasons.

(b) Retention Bonus

An agency may award a bonus to an employee who has unusually high or unique qualifications that are essential for the agency to retain.

(c) Recruitment or Signing Bonus

An agency may award a bonus to a qualified job candidate to incentivize the candidate to work for the state.

(d) Scarce Skills Bonus

An agency may award a bonus to a qualified job candidate that has the scarce skills required for the job.

(e) Relocation Bonus

An agency may award a bonus to a current employee who must relocate to accept a position in a different commuting area.

(f) Referral Bonus

An agency may award a bonus to a current employee who refers a job applicant who is subsequently selected.

(g) Geographic Job Market Bonus

An agency may award a bonus to incentivize an employee to accept and/or continue an assignment in a specific geographic area.

R477-6-8. Employee Benefits.

(1) An employee shall be eligible for benefits when:

(a) in a position designated by the agency as eligible for benefits; and

(b) in a position which normally requires working a minimum of 40 hours per pay period.

(2) An eligible employee has 30 days from the hire date to enroll in or decline one of the traditional medical insurance plans and 60 days from the hire date to enroll in or decline one of the HSA-qualified medical insurance plans or other tax-advantaged arrangement offered by PEHP and authorized under the Internal Revenue Code for the benefit of the employee.

(a) An employee shall only be permitted to change medical plans during the annual open enrollment period for all state employees.

(3) An eligible employee has 60 days from the hire date to enroll in dental, vision, and a flexible spending account.

(4) An employee shall enroll in guaranteed issue life insurance within 60 days of the hire date to avoid having to provide proof of insurability.

(a) An employee may enroll in additional life insurance and accidental death and dismemberment insurance at any time and may be required to provide proof of insurability.

(5) An employee eligible for retirement benefits shall be electronically enrolled using the URS online certification process as follows:

(a) An employee with any service time with Utah Retirement Systems prior to July 1, 2011, from any URS eligible employer, shall be automatically enrolled in the Tier I defined benefit plan and the Tier I defined contribution plan.

(i) Eligibility for Tier I shall be determined by Utah Retirement Systems.

(ii) An employee eligible for Tier I shall remain in the Tier I system, even after a break in service.

(b) An employee with no previous service time with Utah Retirement Systems in Tier I shall be enrolled in the Tier II retirement system.

(i) An employee has one year from the date of eligibility to elect whether to participate in the Tier II hybrid retirement system or the Tier II defined contribution plan.

(A) If no election is made the employee shall be automatically enrolled in the Tier II hybrid retirement system.

(ii) An employee eligible for the Tier II system has one year from the date of eligibility to change the election or it is irrevocable.

(c) Changes in employee contributions, beneficiaries, and investment strategies shall be submitted electronically to URS through the URS website.

(6) A reemployed veteran under USERRA shall be entitled to the same employee benefits given to other continuously employed eligible employees to include seniority based increased pension and leave accrual.

(7) All insurance coverage, excluding COBRA, shall end:

(a) at midnight on the last day of the pay period in which the employee receives a paycheck for employees hired prior to February 15, 2003; or

(b) at midnight on the last day of the pay period in which the employment termination date became effective for employees hired on February 15, 2003, or later.

(8) An employee who is not eligible for benefits under R477-6-8(1) but does meet the minimum qualifications under the Affordable Care Act shall be eligible for medical insurance only.

R477-6-9. Employee Converting from Career Service to

Schedule AC, AD, AR, or AS.

(1) A career service employee in a position meeting the criteria for career service exempt schedule AC, AD, AR, or AS shall have 60 days from the date of offer to elect to convert from career service to career service exempt. As an incentive to convert, an employee shall be provided the following:

(a) an administrative salary increase of at least 1/2% or up to the current salary range maximum. An employee at or above the current salary range maximum shall receive, in lieu of the salary adjustment, a one time bonus, as determined by the agency head or designee, not to exceed limits in Subsection R477-6-7(1)(b);

(b) state paid term life insurance coverage if determined eligible by the Group Insurance Office to participate in the Term Life Program, Public Employees Health Plan, as provided in Section R477-6-10.

(2) An employee electing to convert to career service exempt after the 60 day election period may not be eligible for the wage increase, but shall be entitled to apply for the insurance coverage through the Group Insurance Office.

(3) An employee electing not to convert to career service exemption shall retain career service status even though the position shall be designated as schedule AC, AD, AR or AS. When these career service employees vacate these positions, subsequent appointments shall be career service exempt.

(4) An agency head may reorganize so that a current career service exempt position no longer meets the criteria for exemption. In this case, the employee shall be designated as career service if the employee had previously earned career service. However, the employee may not be eligible for a severance package, increased annual leave accrual, or exempt life insurance. In this situation, the agency and employee shall make arrangements through the Group Insurance Office to discontinue the exempt life insurance coverage.

(5) A career service exempt employee without prior career service status shall remain exempt. When the employee leaves the position, subsequent appointments shall be consistent with R477-4.

(6) Agencies shall communicate to all impacted and future eligible employees the conditions and limitations of this incentive program.

R477-6-10. State Paid Life Insurance.

(1) A benefits eligible career service exempt employee on schedule AA, AB, AD, AR and AT shall be provided the following benefits if the employee is approved through underwriting:

(a) State paid term life insurance coverage if determined eligible by the Group Insurance Office to participate in the Term Life Program Public Employees Health Plan:

(i) Hourly wage $24.03 or less shall receive $125,000 of term life insurance;

(ii) Hourly wage between $24.04 and $28.84 shall receive $150,000 of term life insurance;

(iii) Hourly wage $28.85 or highger shall receive $200,000 of term life insurance.

(2) An employee on schedule AC or AS may be provided these benefits at the discretion of the appointing authority.

R477-6-11. Severance Benefit.

(1) At the discretion of the appointing authority a benefits eligible career service exempt employee on schedule AB, AC, AD, AR, AS or AT who is separated from state service through an action initiated by management, to include resignation in lieu of termination, may receive at the time of separation a severance benefit equal to:

(a) one week of salary, up to a maximum of 12 weeks, for each year of consecutive exempt service in the executive branch; and

(b) if eligible for COBRA, medical insurance coverage only shall be provided for two pay periods for each year of consecutive exempt service, up to a maximum of 13 pay periods, at the level of coverage the employee has at the time of severance, to be paid in a lump sum payment to the state's health care provider.

R477-6-12. Human Resource Transactions.

The Executive Director, DHRM, shall publicize procedures for processing payroll and human resource transactions and documents.

KEY: wages, employee benefit plans, insurance, personnel management

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R477. Human Resource Management, Administration.
R477-7. Leave.
R477-7-1. Conditions of Leave.

(1) An employee shall be eligible for a leave benefit when:

(a) in a position designated by the agency as eligible for benefits; and

(b) in a position which normally requires working a minimum of 40 hours per pay period.

(2) An eligible employee shall accrue annual, sick and holiday leave in proportion to the time paid as determined by DHRM.

(3) An employee shall use leave in no less than quarter hour increments.

(4) An employee may not use annual, sick, or holiday leave before accrued. Leave accrued during a pay period may not be used until the following pay period.

(5) An employee may not use annual leave, converted sick leave used as annual leave, or use excess or compensatory hours without advance approval by management.

(6) An employee may not use any type of leave except military and jury leave to accrue excess hours.

(7) An employee transferring from one agency to another is entitled to transfer all accrued annual, sick, and converted sick leave to the new agency.

(8) An employee separating from state service shall be paid in a lump sum for all annual leave and excess hours. An FLSA nonexempt employee shall also be paid in a lump sum for all compensatory hours.

(a) An employee separating from state service for reasons other than retirement shall be paid in a lump sum for all converted sick leave.

(b) Converted sick leave for a retiring employee shall be subject to Section R477-7-5.

(c) Annual, sick and holiday leave may not be used or accrued after the last day worked, except for:

(i) leave without pay;

(ii) administrative leave specifically approved by management to be used after the last day worked;

(iii) leave granted under the FMLA; or

(iv) leave granted for other medical reasons that was approved prior to the commencement of the leave period.

(9) After four months cumulative leave in a 24 month period, the employee may be separated from employment regardless of paid leave status unless prohibited by state or federal law. Decisions to separate the employee shall be made by the agency head in consultation with DHRM.

(10) Contributions to benefits may not be paid on cashed out leave, other than FICA tax, except as it applies to converted sick leave in Section R477-7-5(2) and the Retirement Benefit in Section R477-7-6.

R477-7-2. Holiday Leave.

(1) The following dates are paid holidays for eligible employees:

(a) New Years Day -- January 1

(b) Dr. Martin Luther King Jr. Day -- third Monday of January

(c) Washington and Lincoln Day -- third Monday of February

(d) Memorial Day -- last Monday of May

(e) Independence Day -- July 4

(f) Pioneer Day -- July 24

(g) Labor Day -- first Monday of September

(h) Columbus Day -- second Monday of October

(i) Veterans' Day -- November 11

(j) Thanksgiving Day -- fourth Thursday of November

(k) Christmas Day -- December 25

(l) Any other day designated as a paid holiday by the Governor.

(2) If a holiday falls or is observed on a regularly scheduled day off, an eligible employee shall receive equivalent time off, not to exceed eight hours, or shall accrue excess hours.

(a) If a holiday falls on a Sunday, the following Monday shall be observed as a holiday.

(b) If a holiday falls on a Saturday, the preceding Friday shall be observed as a holiday.

(3) If an employee is required to work on an observed holiday, the employee shall receive appropriate holiday leave, or shall accrue excess hours.

(4) A new hire shall be in a paid status on or before the holiday in order to receive holiday leave.

(5) A separating employee shall be in a paid status on or after the holiday in order to receive holiday leave.

R477-7-3. Annual Leave.

(1) An eligible employee shall accrue leave based on the following years of state service:

(a) less than 5 years -- four hours per pay period;

(b) at least 5 and less than 10 years -- five hours per pay period;

(c) at least 10 and less than 20 years --six hours per pay period;

(d) 20 years or more -- seven hours per pay period.

(2) The maximum annual leave accrual rate shall be granted to an employee under the following conditions:

(a) an employee in schedule AB, and agency deputy directors and division directors appointed to career service exempt positions.

(b) an employee who is schedule A, FLSA exempt and who has a direct reporting relationship to an elected official, executive director, deputy director, commissioner or board.

(c) The maximum accrual rate shall be effective from the day the employee is appointed through the duration of the appointment. Employees in these positions on July 1, 2003, shall have the leave accrual rate adjusted prospectively.

(3) The accrual rate for an employee rehired to a position which receives leave benefits shall be based on all eligible employment in which the employee accrued leave.

(4) The first eight hours of annual leave used by an employee in the calendar leave year shall be the employee's personal preference day.

(5) Agency management shall allow every employee the option to use annual leave each year for at least the amount accrued in the year.

(6) Unused accrued annual leave time in excess of 320 hours shall be forfeited during year end processing for each calendar year.

R477-7-4. Sick Leave.

(1) An eligible employee shall accrue sick leave, not to exceed four hours per pay period. Sick leave shall accrue without limit.

(2) Agency management may grant sick leave for preventive health and dental care, maternity, paternity, and adoption care, or for absence from duty because of illness, injury or disability of the employee, a spouse, children, or parents living in the employee's home; or qualifying FMLA purposes.

(3) Agency management may grant exceptions for other unique medical situations.

(4) When management approves the use of sick leave, an employee may use any combination of Program I, Program II, and Program III sick leave.

(5) An employee shall contact management prior to the beginning of the scheduled workday the employee is absent due to illness or injury.

(6) Any application for a grant of sick leave to cover an absence that exceeds three consecutive working days shall be

supported by administratively acceptable evidence.

(7) If there is reason to believe that an employee is abusing sick leave, a supervisor may require an employee to produce evidence regardless of the number of sick hours used.

(8) Unless retiring, an employee separating from state employment shall forfeit any unused sick leave without compensation.

(a) An employee rehired into a benefited position within one year of separation due to a reduction in force shall have forfeited sick leave reinstated to Program I, Program II, and Program III as accrued prior to the reduction in force.

(b) An employee rehired with benefits within one year of separation for reasons other than a reduction in force shall have forfeited sick leave reinstated as Program III sick leave.

(c) An employee accepting a benefit eligible position within one year of forfeiting unused sick leave for accepting a non-benefit eligible position shall have their sick leave reinstated as Program III.

(d) An employee who retires from state service and is rehired may not reinstate forfeited sick leave.

R477-7-5. Converted Sick Leave.

(1) An employee may not accrue converted sick leave hours on or after January 3, 2014. Converted sick leave hours accrued before January 3, 2014 can be used for retirement per R477-7-5(6) or cashed out if the employee leaves employment.

(a) Converted sick leave hours accrued prior to January 1, 2006 shall remain Program I converted sick leave hours.

(b) Converted sick leave hours accrued after January 1, 2006 shall remain Program II converted sick leave hours.

(2) An employee may use converted sick leave as annual leave or as regular sick leave.

(3) When management approves the use of converted sick leave, an employee may use any combination of Program I and Program II converted sick leave.

(4) Employees retiring from LTD who have converted sick leave balances still intact may use these hours for the unused converted sick leave retirement program at the time they become eligible for retirement.

(5) Upon retirement, 25% of the value of the unused converted sick leave, but not to exceed Internal Revenue Service limitations, shall be placed in the employee's 401(k) account as an employer contribution.

(a) Converted sick leave hours from Program II shall be placed in the 401(k) account before hours from Program I.

(b) The remainder shall be used for:

(i) the purchase of health care insurance and life insurance under Subsection R477-7-6(3)(a) if the converted sick leave was accrued in Program I ; or

(ii) a contribution into the employees PEHP health reimbursement account under Subsection R477-7-6(6)(b) if the converted sick leave was accrued in Program II.

(6) Upon retirement, Program I converted sick leave hours may not be suspended or deferred for future use. This includes retired employees who reemploy with the state and choose to suspend their defined benefit payments.

R477-7-6. Sick Leave Retirement Benefit.

Upon retirement from active employment, an employee shall receive an unused sick leave retirement benefit under Sections 67-19-14.2 and 67-19-14.4.

(1) An employee in the Tier I retirement system or the Tier II hybrid retirement system shall become eligible for this benefit when actively retiring with Utah Retirement Systems.

(2) An employee in the Tier II defined contribution system shall become eligible when terminating employment on or after the retirement date established by the Utah Retirement Systems. This date reflects service time accrued by the employee as if the employee were in the Tier II hybrid retirement system.

(3)(a) Sick leave hours accrued prior to January 1, 2006 shall be Program I sick leave hours.

(b) Sick leave hours accrued on or after January 1, 2006 shall be Program II sick leave hours.

(4) An agency may offer the Unused Sick Leave Retirement Option Program I to an employee who is eligible to receive retirement benefits. However, any decision whether or not to participate in this program shall be agency wide and shall be consistent through an entire fiscal year.

(a) If an agency decides to withdraw for the next fiscal year after initially deciding to participate, the agency shall notify all employees at least 60 days before the new fiscal year begins.

(5) An employee in a participating agency shall receive the following benefit provided by the Unused Sick Leave Retirement Options Program I.

(a) 25% of the value of the unused sick leave and converted sick leave, but not to exceed Internal Revenue Service limitations, shall be placed in the employees 401(k) account as an employer contribution.

(i) Sick leave hours from Program II shall be placed in the 401(k) account before hours from Program I.

(ii) After the 401(k) contribution is made, the remaining Program I sick leave hours and converted sick leave hours from Subsection R477-7-5(5)(b)(i) shall be used to provide the following benefit.

(iii) The purchase of PEHP health insurance, or a state approved program, and life insurance coverage for the employee until the employee reaches the age eligible for Medicare.

(A) Health insurance shall be the same coverage carried by the employee at the time of retirement; i.e., family, two-party, or single.

(B) The purchase rate shall be eight hours of sick leave or converted sick leave for the state paid portion of one month's premium.

(C) The employee shall pay the same percentage of the premium as a current employee on the same plan. The premium amount shall be determined from the approved PEHP retiree rate and not the active employee rates.

(D) Life insurance provided shall be the minimum authorized coverage provided for state employees at the time the employee retires.

(iv) When the employee becomes eligible for Medicare, a Medicare supplement policy provided by PEHP may be purchased at the rate of eight hours of sick leave or converted sick leave for one month's premium.

(v) When the employee becomes eligible for Medicare, a PEHP health insurance policy, or another state approved policy, may be purchased for a spouse until the spouse is eligible for Medicare.

(A) The purchase rate shall be eight hours of sick leave or converted sick leave for one month's premium.

(B) The employee shall pay the same percentage of the premium as a current employee on the same plan. The premium amount shall be determined from the approved PEHP retiree rate and not the active employee rates.

(vi) When the spouse reaches the age eligible for Medicare, the employee may purchase a Medicare supplement policy provided by PEHP for the spouse at the rate of eight hours of sick leave or converted sick leave for one month's premium.

(vii) In the event an employee is killed in the line of duty, the employee's spouse shall be eligible to use the employee's available sick leave hours for the purchase of health and dental insurance under Section 67-19-14.3.

(b) Employees retiring from LTD who have sick leave balances still intact may use these hours for the unused sick leave retirement program at the time they become eligible for retirement.

(c) Upon retirement, Program I sick leave hours may not

be suspended or deferred for future use. This includes retired employees who reemploy with the state and choose to suspend their defined benefit payments.

(6) An employee shall receive the following benefit provided by the Unused Sick Leave Retirement Option Program II.

(a) 25% of the value of the unused sick leave and converted sick leave, but not to exceed Internal Revenue Service limitations, shall be placed in the employee's 401(k) account as an employer contribution.

(b) After the 401(k) contribution the remaining sick leave hours and the converted sick leave hours from Subsection R477-7-5(5)(b)(ii) shall be deposited in the employee's PEHP health reimbursement account at the greater of:

(i) the employee's rate of pay at retirement, or

(ii) the average rate of pay of state employees who retired in the same retirement system in the previous calendar year.

(c) A retired employee who is reemployed in a benefited position with the state shall have a benefit calculated on any Program II sick leave hours if:

(i) The employee chooses to suspend pension;

(ii) The employee was separated for one year or more;

(iii) The employee was reemployed before January 2, 2014; and

(iv) The employee must work for two years or more to receive this benefit.

(7) A retired employee who is reemployed in a benefited position with the state after January 4, 2014 shall accrue Program III sick leave, which shall have no benefit upon subsequent retirement.

R477-7-7. Administrative Leave.

(1) Administrative leave may be granted consistent with agency policy for the following reasons:

(a) administrative;

(i) governor approved holiday leave;

(ii) during management decisions that benefit the organization;

(iii) when no work is available due to unavoidable conditions or influences; or

(iv) other reasons consistent with agency policy.

(b) protected;

(i) suspension with pay pending hearing results;

(ii) personal decision making prior to discipline;

(iii) removal from adverse or hostile work environment situations;

(iv) fitness for duty or employee assistance; or

(v) other reasons consistent with agency policy.

(c) reward in lieu of cash;

(i) the agency head or designee may grant paid administrative leave up to one day per occurrence;

(ii) administrative leave in excess of one day may be granted with written approval by the agency head.

(iii) administrative leave given as a reward in lieu of cash may not exceed 40 hours in a fiscal year.

(iv) administrative leave given as a reward in lieu of cash may be given from one agency to employees of another agency if both agency heads agree in advance.

(d) employee education assistance.

(2) An employee shall be granted up to two hours of administrative leave to vote in an official election if the employee has fewer than three total hours off the job between the time the polls open and close, and the employee applies for the leave at least 24 hours in advance.

(a) Management may specify the hours when the employee may be absent.

(3) Administrative leave shall be given for non-performance based purposes to employees who are on Family and Medical Leave or a military leave of absence if the leave would have been given had the employee been in a working status.

(4) With the exception of administrative leave used as a reward, under Subsection R477-7-7(1)(c), the agency head or designee may grant paid administrative leave.

(5) Administrative leave taken shall be documented in the employee's leave record.

R477-7-8. Witness and Jury Leave.

(1) An employee is entitled to a leave of absence from a regularly scheduled work day with full pay when, in obedience to a subpoena or direction by proper authority, the employee is required to:

(a) appear as a witness as part of the employee's position for the federal government, the State of Utah, or a political subdivision of the state; or

(b) serve as a witness in a grievance hearing under Section 67-19-31 and Title 67, Chapter 19a; or

(c) serve on a jury.

(2) An employee on jury leave may accrue excess hours in the same pay period during which the jury leave is used.

(3) An employee choosing to use accrued leave while on jury duty shall be entitled to keep juror's fees; otherwise, juror's fees received shall be returned to agency finance or agency payroll staff for deposit with the State Treasurer.

(4) An employee who is absent in order to litigate in matters unrelated to state employment shall use eligible accrued leave or leave without pay.

R477-7-9. Bereavement Leave.

An employee may receive a maximum of three work days bereavement leave per occurrence with pay, at management's discretion, following the death of a member of the employee's immediate family. Bereavement leave may not be charged against accrued sick or annual leave.

(1) The immediate family means relatives of the employee or spouse including in-laws, step-relatives, or equivalent relationship as follows:

(a) spouse;

(b) parents;

(c) siblings;

(d) children;

(e) all levels of grandparents; or

(f) all levels of grandchildren.

R477-7-10. Military Leave.

A benefited or non-benefited employee who is a member of the National Guard or Military Reserves and is on official military orders is entitled to paid military leave not to exceed 120 hours each calendar year, including travel time, under Section 39-3-2. Military leave for part-time employees shall be based on a prorated basis that is no more than the average hours worked in the last 12 months, or if employed less than 12 months, the average hours worked since date of hire.

(1) An employee may not claim salary for nonworking days spent in military training or for traditional weekend training.

(2) An employee may use any combination of military leave, accrued leave or leave without pay under Section R477-7-13.

(a) Accrued sick leave may only be used if the reason for leave meets the conditions in Section R477-7-4.

(3) An employee on military leave is eligible for any service awards or non-performance administrative leave the employee would otherwise be eligible to receive.

(4) An employee shall give notice of official military orders as soon as possible.

(5) Upon release from official military orders under honorable conditions, an employee shall be placed in a position

in the following order of priority.

(a) If the period of service was for less than 91 days, the employee shall be placed:

(i) in the same position the employee held on the date of the commencement of the service in the uniformed services; or

(ii) in the same position the employee would have held if the continuous employment of the employee had not been interrupted by the service.

(b) If the period of service was for more than 90 days, the employee shall be placed:

(i) in a position of like seniority, status and salary, of the position the employee held on the date of the commencement of the service in the uniformed services; or

(ii) in a position of like seniority, status, and salary the employee would have held if the continuous employment of the employee had not been interrupted by the service.

(c) When a disability is incurred or aggravated while on official military orders, the employing agency shall adhere to the Uniformed Services Employment and Reemployment Rights Act (USERRA), United States Code, Title 38, Chapter 43.

(d) The cumulative length of time allowed for reemployment may not exceed five years. This rule incorporates by reference 20CFR1002.103 for the purposes of calculating cumulative time.

(e) An employee is entitled to reemployment rights and benefits including increased pension and leave accrual to which the employee would have been entitled had the employee not been absent due to military service. An employee entering military leave may elect to have payment for annual leave deferred.

(6) In order to be reemployed, an employee shall present evidence of military service, and:

(a) for service less than 31 days, return at the beginning of the next regularly scheduled work period on the first full day after release from service unless impossible or unreasonable through no fault of the employee;

(b) for service of more than 30 days but less than 181 days, submit a request for reemployment within 14 days of release from service, unless impossible or unreasonable through no fault of the employee; or

(c) for service of more than 180 days, submit a request for reemployment within 90 days of release from service.

R477-7-11. Disaster Relief Volunteer Leave.

(1) An employee may be granted leave from work with pay, by the agency head or designee, for an aggregate of 15 working days in any 12 month period to participate in disaster relief services for a disaster relief organization. To request this leave an employee shall be a certified disaster relief volunteer and file a written request with the employing agency. The request shall include:

(a) a copy of a written request for the employee's services from an official of the disaster relief organization;

(b) the anticipated duration of the absence;

(c) the type of service the employee is to provide; and

(d) the nature and location of the disaster where the employee's services will be provided.

R477-7-12. Organ Donor Leave.

An employee who serves as a bone marrow or human organ donor shall be granted paid leave for the donation and recovery.

(1) An employee who donates bone marrow shall be granted up to seven days of paid leave.

(2) An employee who donates a human organ shall be granted up to 30 days of paid leave.

R477-7-13. Leave of Absence Without Pay.

(1) An employee shall apply in writing to agency management and be approved before taking a leave of absence without pay.

(2) Leave without pay may be granted only when there is an expectation that the employee will return to work.

(3) A leave of absence may not be granted when documentation from one or more qualified healthcare providers clearly establishes that the employee has a permanent condition preventing the employee from returning to the last held regular position unless prohibited by state or federal law.

(4) An employee who receives no compensation for a complete pay period shall be responsible for payment of the full premium of state provided benefits.

(5) An employee who returns to work on or before the expiration of leave without pay shall be placed in a position with comparable pay and seniority to the previously held position.

(6) Upon request, an employee who is granted this leave shall provide a monthly return to work status update to the employee's supervisor.

R477-7-14. Furlough.

(1) Agency management may furlough employees as a means of saving salary costs in lieu of or in addition to a reduction in force. Furlough plans are subject to the approval of the agency head and the following conditions:

(a) Furlough hours shall be counted for purposes of annual, sick and holiday leave accrual.

(b) Payment of all state paid benefits shall continue at the agency's expense.

(i) Benefits that have fixed costs shall be paid at the full rate regardless of how many days an employee is furloughed.

(ii) Benefits that are paid as a percentage of actual wages shall continue to be paid as percentage of actual wages if the furlough is less than one pay period. Employees who are furloughed for a full pay period shall have no percentage based benefits paid.

(c) An employee who is furloughed shall continue to pay the employee portion of all benefits. Voluntary benefits shall remain entirely at the employee's expense.

(d) An employee shall return to the current position.

(e) Furlough is applied equitably; e.g., to all persons in a given class, all program staff, or all staff in an organization.

R477-7-15. Family and Medical Leave.

(1) An eligible employee is allowed up to 12 work weeks of family and medical leave each calendar year for any of the following reasons:

(a) birth of a child;

(b) adoption of a child;

(c) placement of a foster child;

(d) a serious health condition of the employee; or

(e) care of a spouse, child, or parent with a serious medical condition.

(f) A qualifying exigency arising as a result of a spouse, son, daughter or parent being on active duty or having been notified of an impending call or order to active duty in the Armed Forces.

(2) An employee is allowed up to 26 work weeks of family and medical leave during a 12 month period to care for a spouse, son, daughter, parent or next of kin who is a recovering service member as defined by the National Defense Authorization Act.

(3) An employee on FMLA leave shall continue to receive the same health insurance benefits the employee was receiving prior to the commencement of FMLA leave provided the employee pays the employee share of the health insurance premium.

(4) An employee on FMLA leave shall receive any administrative leave given for non-performance based reasons if the leave would have been given had the employee been in a

working status.

(5) To be eligible for family and medical leave, the employee shall:

(a) be employed by the state for at least 12 months;

(b) be employed by the state for a minimum of 1250 hours worked, as determined under FMLA, during the 12 month period immediately preceding the commencement of leave.

(6) To request FMLA leave, the employee or an appropriate spokesperson, shall apply in writing for the initial leave and when the reason for requesting family medical leave changes:

(a) thirty days in advance for foreseeable needs; or

(b) as soon as practicable in emergencies.

(7) An employee with a serious health condition may use accrued annual leave, sick leave, converted sick leave, excess hours and compensatory time prior to going into leave without pay status for the family and medical leave period.

(a) An employee who chooses to use accrued annual leave, sick leave, converted sick leave, excess hours and compensatory time prior to going into leave without pay status for the family and medical leave period shall notify the agency.

(b) If an employee fails to notify the agency under this Subsection, accrued leave will be used to pay the employee's payroll deductions in the following order:

(i) Program III sick leave;

(ii)(A) Compensatory time;

(B) Excess leave; or

(C) Annual leave;

(iii)(A) Converted sick leave;

(B) Program II sick leave; or

(C) Program I sick leave.

(8) An employee who chooses to use FMLA leave shall use FMLA leave for all absences related to that qualifying event.

(9) Any period of leave for an employee with a serious health condition who is determined by a health care provider to be incapable of applying for Family and Medical Leave and has no agent or designee shall be designated as FMLA leave.

(10) An employee with a serious health condition covered under workers' compensation may use FMLA leave concurrently with the workers' compensation benefit.

(11) If an employee has gone into leave without pay status and fails to return to work after FMLA leave has ended, an agency may recover, with certain exceptions, the health insurance premiums paid by the agency on the employee's behalf. An employee is considered to have returned to work if the employee returns for at least 30 calendar days.

(a) Exceptions to this provision include:

(i) an FLSA exempt and schedule AB, AD and AR employee who has been denied restoration upon expiration of their leave time;

(ii) an employee whose circumstances change unexpectedly beyond the employee's control during the leave period preventing the return to work at the end of 12 weeks.

(12) Leave taken for purposes of childbirth, adoption, placement for adoption or foster care may not be taken intermittently or on a reduced leave schedule unless the employee and employer mutually agree.

(13) Medical records created for purposes of FMLA and the Americans with Disabilities Act shall be maintained in accordance with confidentiality requirements of Subsection R477-2-5.

R477-7-16. Workers Compensation Leave.

(1) An employee may use accrued leave benefits to supplement the workers compensation benefit.

(a) The combination of leave benefit, wages and workers compensation benefit may not exceed the employee's gross salary. Leave benefits shall only be used in increments of one hour in making up any difference.

(b) The use of accrued leave to supplement the worker compensation benefit shall be terminated if the:

(i) employee is declared medically stable by a licensed medical authority;

(ii) workers compensation fund terminates the benefit;

(iv) employee refuses to accept appropriate employment offered by the state; or

(v) employee is notified of approval for Long Term Disability or Social Security Disability benefits.

(c) The employee shall refund to the state any accrued leave paid which exceeds the employee's gross salary for the period for which the benefit was received.

(2) Workers compensation hours shall be counted for purposes of annual, sick and holiday leave accrual while the employee is receiving a workers compensation time loss benefit for up to six months from the last day worked in the regular position.

(3) Health insurance benefits shall continue for an employee on leave without pay while receiving workers compensation benefits. The employee is responsible for the payment of the employee share of the premium.

(4) If an employee has applied for LTD and is approved, the employee shall be eligible to receive a medical coverage stipend in their LTD check each month, beginning the day after the employee's last day worked pursuant to R477-7-17(2).

(5) If the employee is able to return to work in the employee's regular position, the agency shall place the employee in the previously held position or a similar position at a comparable salary range.

(6) If the employee is unable to return to work in the regular position, or if documentation from one or more qualified health care providers clearly establishes that the employee has a permanent condition preventing the employee from returning to the last held regular position, the employee may be separated from state employment unless prohibited by state or federal law. Exceptions may be granted by the agency head in consultation with DHRM.

(7) An employee who files a fraudulent workers compensation claim shall be disciplined under Rule R477-11.

(8) An employee covered under 67-19-27 who is injured in the course of employment shall be given a leave of absence with full pay during the period the employee is temporarily disabled.

(a) the employee shall be placed on administrative leave; and

(b) any compensation received from the state's workers compensation administrator shall be returned to the agency payroll clerks for deposit with the State Treasurer as a refund of expenditure in the unit number where the salary is recorded.

R477-7-17. Long Term Disability Leave.

(1) An employee determined eligible for Long Term Disability benefits shall be eligible to receive a medical coverage stipend in their LTD check each month, beginning the day after the employee's last day worked or the last day of FMLA leave.

(2) Upon approval of the LTD claim:

(a) Biweekly salary payments that the employee may be receiving shall cease. If the employee received any salary payments after the three month waiting period, the LTD benefit shall be offset by the amount received.

(b) The employee shall be paid for remaining balances of annual leave, excess hours, and compensatory hours earned by FLSA non-exempt employees in a lump sum payment. This payment shall be made at the time LTD is approved unless the employee requests in writing to receive it upon separation from state employment. No reduction of the LTD payment shall be made to offset this payment. Upon return to work from an approved leave of absence, the employee has the option of

buying back annual leave at the current hourly rate.

(c) An employee with a converted sick leave balance at the time of LTD eligibility shall have the option to receive a lump sum payout of all or part of the balance or to keep the balance intact to pay for health and life insurance upon retirement. The payout shall be at the rate at the time of LTD eligibility.

(d) An employee who retires from state government directly from LTD may be eligible for health and life insurance under Subsection 67-19-14.

(e) Unused sick leave balance shall remain intact until the employee retires. At retirement, the employee shall be eligible for the 401(k) contribution and the purchase of health and life insurance under Subsection 67-19-14.2.

(3) An employee in the Tier I retirement system shall continue to accrue service credit for retirement purposes while receiving long term disability benefits.

(4) Conditions for return from long term disability include:

(a) If an employee provides an administratively acceptable medical release allowing a return to work prior to termination under this section, the agency shall place the employee in the previously held position or similar position in a comparable salary range provided the employee is able to perform the essential functions of the job with or without a reasonable accommodation.

(5) An employee who files a fraudulent long term disability claim shall be disciplined under Rule R477-11.

(6) Long term disability benefits are provided to eligible employees in accordance with 49-21-403.

R477-7-18. Disabled Law Enforcement Officer Amendments.

(1) A law enforcement officer or state correctional officer, as defined in 67-19-27, who is injured in the course of employment, as defined in 67-19-27, shall be given a leave of absence with 100% of the officer's regular monthly salary and benefits, either:

(a) during the period the employee has a temporary disability; or

(b) in the case of a total disability, until the employee is eligible for an unreduced retirement under Title 49 or reaches the retirement age of 62 years, whichever occurs first.

(2) The eligible employee shall disclose to the agency any time-loss benefit amounts received by, or payable to, the employee, from outside sources, as soon as the employee is made aware.

(a) These amounts do not include benefits received from sources in which the employee pays the full premium.

(3) The agency shall apply R477-7-16, workers compensation leave, and R477-7-17, long term disability leave rules first. They then must consider any benefit amounts received under (2). If the total of these benefits is less than 100% of the employee's monthly salary and benefits, the agency shall make arrangements through payroll to pay the employee the difference.

(4) DHRM shall work with the Division of Risk Management, Workers' Compensation, and the Public Employee's Health Program on a periodic and case-by-case basis to assure that eligible employees receive full benefits.

(a) If at any time it is discovered that the employee is receiving less than 100% of their regular monthly salary and benefits, the agency shall make up the difference to the employee.

(5) If an employee discloses other time-loss benefits received under (2) after these additional payments by the agency have been made, the employee shall reimburse the agency for salary and benefits paid in overage.

R477-7-19. Leave Bank.

With the approval of the agency head, agencies may establish a leave bank program.

(1) A leave bank program shall include a policy with the following:

(a) Access to a leave bank is not an employee right and shall be authorized at management discretion.

(b) Any application for a leave bank program shall be supported by administratively acceptable medical documentation.

(c) An approval process that prohibits leave donors, supervisors, managers or management teams from reviewing any employee's medical certifications or physician statements.

(d) An employee may not receive donated leave until all individually accrued leave is exhausted.

(e) Leave shall be accrued if an employee is on sick leave donated from an approved leave bank program.

(f) Employees using donated leave may not work a second job without written consent of the agency head.

(g) Only compensatory time earned by an FLSA nonexempt employee, annual leave, excess hours, and converted sick leave hours may be donated to a leave bank.

(h) Only employees of agencies with approved leave bank programs may donate leave hours to another agency with a leave bank program, if mutually agreed on by both agencies.

(3) All medical records created for the purpose of a leave bank, shall be maintained in accordance with confidentiality requirements of Subsection R477-2-5.

R477-7-20. Policy Exceptions.

The Executive Director, DHRM, may authorize exceptions to this rule consistent with Subsection R477-2-2(1).

KEY: holidays, leave benefits, vacations

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	67-19-6
	67-19-12.9
	67-19-14

R477. Human Resource Management, Administration.
R477-8. Working Conditions.
R477-8-1. Work Week.

(1) The state's standard work week begins Saturday at 12:00am and ends the following Friday at 11:59pm. FLSA nonexempt employees may not deviate from this work week.

(2) State offices are typically open Monday through Friday from 8 a.m. to 5 p.m. Agencies may adopt alternative business hours under Section 67-25-201.

(3) Agency management shall establish work schedules and may approve a flexible starting and ending time for an employee as long as scheduling is consistent with overtime provisions of Section R477-8-4.

(4) An employee is required to be at work on time. An employee who is late, regardless of the reason including inclement weather, shall, with management approval, make up the lost time by using accrued leave, leave without pay or adjusting their work schedule.

(5) An employee's time worked shall be calculated in increments of 15 minutes. This rule incorporates by reference 29 CFR 785.48 (2012) for rounding practices when calculating time worked.

R477-8-2. Telecommuting.

(1) Telecommuting is an agency option, not a universal employee benefit. Agencies utilizing a telecommuting program shall:

(a) establish a written policy governing telecommuting;

(b) enter into a written contract with each participating employee to specify conditions, such as use of state or personal equipment, protecting confidential information, and results such as identifiable benefits to the state and how customer needs are being met;

(c) not allow participating employees to violate overtime rules;

(d) not compensate for normal commute time; and

(e) document telecommuting authorization in the Utah Performance Management system.

R477-8-3. Lunch, Break and Exercise Release Periods.

(1) Each full time work day may include a minimum of 30 minutes noncompensated lunch period, at the discretion of agency management.

(a) Lunch periods may not be used to shorten a work day.

(2) An employee may take a 15 minute compensated break period for every four hours worked.

(a) Break periods may not be accumulated to accommodate a shorter work day or longer lunch period.

(3) Compensated exercise release time may be allowed at agency discretion for up to three days per week for 30 minutes.

(a) Participating agencies shall have a written policy regarding exercise release time.

(b) Work time exercise that is a bona fide job requirement is not subject to this section.

(4) Authorization for exercise time and regular scheduled lunch breaks less than 30 minutes shall be documented in the Utah Performance Management system.

(5) As requested and after consultation with an employee, reasonable, daily break periods shall be granted for the first year following the birth of a child to allow an employee to express breast milk for her child.

(a) A private location, other than a restroom, shall be provided.

(b) Appropriate temporary storage shall be provided for expressed milk.

R477-8-4. Overtime Standards.

The state's policy for overtime is adopted and incorporated from the Fair Labor Standards Act, 29 CFR Parts 500 to 899(2002) and Section 67-19-6.7.

(1) Management may direct an employee to work overtime. Each agency shall develop internal rules and procedures to ensure overtime usage is efficient and economical. These policies and procedures shall include:

(a) prior supervisory approval for all overtime worked;

(b) recordkeeping guidelines for all overtime worked;

(c) verification that there are sufficient funds in the budget to compensate for overtime worked.

(2) Overtime compensation designations are identified for each job title in HRE as either FLSA nonexempt, or FLSA exempt.

(a) An employee may appeal the FLSA designation to the agency human resource field office. Further appeals may be filed directly with the United States Department of Labor, Wage and Hour Division. Sections 67-19-31, 67-19a-301 and Title 63G, Chapter 4 may not be applied for FLSA appeals purposes.

(3) An FLSA nonexempt employee may not work more than 40 hours a week without management approval. Overtime shall accrue when the employee actually works more than 40 hours a week. Leave and holiday time taken within the work period may not be counted as hours worked when calculating overtime accrual. Hours worked over two or more weeks may not be averaged with the exception of certain types of law enforcement, fire protection, and correctional employees.

(4) Agency management shall arrange for an employee's use of compensatory time as soon as possible without unduly disrupting agency operations or endangering public health, safety or property.

R477-8-5. Compensatory Time for FLSA Nonexempt Employees.

(1) An FLSA nonexempt employee shall sign a prior overtime agreement authorizing management to compensate the employee for overtime worked by actual payment or accrual of compensatory time at time and one half.

(a) An FLSA nonexempt employee may receive compensatory time for overtime up to a maximum of 80 hours. Only with prior approval of the Executive Director, DHRM, may compensatory time accrue up to 240 hours for regular employees or up to 480 hours for peace or correctional officers, emergency or seasonal employees. Once an employee reaches the maximum, additional overtime shall be paid on the payday for the period in which it was earned.

(b) Compensatory time balances for an FLSA nonexempt employee shall be paid down to zero at the rate of pay in the old position in the same pay period that the employee is:

(i) transferred from one agency to a different agency; or

(ii) promoted, reclassified, reassigned or transferred to an FLSA exempt position.

R477-8-6. Compensatory Time for FLSA Exempt Employees.

(1) An FLSA exempt employee may not work more than 80 hours in a pay period without management approval. Compensatory time shall accrue when the employee actually works more than 80 hours in a work period. Leave and holiday time taken within the work period may not count as hours worked when calculating compensatory time. Each agency shall compensate an FLSA exempt employee who works overtime by granting time off. For each hour of overtime worked, an FLSA exempt employee shall accrue an hour of compensatory time.

(a) Agencies shall establish in written policy a uniform overtime year either for the agency as a whole or by unit number and communicate it to employees. Overtime years shall be set at one of the following pay periods: Five, Ten, Fifteen, Twenty, or the last pay period of the calendar year. If an agency fails to establish a uniform overtime year, the Executive Director, DHRM, and the Director of Finance, Department of

Administrative Services, will establish the date for the agency at the last pay period of the calendar year. An agency may change the established overtime year only after the current overtime year has lapsed, unless justifiable reasons exist and the Executive Director, DHRM, has granted a written exception.

(b) DHRM shall establish the limit on compensatory time earned by an FLSA exempt employee.

(i) Any compensatory time earned by an FLSA exempt employee over the limit shall be paid out in the pay period it is earned.

(c) Any compensatory time earned by an FLSA exempt employee is not an entitlement, a benefit, nor a vested right.

(d) Any compensatory time earned by an FLSA exempt employee shall lapse upon occurrence of any one of the following events:

(i) at the end of the employee's established overtime year;

(ii) upon assignment to another agency; or

(iii) when an employee terminates, retires, or otherwise does not return to work before the end of the overtime year.

(e) If an FLSA exempt employee's status changes to nonexempt, that employee's compensatory time earned while in exempt status shall lapse if not used by the end of the current overtime year.

(f) Schedule AB employees may not be compensated for compensatory time except with time off.

R477-8-7. Nonexempt Public Safety Personnel.

(1) To be considered for overtime compensation under this rule, a law enforcement or correctional officer shall meet the following criteria:

(a) be a uniformed or plain clothes sworn officer;

(b) be empowered by statute or local ordinance to enforce laws designed to maintain public peace and order, to protect life and property from accident or willful injury, and to prevent and detect crimes;

(c) have the power to arrest;

(d) be POST certified or scheduled for POST training; and

(e) perform over 80% law enforcement duties.

(2) Agencies shall select one of the following maximum work hour thresholds to determine when overtime compensation is granted to law enforcement or correctional officers designated FLSA nonexempt and covered under this rule.

(a) 171 hours in a work period of 28 consecutive days; or

(b) 86 hours in a work period of 14 consecutive days.

(3) Agencies shall select one of the following maximum work hour thresholds to determine when overtime compensation is granted to fire protection employees.

(a) 212 hours in a work period of 28 consecutive days; or

(b) 106 hours in a work period of 14 consecutive days.

(4) Agencies may designate a lesser threshold in a 14 day or 28 day consecutive work period as long as it conforms to the following:

(a) the Fair Labor Standards Act, Section 207(k);

(b) 29 CFR 553.230;

(c) the state's payroll period; and

(d) the approval of the Executive Director, DHRM.

R477-8-8. Time Reporting.

(1) Employees shall complete and submit a state approved biweekly time record that accurately reflects the hours actually worked, including:

(a) approved and unapproved overtime;

(b) on-call time;

(c) stand-by time;

(d) meal periods of public safety and correctional officers who are on duty more than 24 consecutive hours; and

(e) approved leave time.

(2) An employee who fails to accurately record time may be disciplined.

(3) Time records developed by the agency shall have the same elements of the state approved time record and be approved by the Department of Administrative Services, Division of Finance.

(4) A Supervisor who directs an employee to submit an inaccurate time record or knowingly approves an inaccurate time record may be disciplined.

(5) A Non-exempt employee who believes FLSA rights have been violated may submit a complaint directly to the Executive Director, DHRM or designee.

R477-8-9. Hours Worked.

(1) An FLSA nonexempt employee shall be compensated for all hours worked. An employee who works unauthorized overtime may be disciplined.

(a) All time that an FLSA nonexempt employee is required to wait for an assignment while on duty, before reporting to duty, or before performing activities is counted towards hours worked.

(b) Time spent waiting after being relieved from duty is not counted as hours worked if one or more of the following conditions apply:

(i) the employee arrives voluntarily before their scheduled shift and waits before starting duties;

(ii) the employee is completely relieved from duty and allowed to leave the job;

(iii) the employee is relieved until a definite specified time; or

(iv) the relief period is long enough for the employee to use as the employee sees fit.

R477-8-10. On-call Time.

(1) An FLSA nonexempt employee required by agency management to be available for on-call work shall be compensated for on-call time at a rate of one hour for every 12 hours the employee is on-call. A FLSA exempt employee required by agency management to be available for on-call work may be compensated at agency discretion, not to exceed a rate of one hour for every 12 hours the employee is on-call.

(a) Time is considered on-call time when the employee has freedom of movement in personal matters as long as the employee is available for a call to duty. An employee may not be in on-call status while using leave or while otherwise unable to respond to a call to duty.

(b) Agencies who enter into on-call agreements with employees shall have an agency policy consistent with this rule and finance policy.

(c) On-call status shall be designated by a supervisor and shall be in writing and documented in the Utah Performance Management system on an annual basis. Carrying a pager or cell phone shall not constitute on-call time without this written agreement.

(d) The employee shall record the hours spent in on-call status, and any actual hours worked, on the official time record, for the specific date the hours were incurred, in order to be paid.

(e) An employee may not record on-call hours and actual hours worked for the same period of time. On-call hours, actual hours worked, and leave hours cannot exceed 24 hours in a day.

(f) An employee shall round on-call hours to the nearest two decimal places. Hours of on-call pay shall be calculated by subtracting the number of hours worked in the on-call period from the number of hours in the on-call period then dividing the result by 12.

R477-8-11. Stand-by Time.

(1) An employee restricted to stand-by at a specified location ready for work shall be paid full-time or overtime, as appropriate. An employee shall be paid for stand-by time if required to stand by the post ready for duty, even during lunch

periods, equipment breakdowns, or other temporary work shutdowns.

(2) The meal periods of police, and other public safety or correctional officers and firefighters who are on duty more than 24 consecutive hours shall be counted as working time, unless an express agreement excludes the time.

R477-8-12. Commuting and Travel Time.

(1) Normal commuting time from home to work and back may not count towards hours worked.

(2) Time an employee spends traveling from one job site to another during the normal work schedule shall count towards hours worked.

(3) Time an employee spends traveling on a special one day assignment shall count towards hours worked except meal time and ordinary home to work travel.

(4) Travel that keeps an employee away from home overnight does not count towards hours worked if it is time spent outside of regular working hours as a passenger on an airplane, train, boat, bus, or automobile.

(5) Travel as a passenger counts toward hours worked if it is time spent during regular working hours. This applies to nonworking days, as well as regular working days. However, regular meal period time is not counted.

R477-8-13. Excess Hours.

(1) An employee may use excess hours the same way as annual leave.

(a) An employee may not work hours which would lead to the accrual of excess hours without prior management approval.

(b) An employee may not use any leave time, other than holiday and jury leave, that results in the accrual of excess hours.

(c) An employee may not accumulate more than 80 excess hours.

(d) Agency management shall pay out excess hours:

(i) for all hours accrued above the limit set by DHRM;

(ii) when an employee is assigned from one agency to another; and

(iii) upon separation.

(e) Agency management may pay out excess hours:

(i) automatically in the same pay period accrued;

(ii) at any time during the year as determined appropriate by a state agency or division; or

(iii) upon request of the employee and approval by the agency head.

R477-8-14. Dual State Employment.

An employee who has more than one position within state government, regardless of schedule is considered to be in a dual employment situation. The following conditions apply to dual employment status.

(1) An employee may work in up to four different positions in state government.

(2) An employee's benefit status for any secondary position(s), regardless of schedule of any of the positions, shall be the same as the primary position.

(3) An employee's FLSA status (exempt or nonexempt) for any secondary position(s) shall be the same as the primary position.

(4) Leave accrual shall be based on all hours worked in all positions and may not exceed the maximum amount allowed in the primary position.

(5) As a condition of dual employment, an employee in dual employment status is prohibited from accruing excess hours in either the primary or secondary positions. All excess hours earned shall be paid at straight time in the pay period in which the excess hours are earned.

(6) As a condition of dual employment, the Overtime or Comp selection shall be as overtime paid regardless of FLSA status. An employee may not accrue comp hours while in dual employment status.

(7) Overtime shall be calculated at straight time or time and one half depending on the FLSA status of the primary position. Time and a half overtime rates shall be calculated based on the weighted average rate of the multiple positions. Refer to Division of Finance's payroll policies, dual employment section.

(8) The Accepting Terms of Dual Employment form shall be completed, signed by the employee and supervisor, and placed in the employee's personnel file with a copy sent to the Division of Finance.

(9) Secondary positions may not interfere with the efficient performance of the employee's primary position or create a conflict of interest. An employee in dual employment status shall comply with conditions under Subsection R477-9-2(1).

R477-8-15. Reasonable Accommodation.

Employees and applicants seeking reasonable accommodation shall be evaluated under state and federal law. This shall be done in conjunction with the agency ADA coordinator. The ADA coordinator shall consult with the Division of Risk management prior to denying any accommodation request.

R477-8-16. Fitness For Duty Evaluations.

Fitness for duty medical evaluations may be performed under any of the following circumstances:

(1) return to work from injury or illness except as prohibited by federal law;

(2) when management determines that there is a direct threat to the health or safety of self or others;

(3) in conjunction with corrective action, performance or conduct issues, or discipline; or

(4) when a fitness for duty evaluation is a bona fide occupational qualification for selection, retention, or promotion.

R477-8-17. Temporary Transitional Assignment.

(1) Agency management may place an employee in a temporary transitional assignment when an employee is unable to perform essential job functions due to temporary health restrictions.

(2) Temporary transitional assignments may also be part of any of the following:

(a) when management determines that there is a direct threat to the health or safety of self or others;

(b) in conjunction with an internal investigation, corrective action, performance or conduct issues, or discipline;

(c) where there is a bona fide occupational qualification for retention in a position;

(d) while an employee is being evaluated to determine if reasonable accommodation is appropriate.

R477-8-18. Change in Work Location.

(1) An involuntary change in work location shall not be permitted if this requires the employee to commute or relocate 50 miles or more, one way, beyond the current one way commute, unless:

(a) the change in work location is communicated to the employee at employment; or

(b) the agency either pays to move the employee consistent with Section R25-6-8 and Finance Policy FIACCT 05-03.03, or reimburses commuting expenses up to the cost of a move.

R477-8-19. Agency Policies and Exemptions.

(1) Each agency may write its own policies for work schedules, overtime, leave usage, and other working conditions

consistent with these rules.

R477-8-20. Background Checks.

In order to protect the citizens of the State of Utah and state resources and with the approval of the agency head, agencies may establish background check policies requiring specific employees to submit to a criminal background check through the Department of Public Safety, Bureau of Criminal Identification.

(1) Agencies who have statewide responsibility for confidential information, sensitive financial information, or handle state funds may require employees to submit to a background check, including employees who work in other state agencies.

(2) The cost of the background check will be the responsibility of the employing agency.

R477-8-21. Policy Exceptions.

The Executive Director, DHRM, may authorize exceptions to this rule, consistent with Subsection R477-2-2(1).

KEY: breaks, telecommuting, overtime, dual employment
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R477. Human Resource Management, Administration.
R477-9. Employee Conduct.
R477-9-1. Standards of Conduct.

An employee shall comply with the standards of conduct established in these rules and the policies and rules established by agency management.

(1) Employees shall apply themselves to and shall fulfill their assigned duties during the full time for which they are compensated.

(a) An employee shall:

(i) comply with the standards established in the individual performance plans;

(ii) maintain an acceptable level of performance and conduct on all other verbal and written job expectations;

(iii) report conditions and circumstances, including controlled substances or alcohol impairment, that may prevent the employee from performing their job effectively and safely;

(iv) inform the supervisor of any unclear instructions or procedures.

(2) An employee shall make prudent and frugal use of state funds, equipment, buildings, time, and supplies.

(3) An employee who reports for duty or attempts to perform the duties of the position while under the influence of alcohol or other intoxicant, including use of illicit drugs, nonprescribed controlled substances, and misuse of volatile substances, shall be subject to administrative action in accordance with Section R477-10-2, Rule R477-11 and R477-14.

(a) The agency may decline to defend and indemnify an employee found violating this rule, in accordance with Section 63G-7-202 of the Utah Governmental Immunity Act.

(4) An employee may not drive a state vehicle or any other vehicle, on state time, while under the influence of alcohol or controlled substances.

(a) An employee who violates this rule shall be subject to administrative action under Section R477-10-2, Rules R477-11 and R477-14.

(b) The agency may decline to defend or indemnify an employee who violates this rule, according to Subsection 63G-7-202(3)(c)(ii) of the Utah Governmental Immunity Act.

(5) An employee shall provide the agency with a current personal mailing address.

(a) The employee shall notify the agency in writing of any change in address.

(b) Mail sent to the current address on record shall be deemed to be delivered for purposes of these rules.

R477-9-2. Outside Employment.

(1) An employee shall notify agency management in writing of outside employment. Failure to notify the employer and to gain approval for outside employment is grounds for disciplinary action.

(2) State employment shall be the principal vocation for a full-time employee governed by these rules. An employee may engage in outside employment under the following conditions:

(a) Outside employment may not interfere with an employee's performance.

(b) Outside employment may not conflict with the interests of the agency nor the State of Utah.

(c) Outside employment may not give reason for criticism nor suspicion of conflicting interests or duties.

(3) Agency management may deny an employee permission to engage in outside employment, or to receive payment, if the outside activity is determined to cause a real or potential conflict of interest.

(4) The provisions of this rule do not apply when two or more government positions are held by the same individual, unless the personal interest of the individual is not shared by the general public.

R477-9-3. Conflict of Interest.

(1) An employee may receive honoraria or paid expenses for activities outside of state employment under the following conditions:

(a) Outside activities may not interfere with an employee's performance, the interests of the agency nor the State of Utah.

(b) Outside activities may not give reasons for criticism nor suspicion of conflicting interests or duties.

(2) An employee may not use a state position; any influence, power, authority or confidential information received in that position; nor state time, equipment, property, or supplies for private gain.

(3) An employee may not accept economic benefit tantamount to a gift, under Section 67-16-5 and the Governor's Executive Order, 1/26/2010, nor accept other compensation that might be intended to influence or reward the employee in the performance of official business.

(4) An employee shall declare a potential conflict of interest when required to do or decide something that could be interpreted as a conflict of interest. Agency management shall then excuse the employee from making decisions or taking actions that may cause a conflict of interest.

R477-9-4. Political Activity.

A state employee may voluntarily participate in political activity, except as restricted by this section or the federal Hatch Act, 5 U.S.C. Sec. 1501 through 1508.

(1) As modified by the Hatch Modernization Act of 2012, 5 U.S.C. Section 1502(a)(3), the federal Hatch Act restricts the political activity of state government employees whose salary is 100% funded by federal loans or grants.

(a) State employees in positions covered by the Hatch Act may run for public office in nonpartisan elections, campaign for and hold office in political clubs and organizations, actively campaign for candidates for public office in partisan and nonpartisan elections, contribute money to political organizations, and attend political fundraising functions.

(b) State employees in positions covered by the federal Hatch Act may not be candidates for public office in a partisan election, use official authority or influence to interfere with or affect the results of an election or nomination, or directly or indirectly coerce contributions from subordinates in support of a political party or candidate.

(2) Prior to filing for candidacy, a state employee who is considering running for a partisan office shall submit a statement of intent to become a candidate to the agency head.

(a) The agency head shall consult with DHRM.

(b) DHRM shall determine whether the employee's intent to become a candidate is covered under the Hatch Act.

(c) Employees in violation of section R477-9-4(1)(b) may be disciplined up to dismissal.

(3) If a determination is made that the employee's position is covered by the Hatch Act, the employee may not run for a partisan political office.

(a) If it is determined that the employee's position is covered by the Hatch Act, the state shall dismiss the employee if the employee files for candidacy.

(4) Any career service employee elected to any partisan or full-time nonpartisan political office shall be granted a leave of absence without pay for times when monetary compensation is received for service in political office.

(5) During work time, no employee may engage in any political activity. No person shall solicit political contributions from employees of the executive branch during hours of employment. However, a state employee may voluntarily contribute to any party or any candidate.

(6) Decisions regarding employment, promotion, demotion or dismissal or any other human resource actions may not be based on partisan political activity.

R477-9-5. Employee Reporting Protections.

(1) Under Section 67-21-3, an agency may not adversely affect the employment conditions of an employee who communicates in good faith, and in accordance with statute:

(a) the waste or misuse of public property, manpower, or funds;

(b) gross mismanagement;

(c) unethical conduct;

(d) abuse of authority; or

(e) violation of law, rule, or regulations.

R477-9-6. Employee Indebtedness to the State.

(1) An employee indebted to the state because of an action or performance in official duties may have a portion of salary that exceeds the minimum federal wage withheld. Overtime salary shall not be withheld.

(a) The following three conditions shall be met before withholding of salary may occur:

(i) The debt shall be a legitimately owed amount which can be validated through physical documentation or other evidence.

(ii) The employee shall know about and, in most cases, acknowledge the debt. As much as possible, the employee should provide written authorization to withhold the salary.

(iii) An employee shall be notified of this rule which allows the state to withhold salary.

(b) An employee separating from state service will have salary withheld from the last paycheck.

(c) An employee going on leave without pay for more than two pay periods may have salary withheld from their last paycheck.

(d) The state may withhold an employee's salary to satisfy the following specific obligations:

(i) travel advances where travel and reimbursement for the travel has already occurred;

(ii) state credit card obligations where the state's share of the obligation has been reimbursed to the employee but not paid to the credit card company by the employee;

(iii) evidence that the employee negligently caused loss or damage of state property;

(iv) payroll advance obligations that are signed by the employee and that the Division of Finance authorizes;

(v) misappropriation of state assets for unauthorized personal use or for personal financial gain. This includes reparation for employee theft of state property or use of state property for personal financial gain or benefit;

(vi) overpayment of salary determined by evidence that an employee did not work the hours for which they received salary or was not eligible for the benefits received and paid for by the state;

(vii) excessive reimbursement of funds from flexible reimbursement accounts;

(viii) other obligations that satisfy the requirements of Subsection R477-9-5(1) above.

(2) This rule does not apply to state employee obligations to other state agencies where the obligation was not caused by their actions or performance as an employee.

R477-9-7. Acceptable Use of Information Technology Resources.

Information technology resources are provided to a state employee to assist in the performance of assigned tasks and in the efficient day to day operations of state government.

(1) An employee shall use assigned information technology resources in compliance with Rule R895-7, Acceptable Use of Information Technology Resources.

(2) An employee who violates the Acceptable Use of Information Technology Resources policy may be disciplined according to Rule R477-11.

R477-9-8. Personal Blogs and Social Media Sites.

(1) An employee who participates in blogs and social networking sites for personal purposes may not:

(a) claim to represent the position of the State of Utah or an agency;

(b) post the seal of the State of Utah, or trademark or logo of an agency;

(c) post protected or confidential information, including copyrighted information, confidential information received from agency customers, or agency issued documents without permission from the agency head; or

(d) unlawfully discriminate against, harass or otherwise threaten a state employee or a person doing business with the State of Utah.

(2) An agency may establish policy to supplement this section.

(3) An employee may be disciplined according to R477-11 for violations of this section or agency policy.

R477-9-9. Policy Exceptions.

The Executive Director, DHRM, may authorize exceptions to this rule, consistent with Subsection R477-2-2(1).

KEY: conflict of interest, government ethics, Hatch Act, personnel management

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67-19-19

5 USC Section 1502(a)(3)

R477. Human Resource Management, Administration.
R477-10. Employee Development.
R477-10-1. Performance Evaluation.

Agency management shall utilize the Utah Performance Management (UPM) system for employee performance plans and evaluations. The Executive Director, DHRM, may authorize exceptions to the use of UPM and this rule consistent with Section R477-2-2. For this rule, the word employee refers to a career service employee, unless otherwise indicated.

(1) Performance management systems shall satisfy the following criteria:

(a) Agency management shall select an overall performance rating scale.

(b) Performance standards and expectations for each employee shall be specifically written in a performance plan.

(c) Managers or supervisors shall notify employees when their performance plans are implemented or modified.

(d) Managers or supervisors provide employees with regular verbal and written feedback based on the standards of performance and behavior outlined in their performance plans.

(2) Each fiscal year a state employee shall receive a performance evaluation.

(a) An employee shall have the right to include written comments pertaining to the employee's performance evaluation.

(b) A probationary employee may receive a performance evaluation at the end of the probationary period.

R477-10-2. Performance Improvement.

When an employee's performance does not meet established standards due to failure to maintain skills, incompetence, or inefficiency, and after consulting with DHRM, agency management may place an employee on an appropriate, and documented performance improvement plan in accordance with the following rules:

(1) The supervisor shall discuss the substandard performance with the employee and determine appropriate action.

(2) An employee shall have the right to submit written comment to accompany the performance improvement plan.

(3) Performance improvement plans shall identify or provide for:

(a) a designated period of time for improvement;

(b) an opportunity for remediation;

(c) performance expectations;

(d) closer supervision to include regular feedback of the employee's progress;

(e) notice of disciplinary action for failure to improve; and,

(f) written performance evaluation at the conclusion of the performance improvement plan.

(4) Performance improvement plans may also identify or provide for the following based on the nature of the performance issue:

(a) training;

(b) reassignment;

(c) use of appropriate leave;

(5) Following successful completion of a performance improvement plan, the supervisor shall notify the employee of disciplinary consequences for a recurrence of the deficient work performance.

(6) A written warning may also be used as an appropriate form of performance improvement as determined by the supervisor.

R477-10-3. Employee Development and Training.

(1) Agency management may establish programs for training and staff development that shall be agency specific or designed for highly specialized or technical jobs and tasks.

(2) Agency management shall consult with the Executive Director, DHRM, when proposed training and development activities may have statewide impact or may be offered more cost effectively on a statewide basis. The Executive Director, DHRM, shall determine whether DHRM will be responsible for the training standards.

(3) The Executive Director, DHRM, shall work with agency management to establish standards to guide the development of statewide activities and to facilitate sharing of resources statewide.

(4) When an agency directs an employee to participate in an educational program, the agency shall pay full costs.

(5) Agencies are required to provide refresher training and make reasonable efforts to requalify veterans reemployed under USERRA, as long as it does not cause an undue hardship to the employing agency.

R477-10-4. Education Assistance.

State agencies may assist an employee in the pursuit of educational goals by granting administrative leave to attend classes, a subsidy of educational expenses, or both.

(1) Prior to granting education assistance, agencies shall establish policies which shall include the following conditions:

(a) The educational program will provide a benefit to the state.

(b) The employee shall successfully complete the required course work or the educational requirements of a program.

(c) The employee shall agree to repay any assistance received if the employee resigns from state employment within one year of completing educational work.

(i) Agencies may require the employee to repay any assistance received if the employee transfers to another agency within one year of completing educational work.

(d) Education assistance may not exceed $5,250 per employee in any one calendar year unless approved in advance by the agency head.

(e) The employee shall disclose all scholarships, subsidies and grant monies provided to the employee for the educational program.

(i) Except for funding that must be repaid by the employee, the amount reimbursed by the State may not include funding received from sources in Subsection R477-10-4(1)(e).

(2) Agency management shall be responsible for determining the taxable or nontaxable status of educational assistance reimbursements.

KEY: educational tuition, employee performance evaluations, employee productivity, training programs
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R477. Human Resource Management, Administration.
R477-11. Discipline.
R477-11-1. Disciplinary Action.

(1) Agency management may discipline any employee for any of the following causes or reasons:

(a) noncompliance with these rules, agency or other applicable policies, including but not limited to safety policies, agency professional standards, standards of conduct and workplace policies;

(b) work performance that is inefficient or incompetent;

(c) failure to maintain skills and adequate performance levels;

(d) insubordination or disloyalty to the orders of a superior;

(e) misfeasance, malfeasance, or nonfeasance;

(f) any incident involving intimidation, physical harm, or threats of physical harm against co-workers, management, or the public;

(g) no longer meets the requirements of the position;

(h) conduct, on or off duty, which creates a conflict of interest with the employee's public responsibilities or impacts that employee's ability to perform job assignments;

(i) failure to advance the good of the public service, including conduct on or off duty which demeans or harms the effectiveness or ability of the agency to fulfill its mission;

(j) dishonesty; or

(k) misconduct.

(2) Agency management shall consult with DHRM prior to disciplining an employee

(3) All disciplinary actions of career service employees shall be governed by principles of due process and Title 67, Chapter 19a. The disciplinary process shall include all of the following, except as provided under Subsection 67-19-18(4):

(a) The agency representative notifies the employee in writing of the proposed discipline, the reasons supporting the intended action, and the right to reply within five working days.

(b) The employee's reply shall be received within five working days in order to have the agency representative consider the reply before discipline is imposed.

(c) If an employee waives the right to reply or does not reply within the time frame established by the agency representative or within five working days, whichever is longer, discipline may be imposed in accordance with these rules.

(4) After a career service employee has been informed of the reasons for the proposed discipline and has been given an opportunity to respond and be responded to, the agency representative may discipline that employee, or any career service exempt employee not subject to the same procedural rights, by imposing one or more of the following forms of disciplinary action:

(a) written reprimand;

(b) suspension without pay up to 30 calendar days per incident requiring discipline;

(c) demotion of any employee, in accordance with Section R477-11-2, through one of the following actions:

(i) An employee may be moved from a position in one job to a position in another job having a lower maximum salary range and shall receive a reduction in the current actual wage.

(ii) An employee's current actual wage may be lowered within the current salary range, as determined by the agency head or designee.

(d) dismissal in accordance with Section R477-11-2.

(5) If agency management determines that a career service employee endangers or threatens the peace and safety of others or poses a grave threat to the public service or is charged with aggravated or repeated misconduct, the agency may impose the following actions, under Subsection 67-19-18(4), pending an investigation and determination of facts:

(a) paid administrative leave; or

(b) temporary reassignment to another position or work location at the same current actual wage.

(6) At the time disciplinary action is imposed, the employee shall be notified in writing of the discipline, the reasons for the discipline, the effective date and length of the discipline.

(7) Disciplinary actions are subject to the grievance and appeals procedure by law for career service employees, except under Section 67-19a-402.5. The employee and the agency representative may agree in writing to waive or extend any grievance step, or the time limits specified for any grievance step.

R477-11-2. Dismissal or Demotion.

An employee may be dismissed or demoted for cause under Subsection R477-10-2(3)(e) and Section R477-11-1, and through the process outlined in this rule.

(1) An agency head or appointing officer may dismiss or demote a probationary employee or career service exempt employee without right of appeal, except under Sections 67-21-2 and 67-19a-402.5. Such dismissal or demotion may be for any reason or for no reason.

(2) No career service employee shall be dismissed or demoted from a career service position unless the agency head or designee has observed the Grievance Procedure Rules and law cited in Section R137-1-13 and Title 67, Chapter 19a, and the following procedures:

(a) The agency head or designee shall notify the employee in writing of the specific reasons for the proposed dismissal or demotion.

(b) The employee shall have up to five working days to reply. The employee shall reply within five working days for the agency head or designee to consider the reply before discipline is imposed.

(c) The employee shall have an opportunity to be heard by the agency head or designee. This meeting shall be strictly limited to the specific reasons raised in the notice of intent to demote or dismiss.

(i) At the meeting the employee may present, either in person, in writing, or with a representative, comments or reasons as to why the proposed disciplinary action should not be taken. The agency head or designee is not required to receive or allow other witnesses on behalf of the employee.

(ii) The employee may present documents, affidavits or other written materials at the meeting. However, the employee is not entitled to present or discover documents within the possession or control of the department or agency that are private, protected or controlled under Section 63G-2-3.

(d) Following the meeting, the employee may be dismissed or demoted if the agency head finds adequate cause or reason.

(e) The employee shall be notified in writing of the agency head's decision. The reasons shall be provided if the decision is a demotion or dismissal.

(3) Agency management may place an employee on paid administrative leave pending the administrative appeal to the agency head.

R477-11-3. Discretionary Factors.

(1) When deciding the specific type and severity of discipline, the agency head or representative may consider the following factors:

(a) consistent application of rules and standards;

(i) the agency head or representative need only consider those cases decided under the administration of the current agency head. Decisions in cases prior to the administration of the current agency head are not binding upon the current agency head and are not relevant in determining consistent application of rules and standards.

(ii) In determining consistent application of rules and

standards, the disciplinary actions imposed by one agency may not be binding upon any other agency and may not be used for comparison purposes in hearings wherein the consistent application of rules and standards is at issue.

(b) prior knowledge of rules and standards;

(c) the severity of the infraction;

(d) the repeated nature of violations;

(e) prior disciplinary/corrective actions;

(f) previous oral warnings, written warnings and discussions;

(g) the employee's past work record;

(h) the effect on agency operations;

(i) the potential of the violations for causing damage to persons or property.

KEY: discipline of employees, dismissal of employees, grievances, government hearings

July 1, 2016 67-19-6

Notice of Continuation April 27, 2017 67-19-18

63G-2-3

R477. Human Resource Management, Administration.
R477-12. Separations.
R477-12-1. Resignation.

A career service employee may resign or retire by giving written or verbal notice to the supervisor or an appropriate representative of management in the work unit.

(1) Agency management shall accept an employee's notice of resignation or retirement without prejudice when received at least two weeks before its effective date.

(2) After giving a notice of resignation or retirement, an employee may withdraw it on the next working day by notifying the supervisor or an appropriate representative of management in the work unit.

(a) If the withdrawal notice is verbal, the employee shall submit a written notification within 24 hours of the verbal notice.

(b) After the close of the next working day following submission, withdrawal of a resignation or retirement may occur only with the consent of agency management.

R477-12-2. Abandonment of Position.

An employee who is absent from work for three consecutive working days without approval shall be considered to have abandoned the position and to have resigned from the employing agency.

(1) An employee who has abandoned his position may be separated from state employment. Management shall inform the employee of the action in writing.

(a) Management shall send the employee notice of intent to separate to the employee's last known address.

(b) The employee shall have the right to appeal separation to the agency head within five working of receipt, delivery, or attempted postal delivery of the notice of abandonment to the last known address.

(c) If the separation is appealed, management may not be required to prove intent to abandon the position.

R477-12-3. Reduction in Force.

Reductions in force (RIF) shall be governed by DHRM rules and business practices.

(1) When staff will be reduced in one or more categories of work, agency management shall develop a work force adjustment plan (WFAP). A career service employee shall only be given formal written notification of separation after a WFAP has been reviewed by the Executive Director, DHRM, or designee and approved by Agency Head or designee. The following items shall be addressed in the WFAP:

(a) the categories of work to be eliminated, including positions impacted through bumping;

(b) a decision by agency management allowing or disallowing bumping;

(c) specifications of measures taken to facilitate the placement of affected employees through reassignment, transfer and relocation to vacant positions for which the employee qualifies;

(d) job-related criteria as identified in Subsection R477-12-3(3)(a) used for determining retention points; and

(e) When more than one employee is affected, employees shall be listed in order of retention points.

(f) Retention points do not have to be calculated for a single incumbent WFAP.

(2) Eligibility for RIF.

(a) Only career service employees who have been identified in an approved WFAP and given an opportunity to be heard by the agency head or designee may be RIF'd.

(b) An employee covered by USERRA shall be identified, assigned retention points, and notified of the RIF in the same manner as a career service employee.

(3) Retention points shall be determined for all affected employees within a category of work by giving appropriate consideration for proficiency and seniority with proficiency being the primary factor.

(a) Performance evaluations and performance information for the past three years may be taken into account for assessing job proficiency.

(b) Seniority shall be determined by the length of most recent continuous career service, which commenced in a career service position for which the probationary period was successfully completed.

(i) Exempt service time subsequent to attaining career service tenure with no break in service shall be counted for purposes of seniority.

(c) In each WFAP, agency management shall develop the criteria they will use for determining retention points.

(i) Agency Management shall consult with Executive Director, DHRM or designee.

(ii) Agency plans shall comply with current DHRM business practices.

(4) The order of separation shall be:

(a) temporary employees in schedule IN or TL positions;

(b) probationary employees; then

(c) career service employees with the lowest retention points.

(5) An employee, including one covered under USERRA, who is separated due to a RIF shall be given formal written notification of separation, allowing for a minimum of 20 working days prior to the effective date of the RIF.

(6) An employee notified of separation due to a RIF may appeal to the agency head by submitting a written notice of appeal within 20 working days after the receipt of written notification of separation.

(a) The employee may appeal the decision of the agency head according to the appeals procedure of the Career Service Review Office.

(7) A career service employee who is separated in a RIF shall be governed by the rules in place at the time of separation.

(8) A career service employee who is separated in a RIF shall be given preferential consideration to the application score in the process of developing the hiring list as outlined in DHRM business practices when applying for a career service position.

(a) Preferential consideration shall end once the RIF'd individual accepts a career service position.

(b) A RIF'd individual may be rehired under Section R477-4-6.

(c) At agency discretion, an individual rehired to a career service position may buy back part or all accumulated annual and converted sick leave that was cashed out when RIF'd.

(9) A career service employee accepting an exempt position without a break in service, who is later not retained by the appointing officer, unless discharged for cause under these rules, shall be given preferential consideration as outlined in Subsection R477-12-3(8).

(10) Prior to separation and in lieu of a RIF, management may reassign an employee to a vacant career service position for which the employee qualifies under Section R477-4-5.

R477-12-4. Exceptions.

The Executive Director, DHRM, may authorize exceptions to this rule consistent with Subsection R477-2-2(1).

KEY: administrative procedures, employees' rights, grievances, retirement
July 1, 2016 67-19-6
Notice of Continuation April 27, 2017 67-19-17
67-19-18

R477. Human Resource Management, Administration.
R477-13. Volunteer Programs.
R477-13-1. Volunteer Programs.

(1) Agency management may establish a volunteer program.

(a) A volunteer program shall include:

(i) documented agreement of the type of work and duration for which the volunteer services will be provided;

(ii) orientation to the conditions of state service and the volunteer's specific assignments;

(iii) adequate supervision of the volunteer; and

(iv) documented hours worked by a volunteer.

(2) A volunteer may not donate any service to an agency unless the volunteer's services are approved by the agency head or designee, and by DHRM.

(a) Agency management shall approve all work programs for volunteers before volunteers serve the state or any agency or subdivisions of the state.

(3) A volunteer is considered a government employee for purposes of workers' compensation, operation of motor vehicles or equipment, if properly licensed and authorized to do so, and liability protection and indemnification.

(4) The Executive Director, DHRM, may authorize exceptions to this rule consistent with Subsection R477-2-2(1).

KEY: personnel management, administrative rules, rules and procedures, volunteers

July 1, 2013	**67-19-6**
Notice of Continuation April 27, 2017	**67-20-3**
	67-20-4
	67-20-8

R477. Human Resource Management, Administration.
R477-15. Workplace Harassment Prevention.
R477-15-1. Policy.

It is the policy of the State of Utah to provide a work environment free from discrimination and harassment based on race, religion, national origin, color, sex, age, disability, pregnancy, sexual orientation, gender identity, or protected activity or class under state or federal law.

(1) Workplace harassment includes the following subtypes:

(a) conduct in violation of Section R477-15-1 that is unwelcome, pervasive, demeaning, ridiculing, derisive, or coercive, and results in a hostile, offensive, or intimidating work environment;

(b) conduct in violation of Section R477-15-1 that results in a tangible employment action against the harassed employee.

(2) An employee may be subject to discipline for violating workplace policies, even if the conduct occurs outside of scheduled work time or work location, or if the the conduct is not sufficiently severe to warrant a finding of unlawful harassment.

(3) Once a complaint has been filed, the accused may not communicate with the complainant regarding allegations of harassment.

R477-15-2. Retaliation.

(1) No person may retaliate against any employee who opposes a practice forbidden under this policy, or has filed a charge, testified, assisted or participated in any manner in an investigation, proceeding or hearing, or is otherwise engaged in protected activity.

R477-15-3. Complaint Procedure.

Management shall permit employees who allege workplace harassment, retaliation, or both to file complaints and engage in a review process free from bias, collusion, intimidation or retaliation. Complainants shall be provided a reasonable amount of work time to prepare for and participate in internal complaint processes.

(1) Employees who feel they are being subjected to workplace harassment, retaliation, or both should do the following:

(a) document the occurrence;

(b) continue to report to work; and

(c) identify a witness(es), if applicable.

(2) An employee may file an oral or written complaint of workplace harassment, retaliation, or both with their immediate supervisor, any other supervisor within their direct chain of command, or the Department of Human Resource Management, including the agency human resource field office.

(a) Complaints may be submitted by any employee, witness, volunteer or other individual.

(b) Complaints may be made through either oral or written notification and shall be handled in compliance with investigative procedures and records requirements in Sections R477-15-5 and R477-15-6.

(c) Any supervisor who has knowledge of workplace harassment, retaliation, or both shall take immediate, appropriate action in consultation with DHRM and document the action.

(3) All complaints of workplace harassment, retaliation, or both shall be acted upon following receipt of the complaint.

(4) If an immediate investigation by agency management is deemed unwarranted, the complainant shall be notified.

R477-15-4. Investigative Procedure.

(1) When warranted investigations shall be conducted based on DHRM standards and business practices.

(2) Results of Investigation

(a) If the investigation finds the allegations to be sustained, agency management shall take appropriate administrative action.

(b) If an investigation reveals evidence of criminal conduct in workplace harassment allegations, the agency head or Executive Director, DHRM, may refer the matter to the appropriate law enforcement agency.

(c) At the conclusion of the investigation, the appropriate parties shall be notified.

R477-15-5. Workplace Harassment Records.

(1) A separate confidential file of all workplace harassment and retaliation complaints shall be maintained and stored in the agency human resource field office, or in the possession of an authorized official.

(a) Removal or disposal of these files shall only be done with the approval of the agency head or Executive Director, DHRM.

(b) Files shall be retained in accordance with the retention schedule after the active case ends.

(c) All information contained in the complaint file shall be classified as protected under Section 63G-2-305.

(d) Information contained in the workplace harassment and retaliation file shall only be released by the agency head or Executive Director, DHRM, when required by law.

(2) Supervisors may not keep separate files related to complaints of workplace harassment or retaliation.

(3) Participants in any workplace harassment or retaliation proceeding shall treat all information pertaining to the case as confidential.

R477-15-6. Training.

(1) DHRM shall provide employees training, including additional training for supervisors, on the prevention of workplace harassment.

(a) The curriculum shall be approved by DHRM and the Division of Risk Management.

(b) Agencies shall ensure updated or refresher training is provided to employees every two years.

(c) Training shall be developed and provided by qualified individuals.

(d) Training records shall be maintained, including who provided the training, who attended the training and when they attended it.

KEY: administrative procedures, hostile work environment
July 1, 2016 67-19-6
Notice of Continuation April 27, 2017 67-19-18
63G-2-305
E.O. No. 12 "Prohibiting Unlawful Harassment" (December 2006)

R512. Human Services, Child and Family Services.
R512-204. Child Protective Services, New Caseworker Training.
R512-204-1. Purpose and Authority.

(1) Pursuant to Section 62A-4a-107, the Division of Child and Family Services (Child and Family Services) mandates that before assuming significant independent casework responsibilities, all caseworkers shall successfully complete the core curriculum training.

(2) Section 62A-4a-102 gives Child and Family Services rulemaking authority.

R512-204-2. Conflict Training.

(1) The child welfare training coordinator for Child and Family Services is charged with the responsibility for ensuring that the core curriculum is inclusive of information about working with families where there is a conflictual relationship born out of divorce proceedings. This training must include information on fraudulent reporting in Child Protective Services investigations. Other training information must be provided that assists the caseworker in using a variety of techniques to develop a complete picture of the family dynamics and how this may impact the information gathered and the conclusions reached at the end of an investigation.

KEY: child welfare, child abuse, caseworker training

October 22, 2009	**62A-4a-105**
Notice of Continuation April 18, 2017	**62A-4a-107**
	62A-4a-102

R527. Human Services, Recovery Services.
R527-250. Emancipation.
R527-250-1. Purpose and Authority.

1. Section 62A-11-107 authorizes the Office of Recovery Services/Child Support Services (ORS/CSS) to adopt, amend and enforce rules.

2. The purpose of this rule is to outline how ORS/CSS will apply Utah statute when determining the appropriate emancipation date for IV-D child support cases, particularly when determining the "child's normal and expected year of graduation" referenced in U.C.A. 78B-12-219 for Utah child support orders issued on or after July 1, 1994.

R527-250-2. Normal and Expected Year of Graduation.

1. For a child attending school in Utah, the normal and expected year of graduation is based on kindergarten plus twelve years of school, unless an exception as listed below applies.

2. For a child attending school in Utah, ORS/CSS will presume that the normal and expected month of graduation is May of the expected graduating year, unless the parents provide documentation of a specific graduation date for their child.

3. If a deviation to the "kindergarten plus twelve years" standard is known at the time of entry of the child support order, the expected year of graduation is altered accordingly. If a child has been held back a grade or experienced another delay in education before the child support order is entered, the "expected" year of graduation will be changed to extend the support obligation based on the known facts about the delay in education. If the child has been advanced a grade or experienced some other acceleration in education before the child support order is entered, the "expected" year of graduation will be changed to potentially shorten the support obligation based on the facts about the acceleration in education.

4. If a deviation to the "kindergarten plus twelve years" standard is not known until after the entry of the child support order, the "expected" year of graduation is not altered based on the new facts unless the child receives an early high school diploma, a high school equivalency diploma, or documentation is provided of early completion of high school course requirements.

R527-250-3. Early Graduation, High School Equivalency Diploma, and General Educational Development (GED).

ORS may cease collection of child support the month following in which the child is no longer enrolled in school, is 18 years old, and:

1. the child receives a high school diploma at the time of early graduation;

2. documentation is provided of the child's early completion of high school course requirements; or

3. the child receives a high school equivalency diploma.

R527-250-4. Dropping Out of School.

A child who no longer attends school is not considered emancipated until becoming 18 years old or the graduation of his/her normal and expected graduating class has occurred, whichever occurs later.

R527-250-5. Burden of Proof.

1. ORS/CSS will enforce child support based on the "kindergarten plus twelve years" standard until a parent or guardian has provided appropriate documentation to support an emancipation date other than that standard.

2. A parent or guardian requesting the deviation from the standard is responsible for gathering the appropriate documentation and providing the information to ORS/CSS.

3. Changes to the child support amount due will not be effective until the month following the emancipation date.

4. Changes to the child support amount which are based on a date other than the 18th birthday or the "kindergarten plus twelve year" standard will not be effective until the month following the determined date of emancipation or the month following in which the parent or guardian provides sufficient documentation to support the new emancipation date, whichever occurs later. If an over collection occurs due to the parent not providing documentation, the parent will be responsible for recovering any overpaid amounts without involving ORS/CSS.

KEY: child support, emancipation

April 14, 2017	**62A-11-107**
Notice of Continuation January 5, 2016	**62A-11-303**
	62A-11-401
	78B-12-102
	78B-12-219

R590. Insurance, Administration.
R590-68. Insider Trading of Equity Securities of Domestic Stock Insurance Companies.
R590-68-1. Authority.

This rule is adopted pursuant to Subsection 31A-2-201(3), which authorizes rules to implement the Insurance Code, and Subsection 31A-5-303(3)(a), which allows the commissioner to adopt a rule to "define terms and prescribe conditions regarding securities held in the ordinary course of business and incident to the establishment of maintenance of a primary or secondary market."

R590-68-2. Definition of Certain Terms.

A. "Insurer" means any domestic stock insurance company with an equity security subject to the provisions of Section 31A-5-303.

B. "Act" means the Federal Securities Exchange Act of 1934.

C. "Officer" means a president, vice president, treasurer, actuary, secretary, controller and any other person who performs for the insurer functions corresponding to those performed by the foregoing officers.

D. "Equity security" means any stock or similar security; or any voting trust certificate or certificate of deposit for a security; or any security convertible, with or without consideration, into a security, or carrying any warrant or right to subscribe to or purchase a security; or warrant or right.

E. Securities "held of record."

1. For the purpose of determining whether the equity securities of an insurer are held of record by 100 or more persons, securities shall be considered "held of record" by each person who is identified as the owner of securities on records of security holders maintained by or on behalf of the insurer, subject to the following:

(a) where the records of security holders have not been maintained in accordance with accepted practice, any additional person who would be identified as an owner on these records if they had been maintained in accordance with accepted practice shall be included as a holder of record;

(b) securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be included as so held by one person;

(c) securities identified as held of record by one or more persons as trustees, executors, guardians, custodians, or in other fiduciary capacities with respect to a single trust, estate or account shall be included as held of record by one person;

(d) securities held by two or more persons as co-owners shall be included as held by one person;

(e) each outstanding unregistered or bearer certificate shall be included as held of record by a separate person, except to the extent that the insurer can establish that, if securities were registered, they would be held of record, under the provisions of this rule, by a lesser number of person; and

(f) Securities registered in substantially similar names where the insurer has reason to believe, because of the address or other indications, represent the same person and may be included as held of record by one person.

2. Notwithstanding Subsection E.(1) of this section:

(a) securities held to the knowledge of the insurer, subject to a voting trust, deposit agreement or similar arrangement shall be included as held of record by the record holders of the voting trust certificates, certificates of deposit, receipts or similar evidences of interest in these securities; provided however, that the insurer may rely in good faith on information received in response to its request from a nonaffiliated insurer of the certificates or evidences of interest; and

(b) if the insurer knows or has reason to know that the form of holding securities of record is used primarily to circumvent the provisions of the Act, the beneficial owners of securities shall be considered the record owners.

E. "Class" means securities of an insurer which are of substantially similar character and the holders of which enjoy substantially similar rights and privileges.

R590-68-3. Transactions Exempted From the Operation of Section 31A-5-303.

Any acquisition or disposition of any equity security by a director or officer of an insurer within six months prior to the date on which the Act shall first become applicable with respect to the equity securities of the insurer shall not be subject to the operation of Section 31A-5-303.

R590-68-4. Filing of Statements.

Initial statements of beneficial ownership of equity securities required by Section 31A-5-303 shall be filed on Form A, entitled "Initial Statement of Beneficial Ownership of Equity Securities." The statements shall be prepared and ownership required by Section 31A-5-303, and shall be filed on Form B, entitled "Statement of Changes in Beneficial Ownership of Securities." Statements of changes in a beneficial ownership shall be filed in accordance with the requirements of the applicable form. These forms are available from the Insurance Department.

In determining, for the purpose of Section 31A-5-303, whether a person is the beneficial owner, directly or indirectly, of more than ten per cent of any class of any equity security, the class shall consist of the total amount of the class outstanding, exclusive of any securities of the class held by or for the account of the insurer or a subsidiary of the insurer; except that for the purpose of determining percentage ownership of voting trust certificates or certificates of deposit for equity securities, the class of voting trust certificates or certificates of deposit shall consist of the amount of voting trust certificates or certificates of deposit issuable with respect to the total amount of outstanding equity securities of the class which may be deposited under the voting trust agreement or deposit agreement in question, whether or not outstanding securities have been so deposited. For the purpose of this section a person acting in good faith may rely on the information contained in the latest Convention Form Statement filed with the commissioner with respect to the amount of Securities of a class outstanding, or in the case of voting trust certificates or certificates of deposit, the amount issuable.

R590-68-5. Disclaimer of Beneficial Ownership.

Any person filing a statement may expressly declare, for the purpose of the Act, that the filing of the statement shall not be construed as an admission that a person is the beneficial owner of any equity securities covered by the statement.

R590-68-6. Exemptions from Section 31A-5-303.

A. During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from Section 31A-5-303:

1. executors or administrators of the estate of a decedent;

2. guardians or committees for an incompetent; and

3. receivers, trustees in bankruptcy, assignees for the benefit of creditors, conservators, liquidating agents, and other similar persons duly authorized by law to administer the estate or assets of other persons.

B. After the 12 month period following their appointment or qualification, the foregoing persons shall be required to file reports with respect to the securities held by the estates which they administer under Section 31A-5-303, and shall be liable for profits realized from trading securities pursuant to Section 31A-5-303, only when the estate being administered is a beneficial owner of more than ten per cent of any class of equity security of an insurer subject to the Act.

C. Securities reacquired by or for the account of an insurer and held by it for its account shall be exempt from Section 31A-5-303 during the time they are held by the insurer.

R590-68-7. Exemption From the Act of Securities Purchased or Sold by Odd-Lot Dealers.

Securities exempt from the provisions of the Act are purchased or sold by an odd-lot dealer:

(1) in odd lots so far as reasonably necessary to carry on odd-lot transactions; or

(2) in round lots to offset odd-lot transactions previously or simultaneously executed or reasonably anticipated in the usual course of business.

R590-68-8. Certain Transactions Subject to Section 31A-5-303.

The acquisition or disposition of any transferable option, put, call, spread or straddle shall be considered a change in the beneficial ownership of the security to which the privilege relates to require the filing of a statement reflecting the acquisition or disposition of the privilege. Nothing in this section, however, shall exempt any person from filing the statements required upon the exercise of the option, put, call, spread or straddle.

R590-68-9. Ownership of Securities Held in Trust.

A. Beneficial ownership of a security for the purpose of Section 31A-5-303 shall include:

1. the ownership of securities as a trustee where either the trustee or members of his immediate family have a vested interest in the income or corpus of the trust,

2. the ownership of a vested beneficial interest in a trust; and

3. the ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of the beneficiaries.

B. Except as provided in Subsection C., beneficial ownership of securities solely as a settlor or beneficiary of a trust shall be exempt from the provisions of Section 31A-5-303 where less than 20% in market value of the securities having a readily ascertainable market value held by the trust, determined as of the end of the preceding fiscal year of the trust, consists of equity securities with respect to which reports would otherwise be required. Exemption is likewise accorded from Section 31A-5-303 with respect to any obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust, where the ownership, acquisition, or disposition of securities by the trust is made without prior approval by the settlor or beneficiary. No exemption pursuant to this subsection shall, be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in securities otherwise subject to the reporting requirements of Section 31A-5-303.

C. In the event that ten per cent of any class of any equity security of an insurer is held in a trust, that trust and the trustees shall be required to file the reports specified in Section 31A-5-303.

D. Not more than one report need be filed to report any holdings or with respect to any transaction in securities held by a trust, regardless of the number of officers, directors, or ten per cent stockholders who are either trustees, settlors, or beneficiaries of a trust, provided that the report filed shall disclose the names of trustees, settlors and beneficiaries who are officers, directors or ten per cent stockholders. A person having an interest only as a beneficiary of a trust shall not be required to file a report so long as he relies in good faith upon an understanding that the trustee of a trust will file whatever reports might otherwise be required of the beneficiary.

E. As used in this section the "immediate family" of a trustee means:

1. a son or daughter of the trustee, or a descendant of either;

2. a stepson or stepdaughter of the trustee;

3. the father or mother of the trustee, or an ancestor of either;

4. a stepfather or stepmother of the trustee; and

5. a spouse of the trustee.

For the purpose of determining whether any of the foregoing relations exists, a legally adopted child of a person shall be considered a child of the person by blood.

F. In determining, for the purposes of Section 31A-5-303, whether a person is the beneficial owner, directly or indirectly, of more than ten per cent of any class of any equity security, the interest of a person in the remainder of a trust shall be excluded from the computation.

G. No report shall be required by any person, whether or not otherwise subject to the requirement of filing reports under Section 31A-5-303, with respect to his indirect interest in portfolio securities held by:

1. a pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan; and

2. a business trust with over 25 beneficiaries.

H. Nothing in this section shall impose any duties or liabilities with respect to reporting any transaction or holding prior to its effective date.

R590-68-10. Exemption for Small Transactions.

A. Any acquisition of securities shall be exempt from Section 31A-5-303 where:

1. the person effecting the acquisition does not, within six months after, effect any disposition than by way of gift of securities of the same class; and

2. the person effecting an acquisition does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six months' period during which the acquisition occurs.

B. Any acquisition or disposition of securities, by way of gift, where the total amount of gifts does not exceed $3,000 in market value for any six months' period, shall be exempt from Section 31A-5-303 and may be excluded from the computations prescribed in Subsection A.2.

C. Any person exempted by Subsection A. or B. of this section shall include in the first report filed by him, after a transaction within the exemption, a statement showing his acquisitions and dispositions for each six months' period or portion which has elapsed since his last filing.

R590-68-11. Exemption From Section 31A-5-303 of Transactions Which Need Not Be Reported Under Section 31A-5-303.

Any transaction which has been or shall be exempted from the requirements of Subsection 31A-5-303(1) shall, as it is otherwise subject to the provisions of Subsection 31A-5-303(2), be likewise exempted from Subsection 31A-5-303(2).

R590-68-12. Exemption From Section 31A-5-303 of Certain Transactions Effected in Connection With a Distribution.

A. Any transaction of purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of Subsection 31A-5-303(2), to the extent specified in this section as not included within the purpose of Section 31A-5-303, upon the following conditions:

1. the person effecting the transaction is engaged in the business of distributing securities and is participating in good faith in the ordinary course of business in the distribution of a

block of securities;

2. the security involved in the transaction is:

(A) a part of a block of securities and is acquired by the person effecting the transaction with a view to distribution from the insurer or other person on whose behalf securities are being distributed, or from a person who is participating in good faith in the distribution of a block of securities; or

(B) a security purchased in good faith by or for the account of the person effecting the transaction for the purpose of stabilizing the market price of securities of the class being distributed, or to cover an over-allotment or other short position created in connection with the distribution; and

3. other persons not within the purview of Section 31A-5-303, are participating in the distribution of a block of securities on terms at least as favorable as those on which a person is participating and to an extent at least equal to the aggregate participation of persons exempted from the provisions of Section 31A-5-303 by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing these functions shall not preclude an exemption which would otherwise be available under this section.

B. The exemption of a transaction pursuant to this section, with respect to the participation of one party, shall not render the transaction exempt with respect to participation of any other party unless the other party also meets the conditions of this section.

R590-68-13. Exemption From Section 31A-5-303 of Acquisitions of Shares of Stock and Stock Options Under Certain Stock Bonus, Stock Option or Similar Plans.

Any acquisition of shares of stock, other than stock acquired upon the exercise of an option, warrant or right, pursuant to a stock bonus, profit sharing, retirement, incentive, thrift, savings or similar plan, or any acquisition of a qualified or a restricted stock option pursuant to a qualified or a restricted stock option plan, or a stock option pursuant to an employee stock purchase plan by a director or officer of an insurer issuing a stock or stock option, shall be exempt from the operation of Subsection 31A-5-303(2) if the plan meets the following conditions:

A. The plan has been approved, directly or indirectly:

(1) by the affirmative votes of the holders of a majority of the securities of the insurer present, or represented, and entitled to vote at a meeting duly held in accordance with the applicable laws of the State of Utah; or

(2) by the written consent of the holders of a majority of the securities of an insurer entitled to vote: provided, however, that if the vote or written consent was not solicited substantially in accordance with the proxy rules prescribed by the National Association of Insurance Commissioners in effect at the time of a vote or written consent, the insurer shall furnish in writing to the holders of record of the securities entitled to vote for the plan substantially the same information concerning the plan which would be required by rules so prescribed and in effect at the time information is furnished, if proxies to be voted with respect to the approval or disapproval of the plan, were then being solicited, on or prior to the date of the first annual meeting of security holders held subsequent to the later of:

(i) the date the Act first applies to insurer; or

(ii) the acquisition of an equity security for which exemption is claimed. Written information may be furnished by mail to the last known address of the security holders of record within 30 days prior to the date of mailing. Four copies of the written information shall be filed with, or mailed for filing to, the commissioner not later than the date on which it is first sent or given to security holders of the insurer. For the purposes of this subsection, the term "insurer" includes a predecessor corporation if the plan or obligations to participate were assumed by the insurer in connection with the succession.

B. If the selection of any director or officer of the insurer to whom stock may be allocated or to whom qualified, restricted or employee stock purchase plan stock options may be granted pursuant to the plan, or the determination of the number or maximum number of shares of stock which may be allocated to a director or officer or which may be covered by qualified, restricted or employee stock purchase plan stock options granted to any director or officer, is subject to the discretion of any person, then discretion shall be exercised only as follows:

1. with respect to the participation of directors:

(a) by the board of directors of the insurer, a majority of which board and a majority of the directors acting in the matter are disinterested persons;

(b) by, or only in accordance with the recommendations of a committee of three or more persons having full authority to act in the matter of the members of which committee are disinterested persons; or

(c) otherwise in accordance with the plan, if the plan:

(i) specifies the number or maximum number of shares of stock which directors may acquire or which may be subject to qualified, restricted or employee stock purchase plan stock options granted to directors and the terms upon which, and the times at which, or the periods within which, the stock may be acquired or the options may be acquired and exercised; or

(ii) sets forth, by formula or otherwise, effective and determinable limitations with respect to the foregoing, based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares or percentages outstanding from time to time, or similar factors.

2. with respect to the participation of officers who are not directors:

(a) by the board of directors of the insurer or a committee of three or more directors; or

(b) by, or only in accordance with the recommendations of, a committee of three or more persons having full authority to act in the matter, of the members of which committee are disinterested persons.

For the purpose of this subsection, a director or committee member shall be considered a disinterested person only if the person is not eligible at the time the discretion is exercised, and has not at any time within one year prior to this, been eligible for selection as a person to whom stock may be allocated or to whom qualified, restricted, or employee stock purchase plan stock options may be granted pursuant to the plan, or any other plan of the insurer, or any of its affiliates entitling the participants to acquire stock, or qualified, restricted, or employee stock purchase plan stock options of the insurer, or any of its affiliates.

3. The provisions of this subsection shall not apply with respect to any option granted, or other equity security acquired, prior to the date that Subsections 31A-5-303(1)(2) and (3) first became applicable with respect to any class of equity securities of any insurer.

C. As to each participant or as to participants the plan effectively limits the aggregate dollar amount or the aggregate number of shares of stock which may be allocated, or which may be subject to qualified, restricted, or employee stock purchase plan stock options granted, pursuant to the plan. The limitations may be established on an annual basis, or for the duration of the plan, whether or not the plan has a fixed termination date, and may be determined either by fixed or maximum dollar amounts, or fixed or maximum numbers of shares or by formulas based upon earnings of the insurer, dividends paid, compensation received by participants, option prices, market value of shares, outstanding shares, or percentages outstanding from time to time, or similar factors which will result in an effective and determinable limitation.

These limitations may be subject to any provisions for adjustment of the plan or of stock allocable or portions outstanding to prevent dilution or enlargement of rights.

D. Unless the context otherwise requires, terms used in this section shall have the same meaning as in the Act and in Section 1 of this rule. In addition, the following definitions apply:

1. the term "plan" includes any plan, whether or not set forth in any formal written document or documents and whether or not approved in its entirety at one time.

2. The definition of the terms "qualified stock option" and "employee stock purchase plan" that are set forth in Sections 422 and 423 of the Internal Revenue Code of 1954, as amended, are to be applied to those terms where used in this section. The term "restricted stock option" as defined in Subsection 424(b) of the Internal Revenue Code of 1954, as amended, shall be applied to that term as used in this section, provided however, that for the purposes of this section an option which meets the conditions of that section, other than the date of issuance shall be considered a "restricted stock option."

R590-68-14. Exemption From Subsection 31A-5-303(2) of Certain Transactions in Which Securities Are Received by Redeeming Other Securities.

Any acquisition of an equity security, other than a convertible security or right to purchase a security, by a director or officer of the insurer issuing the security shall be exempt from the operation of Subsection 31A-5-303(2) upon condition that:

A. the equity security is acquired by way of redemption of another security of an insurer substantially all of whose assets, other than cash, or government bonds, consist of securities of the insurer issuing the equity security so acquired, and which:

1. represented substantially and in practical effect a stated or readily ascertainable amount of the equity security;

2. had a value which was substantially determined by the value of the equity security; and

3. conferred upon the holder the right to receive the equity security without the payment of any consideration other than the security redeemed.

B. no security of the same class as the security redeemed was acquired by the director or officer within six months prior to redemption or is acquired within six months after redemption; and

C. the insurer issuing the equity security acquired has recognized the applicability of Subsection (a) of this section by appropriate corporate action.

R590-68-15. Exemption of Long Term Profits Incident to Sales Within Six Months of the Exercise of an Option.

A. To the extent specified in Subsection B. of this section, the commissioner shall exempt as not included within the purposes of Subsection 31A-5-303(2) any transaction or transactions involving the purchase and sale, or sale and purchase, of any equity security where the purchase is pursuant to the exercise of an option or similar right either:

(1) acquired more than six months before its exercise; or

(2) acquired pursuant to the terms of an employment contract entered into more than six months before its exercise.

B. Regarding transactions specified in Subsection A., the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest market price of any security of the same class within six months before or after the date of sale. Nothing in this section shall enlarge the amount of profit which would inure to the insurer in the absence of this section.

C. The commissioner also exempts, as not included within the purposes of Subsection 31A-5-303(2), the disposition of a security purchased in a transaction specified in Subsection A. of this section, pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities, or for the exchange of its securities for the securities of another person which has acquired its assets, or which is in control, as defined in Subsection 368(c) of the Internal Revenue Code of 1954, of a person which has acquired its assets, where the terms of the plan or agreement are binding upon stockholders of the insurer except to the extent that dissenting stockholders may be entitled, under statutory provisions or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

D. The exemptions proved by this section shall not apply to any transaction made unlawful by Subsection 31A-5-303(3) or by any rules.

E. The burden of establishing market price of a security for the purpose of this section shall rest upon the person claiming the exemption.

R590-68-16. Exemption From Section 31A-5-303 of Certain Acquisitions and Dispositions of Securities Pursuant to Merger or Consolidations.

A. The following transactions shall be exempt from the provisions of Subsection 31A-5-303(2) as not included within the purpose of this section:

1. The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to merger or consolidation, owned 85% or more of the equity securities of companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

2. The disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to merger or consolidation, owned 85% or more of the equity securities of companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

3. The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to merger or consolidation, held over 85% of the combined assets of the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidations as determined by reference to their most recent available financial statements for a 12 month period prior to the merger or consolidation.

4. The disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to merger or consolidation, held over 85% of the combined assets of the companies undergoing merger or consolidation, computed according to their book values prior to merger or consolidation, as determined by reference to their most recent available financial statements for a 12 month period prior to the merger or consolidation.

B. A merger within the meaning of this section shall include the sale or purchase of substantially all the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

C. Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase, other than a purchase exempted by this section, of a security in any company involved in the merger or consolidation and any sale, other than a sale exempted by this section, of a security in any other company involved in the merger or consolidation within any period of less than six months during which the merger or consolidation took place, the exemption provided by this section shall be unavailable to the officer, director, or stockholder.

R590-68-17. Exemption From Section 31A-5-303(2) of Certain Securities Received Upon Surrender of Similar Equity Securities.

Receipt by a person from an insurer of shares of stock of a

class having general voting power, upon the surrender by the person of an equal number of shares of stock of the insurer of a class which does not have general voting power, pursuant to provisions of the insurer's certificate of incorporation, for the purpose of an accompanied simultaneously or followed immediately by the sale of the shares so received, shall be exempt from the operation of Section 31A-5-303(2) as a transaction not included within the purpose of the section, if the following conditions exist:

A. The person receiving shares is not an officer or director, or the beneficial owner, directly or indirectly, immediately prior to the receipt of more than ten per cent of an equity security of the insurer;

B. The shares surrendered and the shares issued upon the surrender shall be of classes which are freely transferable and entitle the holders to participate equally per share in distributions of earnings and assets;

C. The surrender and issuance are made pursuant to provisions of a certificate of incorporation which require that the shares issued upon the surrender shall be registered upon issuance in the name of a person or persons, other than the holder of the shares surrendered, and may be required to be issued as of right only in connection with the public offering, sale and distribution of the shares and the immediate sale by the holder of the shares for that purpose, or in connection with a gift of the shares;

D. Neither the shares so surrendered, nor any shares of the same class, nor other shares of the same class as those issued upon the surrender, have been or are purchased, otherwise than in a transaction exempted by this section, by the person surrendering the shares within six months before or after the surrender or issuance.

R590-68-18. Exemption From Section 31A-5-303(2) of Certain Transactions Involving an Exchange of Similar Securities.

Any acquisition or disposition of securities made in an exchange of shares of a class or series of stock of an insurer for an equivalent number of shares of another class or series of stock of the same insurer, pursuant to a right of conversion under the terms of the insurer's charter or other governing instruments, shall be exempt from the operation of Section 31A-5-303(2) if:

A. the shares surrendered and those acquired in exchange, evidence substantially the same rights and privileges except that, pursuant to the provisions of the insurer's charter or other governing instruments, the board of directors may declare and pay a lesser dividend per share on shares of the class surrendered than on shares of the class acquired in exchange, or may declare and pay no dividend on shares of the class surrendered; and

B. the transaction was effected in contemplation of a public sale of the shares acquired in the exchange; provided, that this section shall not be construed to exempt from the operation of Section 31A-5-303(2), any purchase or sale of shares of the class surrendered, and any sale or purchase of shares of the class acquired in the exchange, otherwise than in the transaction of exchange exempted by this section, within a period of less than six months.

R590-68-19. Exemption of Certain Securities From Section 31A-5-303(3).

Securities shall be exempt from the operation of Section 31A-5-303(3) to the extent necessary to render lawful under the section the execution by a broker of an order for an account in which he has no direct or indirect interest.

R590-68-20. Exemption From Section 31A-5-303(3) of Certain Transactions Effected in Connection With a Distribution.

Securities shall be exempt from the operation of Section 31A-5-303(3) to the extent necessary to render lawful under this section any sale made by or on behalf of a dealer in connection with a distribution of a substantial block of securities, upon the following conditions:

A. the sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting on his behalf intends in good faith to offset the sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling or soliciting-dealer group of which the dealer is a member at the time of the sale, whether or not the security to be so acquired is subject to a prior offering to existing security holders or some other class of persons; and

B. other persons not within the purview of Section 31A-5-303(3), are participating in the distribution of the block of securities on terms at least as favorable as those on which the dealer is participating and to an extent at least equal to the aggregate participation of persons exempted from the provisions of Section 31A-5-303(3) by this section. However, the performance of the functions of manager of a distributing group and the receipt of a bona fide payment for performing these functions shall not preclude an exemption which would otherwise be available under this section.

R590-68-21. Exemption From Section 31A-5-303(3) of Sales of Securities to Be Acquired.

A. Whenever any person is entitled, as an incident to his ownership of an issued security and without the payment of consideration, to receive another security "when issued" or "when distributed," the security to be acquired shall be exempt from the operation of Section 31A-5-303(3), provided that:

(1) the sale is made subject to the same conditions as those attaching to the right of acquisition; and

(2) a person exercises reasonable diligence to deliver the security to the purchaser promptly after his right of acquisition matures; and

(3) a person reports the sale on the appropriate form for reporting transactions by persons subject to Section 31A-5-303(1).

B. This section shall not be construed as exempting transactions involving both a sale of a security "when issued" or "when distributed" and a sale of the security by virtue of which the seller expects to receive the "when-issued" or "when-distributed" security, if the two transactions combined result in a sale of more units than the aggregate of those owned by the seller plus those to be received by him pursuant to his right of acquisition.

R590-68-22. Arbitrage Transactions under Section 31A-5-303(3).

It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of an insurer, unless he shall include the transaction in the statements required by Section 31A-5-303(1) and shall account to an insurer for the profits arising from the transaction, as provided in Section 31A-5-303(2). The provisions of Section 31A-5-303(3) shall not apply to arbitrage transactions. The provisions of the Act shall not apply to any bona fide foreign or domestic arbitrage transaction to the extent it is effected by any person other than the director or officer of the insurer.

KEY: insurance law

1994	**31A-2-201**
Notice of Continuation April 4, 2017	**31A-5-303**

R590. Insurance, Administration.
R590-85. Individual Accident and Health Insurance and Individual and Group Medicare Supplement Rates.
R590-85-1. Purpose and Authority.

The purpose of this rule is to implement Subsections 31A-22-605(4)(e) and 31A-22-620(3)(e) by establishing minimum loss ratios and implementing procedures for the filing of all individual accident and health insurance and all Medicare supplement premium rates, including the initial filing of rates, and any subsequent rate changes. This rule is promulgated pursuant to the authority vested in the commissioner by Subsections 31A-2-201(3)(a) and 31A-2-201.1.

R590-85-2. Applicability and Scope.

(1) This rule shall apply to:

(a) all individual accident and health insurance policies except as excluded under Subsection 2; and

(b) certificates issued under group Medicare supplement policies.

(2) This rule does not apply to:

(a) policies subject to Chapter 30 that comply with Rule R590-167; and

(b) long-term care policies subject to Rule R590-148-22.

(3) The requirements contained in this rule shall be in addition to any other applicable rules previously adopted.

R590-85-3. Definitions.

(1) "Average Annual Premium Per Policy" means the average computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies, for example, the fractional premium loading may not affect the average annual premium or anticipated loss ratio calculation.

(2) "Conditionally Renewable" (CR) means renewal can be declined by class, geographic area or for stated reasons other than deterioration of health.

(3) "Guaranteed Renewable" (GR) means renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

(4) "Non-Cancelable" (NC) means renewal cannot be declined nor can the rates be revised by the insurance company.

(5) "Optionally Renewable" (OR) means renewal is at the option of the insurance company.

R590-85-4. General Requirements.

(1) When Rate Filing is Required.

(a) Every filing for a policy, certificate or endorsement affecting benefits shall be accompanied by a rate filing that complies with this rule.

(b) A rate filing is not required for an endorsement that has no rating effect.

(c) Any subsequent addition to or change in rates applicable to the policy or endorsement shall also be filed prior to use.

(2) General Contents of All Rate Filings. Each rate submission shall include:

(a) rate sheets for current and proposed rates, if applicable, that are clearly identified;

(b) actuarial memorandum describing the basis on which rates were determined, which includes:

(i) description of the policy, benefits, renewability, general marketing methods, and issue age limits;

(ii) description of how rates were determined, including a general description and source of each assumption used;

(iii) estimated average annual premium per policy for Utah;

(iv) anticipated loss ratio of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Interest shall be used in the calculation;

(v) minimum anticipated loss ratio presumed reasonable in R590-85-5(1); and

(vi) signed certification by a qualified actuary which states that to the best of the actuary's knowledge and judgment the rate filing is in compliance with the applicable laws and rules of the state of Utah and the benefits are reasonable in relation to the premiums charged; and

(c) a statement that the rates have been filed with and approved by the home state. If approval is not required by the home state, then alternative information which includes a list of the states to which the rates were submitted, the date submitted, and any responses, must be included.

(3) Previously Filed Form. Filing a rate change for a previously filed rate shall include the following:

(a) a statement of the scope and reason for the change;

(b) a description of how revised rates were determined, including the general description and source of each assumption used;

(c) an estimated average annual premium per policy in Utah, before and after the proposed rate increase;

(d) a comparison of Utah and average nationwide premiums, for representative rating cells based on the Utah distribution of business;

(e) a comparison of revised premiums with current scale;

(f) a statement as to whether the filing applies to new business, in-force business, or both, and the reasons;

(g) a detailed history of national experience, which includes the data in Subsection 4(4) that shows on a yearly and durational basis:

(i) premiums received;
(ii) earned premiums;
(iii) benefits paid;
(iv) incurred benefits;
(v) increase in active life reserves;
(vi) increase in claim reserves;
(vii) incurred loss ratio;
(viii) cumulative loss ratio; and

(ix) any other available data the insurer may wish to provide;

(h) detailed history of Utah experience, which includes the data in Subsection 4(4) that shows on a yearly basis:

(i) earned premiums;
(ii) incurred benefits;
(iii) incurred loss ratio; and
(iv) cumulative loss ratio;

(i) anticipated nationwide future loss ratio, which includes:

(i) projected premiums;
(ii) projected claims; and
(iii) projected loss ratio; and

(iv) assumptions and calculations. Interest shall be used in the calculation;

(j) anticipated Utah future loss ratio, which includes:

(i) projected premiums;
(ii) projected claims; and
(iii) projected loss ratio; and

(iv) description of assumptions and calculations. Interest shall be used in the calculation;

(k) cumulative past and projected future loss ratio and description of the calculation;

(l) the number of policyholders residing in the state of Utah; and

(m) the date and magnitude of all previous rate changes.

(4) Experience Records

(a) An insurer shall maintain records of premiums collected, earned premiums, benefits paid, incurred benefits and reserves for each calendar year, for each policy form, and applicable endorsements. The records shall be maintained as

required for the Accident and Health Policy Experience Exhibit.

(i) Separate data may be maintained for each endorsement to the extent appropriate.

(ii) Experience under policies that provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued.

(b) A rate revision must provide the information required in Subsection (4)(a) on both a national and state basis.

(5) Evaluating Experience Data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

(a) statistical credibility of premiums and benefits, for example low exposure or low loss frequency;

(b) experience and projected trends relative to the kind of coverage, for example: persistency, inflation in medical expenses, or economic cycles affecting disability income experience;

(c) concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations; and

(d) the mix of business by risk classification.

(6) Implementation of a filed rate increase must be initiated within 12 months from the filed date. A company forfeits the right to implement an increase if they fail to initiate implementation within 12 months of the filed date.

(7) A filing may be rejected or prohibited if the company fails to submit all required information.

R590-85-5. Reasonableness of Benefits in Relation to Premium.

(1) With respect to a new form under which the average annual premium per policy is expected to be at least $200, the anticipated loss ratio shall be at least as great as shown below in this subsection:

(a) Medical Expense Coverage. The minimum loss ratio for:

(i) an optionally renewable form is 60%;

(ii) a conditionally renewable form is 55%;

(iii) a guaranteed renewable form is 55%; and

(iv) a non-cancelable form is 50%.

(b) Income Replacement. The minimum loss ratio for:

(i) an optionally renewable form is 60%;

(ii) a conditionally renewable form is 55%;

(iii) a guaranteed renewable form is 50%; and

(iv) a non-cancelable form is 45%.

(c) For a policy form, including endorsements, under which the expected average annual premium per policy is:

(i) $100 or more but less than $200, subtract five percentage points; or

(ii) less than $100 subtract 10 percentage points.

(d) For Medicare supplement policies, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio meets the requirements of Rule R590-146-14.

(2) Rate Changes. With respect to the filing of a rate change for a previously filed form, the standards of this subsection shall be met.

(a) Both (i) and (ii) as follows shall be at least as great as the standards in Subsection 5(1) and shall include interest in the calculation of benefits, premiums and present values:

(i) the anticipated loss ratio over the entire period for which the changed rates are computed to provide coverage; and

(ii) the ratio of (A) and (B); where

(A) is the sum of the accumulated benefits, from the original effective date of the form to the effective date of the change, and the present value of future benefits; and

(B) is the sum of the accumulated premiums from the original effective date of the form to the effective date of the change and the present value of future premiums, the present values to be taken over the entire period for which the changed rates are computed to provide coverage, and the accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date an accounting was made to the effective date of the change.

(b) If an insurer wishes to charge a premium for policies issued on or after the effective date of the change, which is different from the premium charged for the policies issued prior to the change date, then with respect to policies issued prior to the effective date of the change the requirements of Subsection R590-85-2(a) must be satisfied, and with respect to policies issued on and after the effective date of the change, the standards are the same as in Subsection 5(1), except that the average annual premium shall be determined based on an actual rather than an anticipated distribution of business.

(c) Companies must review their experience periodically and file rate changes, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases. A rate filing requesting an increase may be prohibited if a company has failed to file rate changes in a timely manner.

R590-85-6. Enforcement Date.

The commissioner will begin enforcing the revised provision of this rule 45 days from the rule's effective date.

R590-85-7. Separability.

If any provision of this rule or the application of it to any person is for any reason held to be invalid, the remainder of the rule and the application of any provision to other persons or circumstances may not be affected.

KEY: insurance law

January 31, 2006	**31A-2-201**
Notice of Continuation April 4, 2017	**31A-22-605**
	31A-22-620

R590. Insurance, Administration.
R590-108. Interest Rate During Grace Period or Upon Reinstatement of Policy.
R590-108-1. Authority.

This rule is promulgated by the Commissioner of Insurance under Sections 31A-2-201(3) to adopt rules to implement the provisions of the Utah Insurance Code, and specifically Sections 31A-22-402 and 31A-22-407(1) authorizing the commissioner to establish by rule the rate of interest an insurer may charge in a life insurance or annuity contract upon premiums due or overdue during a grace period or upon subsequent reinstatement of the contract.

R590-108-2. Purpose.

The purpose of this rule is to establish the rate of interest an insurer may charge upon premiums due under a life insurance or annuity contract during a grace period or upon subsequent reinstatement of the contract.

R590-108-3. Definitions.

For the purpose of this rule the commissioner adopts the definitions as particularly stated in Section 31A-1-301.

R590-108-4. Rule.

Under Sections 31A-22-402 and 31A-22-407(1), an insurer is authorized to impose and collect an interest charge upon payment of premiums due or overdue during a grace period or upon subsequent reinstatement of a life insurance policy or annuity contract. The rate of interest to be charged shall be the rate set within the policy, but may not exceed the rate of interest in the policy for policy loans. In the absence of a policy loan provision within the policy, the insurer may not impose or collect an interest charge in excess of the maximum interest rate of 8% as established for policy loans under Section 31A-22-420.

R590-108-5. Penalties.

Any insurer that fails to comply with the provisions of Sections 31A-22-402 and 31A-22-407(1), or with this rule shall be subject to the forfeiture provisions of Section 31A-2-308.

R590-108-6. Separability.

If any provisions of this rule or the application of it to any person is for any reason held to be invalid, the remainder of the rule and the application of any provision to other persons or circumstances may not be affected.

KEY: insurance companies

1987	**31A-2-201**
Notice of Continuation April 4, 2017	**31A-22-402**
	31A-22-407

R590. Insurance, Administration.
R590-120. Surety Bond Forms.
R590-120-1. Authority.

This rule is promulgated pursuant to Subsection 31A-2-201(3) which authorizes rules to implement the Utah Insurance Code, and Subsection 31A-21-101(5) which authorizes rules exempting classes of insurance contracts from any or all provisions of Chapter 21, Title 31A of the Utah Code.

R590-120-2. Purpose and Scope.

The purpose of this rule is to exempt certain surety bond forms from the form filing requirements and other requirements of Chapter 21.

This rule shall apply to all insurers transacting surety insurance in this state.

R590-120-3. Rule.

(1) Surety insurance forms, except bail bond insurance forms, are exempt from the following provisions of Chapter 21: Sections 31A-21-106, 31A-21-201, 31A-21-303, 31A-21-308 and 31A-21-312.

(2) Bail bond surety forms used by surety insurers and bail bond surety companies must be filed in accordance with 31A-21-201.

R590-120-4. Severability.

If any provision of this rule or its application 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 circumstance may not be affected.

KEY: insurance rule

June 4, 1999	**31A-2-201**
Notice of Continuation April 4, 2017	**31A-21-101**

R590. Insurance, Administration.
R590-146. Medicare Supplement Insurance Standards.
R590-146-1. Authority.

This rule is issued pursuant to the authority vested in the commissioner under Section 31A-22-620 requiring the commissioner to adopt rules to establish minimum standards for individual and group Medicare supplement insurance.

R590-146-2. Purpose.

The purpose of this rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare; and to establish rating and reporting requirements.

R590-146-3. Applicability and Scope.

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this rule shall apply to:

(1) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

(2) all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This rule shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination, of the labor organizations.

R590-146-4. Definitions.

For purposes of this rule:

A. "Applicant" means:

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) in the case of a group Medicare supplement policy, the proposed certificateholder.

B. "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

F. "Creditable coverage" has the same meaning as provided in Section 31A-1-301.

G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002, Employee Retirement Income Security Act.

H. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

I. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

J. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

(1) coordinated care plans which provide health care services, including but not limited to health maintenance organization plans, with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

L.(1) "Medicare supplement policy" means a group or individual policy of accident and health insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, 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 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(2) "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan, HCPP, that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

M. "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to December 12, 1994.

N. "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 30, 1992 and with an effective date of coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

O. "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date of coverage on or after June 1, 2010.

P. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Q. "Secretary" means the Secretary of the United States Department of Health and Human Services.

R590-146-5. Policy Definitions and Terms.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms, which conform to the requirements of this section.

A. "Accident," "accidental injury," or "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.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person

which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following:

"Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

R590-146-6. Policy Provisions.

A. Except for permitted preexisting condition clauses as described in Subsections 7.A.(1), 8.A.(1), and 8a.A.(1) of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D. (1) Subject to Subsections 7.A.(4), (5) and (7) and 8.A.(4) and (5) of this rule, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan, and;

(b) Premiums are adjusted to reflect the elimination of outpatient prescription coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

R590-146-7. Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to July 30, 1992.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

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

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in this Subsection (5)(d), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection 8a.B. of this rule.

(c) If membership in a group is terminated, the issuer shall:

(i) offer the certificateholder the conversion opportunities described in Subsection (b); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. Minimum Benefit Standards. Every issuer shall include the following benefits:

(1) coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) coverage under Medicare Part A for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations or already paid for under Part B;

(6) coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible, $100; and

(7) effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

R590-146-8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992 and with an Effective Date for Coverage Prior to June 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992 and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

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

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection (5)(e), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder:

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificateholder the conversion opportunity described in Subsection (5)(c); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in

determining a continuous loss.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed 24 months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period.

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

(d) Reinstitution of coverages as described in Subsections (b) and (c):

(i) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 plan, as described in Section 9 of this rule, to a 2010 plan , as described in Section 9a of this rule, the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the commissioner if the insured replaces a 1990 Plan policy or certificate with an issue age rated 2010 Plan policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer shall be filed with the commissioner.

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(c) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 plan policy for certificate of the insured, but may apply pre-existing condition limitations of no more than six months to any added benefits contained in the new 2010 plan policy or certificate not contained in the exchanged policy.

(d) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

B. Standards for Basic, Core, Benefits Common to All Benefit Plans A through J.

Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system, PPS, rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans B through J only as provided by Section 9 of this rule.

(1) Medicare Part A Deductible: Coverage for all the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) 80% of the Medicare Part B Excess Charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) 100% of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not

covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit.

(a) Coverage for the following preventive health services not covered by Medicare:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from Subsection (b) and patient education to address preventive health care measures; and

(ii) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(b) Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology, AMA CPT, codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations

(i) At-home recovery services provided shall be primarily services, which assist in activities of daily living.

(ii) The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and

(VIII) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

D. Standards for Plans K and L.

(1) Standardized Medicare supplement benefit plan K shall consist of the following:

(a) coverage of 100 % of the part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system, PPS, rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subsection (j);

(e) skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subsection (j);

(f) hospice Care: Coverage for 50% of the cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subsection (j);

(g) coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subsection (j);

(h) except for coverage provided in Subsection (i) below, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subsection (j) below;

(i) coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) coverage of 100% of all cost sharing under Medicare Part A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Part A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Subsections D.(1)(a), (b), (c) and (i);

(b) The benefits described in Subsections D.(1) (d), (e), (f), (g) and (h), but substituting 75% for 50%; and

(c) The benefit described in Subsection D.(1)(j), but substituting $2000 for $4000.

R590-146-8a. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date of coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of Section 9 of this rule.

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

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

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from a sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection A.(5)(e), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificateholder the conversion opportunity described in Subsection (A)(5)(c); or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period, not to exceed 24-months, in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90-days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within 90-days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

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

(d) Reinstitution of coverages as described in Subsections (7)(b) and (c):

(i) shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

B. Standards for Basic, Core, Benefits Common to

Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system, PPS, rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations.

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(6) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, N as provided by Section 9a.

(1) Medicare Part A Deductible: Coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for 100% of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One hundred percent, 100%, of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

R590-146-9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery After July 30, 1992 and with an Effective Date for Coverage Prior to June 1, 2010.

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Subsection 8.B. of this rule.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in Subsection 9.G. and Section 10 of this rule.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A through L listed in this section and conform to the definitions in Section 4 of this rule. Each benefit shall be structured in accordance with the format provided in Subsections 8.B. and 8.C., or 8.D. and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan A shall be limited to the basic, core, benefits common to all benefit plans, as defined in Subsection 8.B. of this rule.

(2) Standardized Medicare supplement benefit plan B shall include only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible as defined in Subsection 8.C.(1).

(3) Standardized Medicare supplement benefit plan C shall include only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Subsections 8.C.(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan D shall include only the following: The core benefit, as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Subsections 8.C.(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan E shall include only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Subsections 8.C.(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan F shall include only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8.C.(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare supplement benefit high deductible plan F shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8.C.(1), (2), (3), (5) and (8) respectively. The annual high deductible plan F

deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplement benefit plan G shall include only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Subsections 8.C.(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare supplement benefit plan H shall consist of only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Subsections 8.C.(1), (2), (6) and (8) respectively. The prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan I shall consist of only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Subsections 8.C.(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan J shall consist of only the following: The core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Subsections 8.C.(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan J shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefit as defined in Subsection 8.B. of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Subsections 8.C.(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(F) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, MMA.

(1) Standardized Medicare supplement benefit plan K shall consist of only those benefits described in Subsection 8.D.(1).

(2) Standardized Medicare supplement benefit plan L shall consist of only those benefits described in Subsection 8.D.(2).

(G) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

R590-146-9a. Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date of coverage before June 1, 2010 remain subject to the requirements of Sections 8a and 9 of this rule.

A.(1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Subsection 8a.B. of this rule.

(2) If an issuer makes available any of the additional benefits described in Subsection 8a.C., or offers standardized benefit Plan K or L, as described in Subsections 9a.E.(8) and (9) of this rule, then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic core benefits as described in Subsection (1), a policy form or certificate form containing either standardized benefit Plan C, as described in Subsection 9a.E.(3) of this rule, or standardized benefit Plan F, as described in Subsection 9a.E.(5) of this rule.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Subsection shall be offered for sale in this state, except as may be permitted in Subsection 9a.F. and in Section 10 of this rule.

C. Benefit plan shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in Section 4 of this rule. Each benefit shall be structured in accordance with the format provide in Subsections 8a.B. and C. of this rule; or, in the case of plans K or L, in Subsections 9a.E.(8) or (9) of this rule and list the benefits in the order shown. For purposes of this subsection, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C, an issuer may use other designations to the extent permitted by law.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic core benefits as defined in Subsection 8a.B. of this rule.

(2) Standardized Medicare supplement benefit Plan B

shall include only the following: the basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible as defined in Subsection 8a.C.(1) of this rule.

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3), (4), and (6) of this rule, respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3), and (6) of this rule, respectively.

(5) Standardized Medicare supplement benefit Plan F shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3), (4), (5), and (6) of this rule, respectively.

(6) Standardized Medicare supplement benefit Plan F With High Deductible shall include only the following: 100% of covered expenses following the payment of the annual deductible set forth in Subsection (b).

(a) The basic core benefit as defined in Subsection 8a.B. of this rule, 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3), (4), (5), and (6) of this rule, respectively.

(b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3), (5), and (6) of this rule, respectively.

(8) Standardized Medicare supplement benefit Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) Part A Hospital Coinsurance 61st through 90th days: Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period:

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period:

(c) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system, PPS, rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance:

(d) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subsection (j):

(e) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subsection (j):

(f) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subsection(j):

(g) Blood: Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subsection (j):

(h) Part B Cost Sharing: Except for coverage provided in Subsection (i), coverage of 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subsection (j):

(i) Part B Preventive Services: Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement benefit Plan L is mandated by The Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in Subsections (8)(a), (b), (c) and (i);

(b) The benefit described in Subsections (8)(d), (e), (f), (g) and (h), but substituting 75% for 50%; and

(c) The benefit described in Subsection (8)(j), but substituting $2000 for $4000.

(10) Standardized Medicare supplement benefit Plan M shall include only the following:

The basic core benefit as defined in Subsection 8a.B. of this rule, plus 50% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign county as defined in Subsections 8a.C.(2), (3) and (6) of this rule, respectively.

(11) Standardized Medicare supplement benefit Plan N shall include only the following: The basic core benefit as defined in Subsection 8a.B. of this rule, plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Subsections 8a.C.(1), (3) and (6) of this rule, respectively, with copayments in the following amounts;

(a) the lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and

(b) the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however,

this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

F. New or Innovative Benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

R590-146-10. Medicare Select Policies and Certificates.

A.(1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act, OBRA, of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this rule.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(b) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals;

(c) there are written agreements with network providers describing specific responsibilities;

(d) emergency care is available 24 hours per day and seven days per week; and

(e) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subsection shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate;

(2) a statement or map providing a clear description of the service area;

(3) a description of the grievance procedure to be utilized;

(4) a description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted;

(5) a list and description, by specialty, of the network providers;

(6) copies of the written information proposed to be used by the issuer to comply with Subsection I; and

(7) any other information requested by the commissioner.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes.

(2) Any changes to the list of network providers shall be filed with the commissioner within 30 days of the change. The submission must include all network providers and clearly identify the new and discontinued providers.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) it is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates;

(2) a description, including address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when

providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than March 31 of each calendar year to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M.(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

R590-146-11. Open Enrollment.

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this section without regard to age.

B.(1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

R590-146-12. Guaranteed Issue for Eligible Persons.

A. Guaranteed Issue.

(1) Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not

discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons.

An eligible person is an individual described in any of the following subsections:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of All-Inclusive Care for the Elderly, PACE, provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) the certification of the organization or plan has been terminated;

(b) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, or the plan is terminated for all individuals within a residence area;

(d) the individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) the organization, or producer or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) the individual meets such other exceptional conditions as the Secretary may provide.

(3)(a) The individual is enrolled with:

(i) an eligible organization under a contract under Section 1876 of the Social Security Act, Medicare cost;

(ii) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) an organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act, health care prepayment plan; or

(iv) an organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage in Subsection 12B(2).

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a)(i) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) of other involuntary termination of coverage or enrollment under the policy;

(b) the issuer of the policy substantially violated a material provision of the policy; or

(c) the issuer, or a producer or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5)(a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act, Medicare cost, any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under Subsection (a) is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment, during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act; or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare, enrolls in a Medicare Advantage plan under part C of Medicare, or in a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

(8) The individual is enrolled under medical assistance under Title XIX of the Social Security Act, Medicaid, and is involuntarily terminated outside of requirements of Subsections 8.A.(7)(a) and (b).

C. Guaranteed Issue Time Periods.

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of:

(a) the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a noticed is not received, noticed that a claim has been denied because of a termination or cessation; or

(b) the date that the applicable coverage terminates or ceases; and ends sixty-three days thereafter;

(2) In case of an individual described in Subsections B(2), (3), (5) or (6), whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three days after the date applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of:

(a) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and

(b) the date that the applicable coverage is terminated, and ends on the date that is sixty-three days after the date the coverage is terminated;

(4) In case of an individual described in Subsections B(2), (4)(b) and (c), (5) or (6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty days before the effective date of the disenrollment and ends on the day that is sixty-three days after the effective date;

(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial

Part D enrollment period ends on the date that is sixty-three days after the effective date of the individual's coverage under Medicare Part D; and

(6) In case of an individual described in Subsection B but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on that date that is sixty-three days after the effective date.

D. Extended Medigap Access for Interrupted Trial Periods

(1) In the case of an individual described in Subsection B(5), or deemed to be so described, pursuant to this subsection, whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve-months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Subsection B(5);

(2) In the case of an individual described in Subsection B(6), or deemed to be so described, pursuant to this subsection, whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve-months of enrollment, and who, without an intervening enrollments, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Subsection B(6).

(3) For the purposes of Subsections B(5) and (6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this subsection after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

(1) Subsections B(1), (2), (3), (4), and (8) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F, including F with a high deductible, K or L offered by any issuer.

(2)(a) Subject to Subsection (b), Subsection B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subsection (1);

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with a outpatient prescription drug benefit, a Medicare supplement policy described in this subsection is:

(i) the policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) at the election of the policyholder, an A, B, C, F, including F with a high deductible, K or L policy that is offered by any issuer;

(3) Subsection B(6) shall include any Medicare supplement policy offered by any issuer;

(4) Subsection B(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, including F with a high deductible, K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

F. Notification provisions.

(1) At the time of an event described in Subsection B because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

R590-146-13. Standards for Claims Payment.

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act, as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987, OBRA, 1987, Pub. L. No. 100-203, by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

R590-146-14. Loss Ratio Standards and Refund or Credit of Premium.

A. Loss Ratio Standards.

(1)(a) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form:

(i) at least 75% of the aggregate amount of premiums earned in the case of group policies; or

(ii) at least 65% of the aggregate amount of premiums earned in the case of individual policies.

(b) The loss ratio shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) home office and overhead costs;

(ii) advertising costs;

(iii) commissions and other acquisition costs;

(iv) taxes;

(v) capital costs;

(vi) administration costs; and

(vii) claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards, and comply with the requirements of R590-85.

(3) For purposes of applying Subsections (1) and 15.D.(3) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual policies.

(4) For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet:

(a) the originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) the appropriate loss ratio requirement from Subsections A(1)(a)(i) and (ii) when combined with actual experience beginning with the effective date of October 31, 1994 as set forth in Bulletin 94-8; and

(c) the appropriate loss ratio requirement from Subsections A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation.

(1) An issuer shall collect and file with the commissioner by May 31 of each year each applicable form;

(a) Medicare Supplement Refund Calculation;

(b) Calculation of Benchmark Ratio Since Inception for Group Policies; and

(c) Calculation of the Benchmark Ratio Since Inception For Individual Policies.

(2) If on the basis of the experience as reported the benchmark ratio since inception, ratio 1, exceeds the adjusted experience ratio since inception, ratio 3, then a refund or credit calculation, is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after the effective date of this rule. The first report shall be due by May 31 each year.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Filing of Premium Rates.

(1) Annual Filing of Premium Rates Report.

(a) An issuer of Medicare supplement policies and certificates issued before or after the effective date of July 30, 1992 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three years.

(b) The Annual Filing of Premium Rates Report shall be filed no later than May 31 each year, and in compliance with R590-220.

(2)(a) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state, appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(c) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings.

The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of July 30, 1996 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

R590-146-15. Filing of Policies, Certificates, and Premium Rates.

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed for use in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed for acceptance in accordance with the filing requirements and procedures prescribed by the commissioner, and Rule R590-85.

D.(1) Except as provided in Subsection (2) an issuer shall not file more than one form of a policy or certificate of each

type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) the inclusion of new or innovative benefits;

(b) the addition of either direct response or producer marketing methods;

(c) the addition of either guaranteed issue or underwritten coverage;

(d) the offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

E.(1) Except as provided in Subsection (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer may no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subsection (a) shall not file a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Subsection (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential, which is in the public interest.

F.(1) Except as provided in Subsection (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Rule R590-146-14.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

R590-146-16. Permitted Compensation Arrangements.

A. An issuer or other entity may provide commission or other compensation to a producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period and shall be provided for no fewer than five renewal years.

C. No issuer or other entity may provide compensation to its producers and no producer may receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finder's fees.

R590-146-17. Required Disclosure Provisions.

A. General Rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate section of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6)(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services, CMS, in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies

or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

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

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

C. MMA Notice Requirements.

Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies.

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

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

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

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

(4) The Outline of Medicare Supplement Coverage, from the National Association of Insurance Commissioners, dated 1998, as incorporated by reference herein, is available for public inspection at the Insurance Department.

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act, 42 U.S.C. 1395 et seq.; a disability income policy; or other policy identified in Subsection 3B of this rule; issued for delivery in this state to persons eligible for Medicare, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

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

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Subsection 25.E., the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

R590-146-18. Requirements for Application Forms and Replacement Coverage.

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

TABLE I

(Statements)
(Boldface Type)

(1) You do not need more than one Medicare supplement policy.
(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary(SLMB).

Questions
(Boldface Type)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with the application. PLEASE ANSWER ALL QUESTIONS.
(Please mark Yes or No below with an "X")
To the best of your knowledge,
(1)(a) Did you turn age 65 in the last 6 months?
Yes No
(b) Did you enroll in Medicare Part B in the last 6 months?
Yes No
(c) If yes, what is the effective date?
(2) Are you covered for medical assistance through the state Medicaid program?
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)
YES NO
(a) Will Medicaid pay your premiums for this Medicare supplement policy?
YES NO
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
YES NO
(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START / / END / /
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
YES NO
(c) Was this your first time in this type of Medicare plan?
YES NO
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?
YES NO
(4)(a) Do you have another Medicare supplement policy in force?
YES NO
(b) If so, with what company, and what plan do you have (optional for Direct Mailers)?
.....
(c) If so, do you intend to replace your current Medicare supplement policy with this policy?
YES NO
(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
YES NO
(a) If so, with what company and what kind of policy?
.....
.....
.....
.....
(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.
START / / END / /

B. Producers shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five years, which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the producer, except where the coverage is sold without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than 12-point type:

TABLE II
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE

(Boldface Type)
(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.
(Boldface Type)

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage.

You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.
STATEMENT TO APPLICANT BY ISSUER, PRODUCER (BROKER OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan.
The replacement policy is being purchased for the following reason(s) (check one):
..... Additional benefits.
..... No change in benefits, but lower premiums.
..... Fewer benefits and lower premiums.
..... My plan has outpatient prescription drug coverage and I am enrolling in Part D.
..... Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. (optional only for Direct Mailer.)
..... Other. (please specify)

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. 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.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, 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

concerning your medical and 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, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

.....
(Signature of Producer, Broker or Other Representative)

(Typed Name and Address of Issuer, Producer or Broker)

.....
(Applicant's Signature)
.....
(Date)

Signature not required for direct response sales.

F. Subsections 1 and 2 of the replacement notice, applicable to preexisting conditions, may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

R590-146-19. Filing Requirements for Advertising.

An issuer shall, upon specific request from the commissioner, file for use a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, electronic, or television medium.

R590-146-20. Standards for Marketing.

A. An issuer, directly or through its producers, shall:

(1) establish marketing procedures to assure that any comparison of policies by its producers will be fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued.

(3) display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses"

(4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

(5) establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in Section 31A-23-302, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

R590-146-21. Appropriateness of Recommended Purchase and Excessive Insurance.

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

R590-146-22. Reporting of Multiple Policies.

A. On or before May 31 of each year, an issuer shall file the report form under Subsection 25.D. for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) policy and certificate number; and

(2) date of issuance.

B. The items set forth above shall be grouped by individual policyholder.

R590-146-23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

R590-146-24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing.

This section applies to all policies with policy years beginning on or after May 21, 2009.

A. An issuer of a Medicare supplement policy or certificate:

(1) shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

(2) shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates)of an individual on the basis of the genetic information with respect to such individual.

B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

(1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members

and to further increase the premium for the group.

C. An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Subsection C shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996 as may be revised from time to time) and consistent with Subsection A.

E. For purposes of carrying out Subsection D, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(a) compliance with the request is voluntary; and

(b) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

G. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

H. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

I. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.

J. For the purposes of this section only:

(1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual, who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means,

(a) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(b) the computation of premium or contribution amounts under the policy;

(c) the application of any pre-existing condition exclusion under the policy; and

(d) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

R590-146-25. Documents Incorporated by Reference.

The following filing documents are hereby incorporated by reference within this rule and are available for public inspection at the Insurance Department or at www.insurance.utah.gov. These forms were adopted by the National Association of Insurance Commissioners' Model Regulation number 651, as approved October 2008:

A. "MEDICARE SUPPLEMENT REFUND CALCULATION FORM;"

B. "REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES;"

C. "REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES;"

D. "FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES;"

E. "DISCLOSURE STATEMENTS;" and

F. "OUTLINE OF MEDICARE SUPPLEMENT COVERAGE."

R590-146-26. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under 31A-2-308.

R590-146-27. Enforcement Date.

The commissioner will begin enforcing the provisions of this rule 45 days from the effective date of the rule.

R590-146-28. Severability.

If any provision of this rule or its application to any person or situation is held to be invalid, that 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: insurance
September 15, 2009 31A-22-620
Notice of Continuation April 4, 2017

R590. Insurance, Administration.
R590-203. Health Grievance Review Process.
R590-203-1. Authority.

This rule is specifically authorized by Subsections 31A-22-629(4) and 31A-4-116, which requires the commissioner to establish minimum standards for grievance review procedures. The rule is also promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. The authority to examine carrier records, files, and documentation is provided by Section 31A-2-203.

R590-203-2. Purpose.

The purpose of this rule is to ensure that a carrier's grievance review procedures for individual and group health insurance and disability income insurance plans comply with 29 CFR 2560.503-1, and Sections 31A-4-116 and 31A-22-629.

R590-203-3. Applicability and Scope.

(1) This rule applies to individual and group:
(a) health care insurance;
(b) disability income policies; and
(c) health maintenance organization contracts.
(2) Long Term Care and Medicare supplement policies are not considered health insurance for the purpose of this rule.
(3) Disability income policies are exempt from R590-203-6.
(4) This rule does not apply to a health benefit plan that complies with R590-261, Health Benefit Plan Adverse Benefit Determinations.

R590-203-4. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purposes of this rule:
(1)(a) "Adverse benefit determination" means the:
(i) denial of a benefit;
(ii) reduction of a benefit;
(iii) termination of a benefit; or
(iv) failure to provide or make payment, in whole or in part, for a benefit.
(b) "Adverse benefit determination" includes:
(i) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a plan;
(ii) a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; and
(iii) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:
(A) experimental;
(B) investigational; or
(C) not a medical necessity or appropriate.
(2) "Carrier" means any person or entity that provides health insurance or disability income insurance in this state including:
(a) an insurance company;
(b) a prepaid hospital or medical care plan;
(c) a health maintenance organization;
(d) a multiple employer welfare arrangement; and
(e) any other person or entity providing a health insurance or disability income insurance plan under Title 31A.
(3) "Consumer Representative" may be an employee of the carrier who is a consumer of a health insurance or a disability income policy, as long as the employee is not:
(a) the individual who made the adverse determination; or
(b) a subordinate to the individual who made the adverse determination.
(4) "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 its 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; and
(b) that 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) scientific evidence;
(B) professional standards; and
(C) expert opinion.
(5)(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.
(6)(a) "Urgent care claim" means a request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination:
(i) could seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or
(ii) in the opinion of a physician with knowledge of the insured's medical condition, would subject the insured to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
(b)(i) Except as provided in Subsection (6)(a)(ii), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
(ii) Any request that a physician with knowledge of the insured's medical condition determines is an urgent care request within the meaning of Subsection (6)(a) shall be treated as an urgent care claim.

R590-203-5. Adverse Benefit Determination.

(1) A carrier's adverse benefit determination review procedure shall be compliant with the adverse benefit determination review requirements set forth in 29 CFR 2560.503-1, effective January 20, 2001. This document is incorporated by reference and available for inspection at the Insurance Department.
(2) A carrier's adverse benefit determination appeal board or body shall include at least one consumer representative that shall be present at every meeting.

R590-203-6. Independent and Expedited Adverse Benefit

Determination Reviews for Health Insurance.

(1) A carrier shall provide an independent review procedure as a voluntary option for the resolution of adverse benefit determinations of medical necessity.

(2) An independent review procedure shall be conducted by an independent review organization, person, or entity other than the carrier, the plan, the plan's fiduciary, the employer, or any employee or agent of any of the foregoing, that do not have any material professional, familial, or financial conflict of interest with the health plan, any officer, director, or management employee of the health plan, the enrollee, the enrollee's health care provider, the provider's medical group or independent practice association, the health care facility where service would be provided and the developer or manufacturer of the service being provided.

(3) Independent review organizations shall be designated by the carrier, and the independent review organization chosen shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with a health insurance plan, a national, state, or local trade association of health insurance plans, and a national, state, or local trade association of health care providers.

(4) The submission to an independent review procedure is purely voluntary and left to the discretion of the claimant.

(5) A carrier's voluntary independent review procedure shall:

(a) waive any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a dispute of medical necessity to a voluntary level of appeal provided by the plan;

(b) agree that any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending;

(c) allow a claimant to submit a dispute of medical necessity to a voluntary level of appeal only after exhaustion of the appeals permitted under 29 CFR Subsection 2560.503-1(c)(2);

(d) upon request from any claimant, provide sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed decision about whether to submit a dispute of medical necessity to the voluntary level of appeal. This information shall contain a statement that the decision to use a voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, and the process for selecting the decision maker.

(e) An independent review conducted in compliance with Section 31A-22-629, and this rule, can be binding on both parties. A claimant's submission to a binding independent review is purely voluntary and appropriate disclosure and notification must be given as required by 29 CFR 2560.503-1.

(6) Standards for voluntary independent review:

(a) The carrier's internal adverse benefit determination process must be exhausted unless the carrier and claimant mutually agree to waive the internal process.

(b) Any adverse benefit determination of medical necessity may be the subject of an independent review.

(c) The claimant has 180 calendar days from the date of the final internal review decision to request an independent review.

(d) A carrier shall use the same minimum standards and times of notification requirement for an independent review that are used for internal levels of review, as set forth in 29 CFR Subsection 2560.503-1(h)(3), (i)(2) and (j).

(7) A carrier shall provide an expedited review process for cases involving urgent care claims.

(8) A request for an expedited review of an adverse benefit determination of medical necessity may be submitted either orally or in writing. If the request is made orally a carrier shall, within 24 hours, send written confirmation to the claimant acknowledging the receipt of the request for an expedited review.

(9) An expedited review requires:

(a) all necessary information, including the plan's original benefit determination, be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method;

(b) a carrier to notify the claimant of the benefit review determination, as soon as possible, taking into account the medical urgency, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination; and

(c) a carrier to use the same minimum standard for timing and notification as set forth in 29 CFR Subsection 2560.503-1(h), 503-1(i)(2)(i), and 503-1(j).

(10) This section, R590-203-6, does not apply to disability income policies.

R590-203-7. Disability Income Adverse Benefit Determination Review.

(1) A carrier will notify a claimant of the benefit determination within 45 days of receipt of the claimant's request for review of an adverse benefit determination.

(2) The time period for making a determination on review may be extended for up to 45 days when necessary due to matters beyond the control of the carrier.

(3) If the time period is extended due to the claimant's failure to submit information necessary to decide a claim, the time period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent until the date on which the claimant responds to the request for additional information.

(4) Upon request, relevant information, free-of-charge, must be provided to the claimant on any adverse benefit determination.

R590-203-8. File and Record Documentation.

A carrier shall:

(1) make available upon request by the commissioner all adverse benefit determination review files and related documentation; and

(2) shall maintain these records for the current calendar year plus five years.

R590-203-9. Enforcement Date.

The commissioner shall begin enforcing the revised provisions of this rule on the effective date.

R590-203-10. Severability.

If a provision or clause of this rule or its application to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of these provisions shall not be affected.

KEY: insurance

December 8, 2011	**31A-2-201**
Notice of Continuation April 4, 2017	**31A-2-203**
	31A-4-116
	31A-22-629

R590. Insurance, Administration.
R590-239. Exemption of Student Health Centers From Insurance Code.
R590-239-1. Authority.

This rule is promulgated and adopted pursuant to Subsection 31A-1-103(3)(d) and Section 31A-2-201.

R590-239-2. Purpose and Scope.

(1) The purpose of this rule is to exempt student health centers established by institutions of higher education from regulation under the Utah Insurance Code.

(2) Health insurance from an insurer made available by an institution to its students is not exempt from provisions of the Utah Insurance Code under this rule, even if use of the institution's student health center is an integral part of the health care coverage under the insurer's policy.

R590-239-3. Definitions.

(1) All definitions in Section 31A-1-301 are incorporated by reference.

(2) "Board" means the State Board of Regents established in Section 53B-1-103.

(3) "Eligible recipient" means:

(a) an eligible student;

(b) a spouse of an eligible student;

(c) a child of, dependent of, or child placed for adoption with, an eligible student;

(d) the institution's officers, faculty, and employees; or

(e) upon application by the institution or the institution's student health center, other persons approved by written order of the commissioner.

(4) "Eligible student" is as defined by each institution, but shall, at a minimum, require that the student be enrolled with the institution.

(5) "Health care provider" means a person who provides health care services.

(6) "Health care services" means "health care," as defined in Section 31A-1-301.

(7) "Institution" means an institution of higher education or postsecondary educational institute that consists of the following:

(a) an institution described in Section 53B-1-102; or

(b) an institution of high education that has been accredited by the Northwest Commission on Colleges and Universities.

(8) "Student health center" means a facility that is operated to provide health care services to eligible recipients:

(a) by that institution or pursuant to contract with that institution;

(b) that employs health care providers, or contracts with health care providers, which may make referrals to other health care providers;

(c) is funded, at least in part, by payment from one of the following sources, which payment grants access to the student health center during the period of time for which the eligible student is registered:

(i) a fee assessed to and paid by each eligible student at registration, which; or

(ii) the tuition paid by the eligible student;

(d) may accept insurance payments, or assist users in completing claims forms for insurance claims; and

(e) may require eligible recipients to pay;

(i) an additional fee for each time the student health center is visited;

(ii) an additional fee for specialty services;

(iii) an additional fee for medical equipment; or

(iv) an additional fee for medication received at the student health center.

(9) "Utah Insurance Code" means Title 31A, Utah Code Annotated.

R590-239-4. Supporting Facts.

(1) Many institutions of higher education establish student health centers to provide for limited health care needs to eligible recipients. A student health center arranges for health care services to be provided by employing health care providers at the student health center, or by contracting with health care providers to provide health care services at the student health center or other facilities, which are usually located in close proximity to the institution's campus. The student health center may also contract with specialists to come to the student health center on a periodic basis, or to provide services off-campus when the student health center provides a referral to that specialist.

(2) The operation of the student health center is paid at least in part either out of funds generated by the tuition of eligible students or from a fee for that express purpose that each eligible student is required to pay at the beginning of the quarter, semester, or school year, usually at the same time tuition and other fees are required to be paid. In return, the eligible student has the right to receive these limited health care services at the student health center during the ensuing quarter, semester, or school year. Eligible students usually pay a nominal fee each time they use the facility.

(3) The student health center does not provide all services required of a health maintenance organizations under the definition of "basic health care services," but does enter into arrangements with at least some of the persons listed in the definition of a limited health plan to provide health care services to the institution's eligible recipients, 31A-8-101. Therefore, while a student health center is not within the definition of a health maintenance organization, it does come within the definition of limited health plan. As such, unless exempted by statute or administrative rule, a student health center is subject to regulation under the Insurance Code.

(4) Institutions have an interest in providing their eligible students with basic preventive and remedial health care in order to reduce the possibility that progress toward a degree will be impeded by unattended medical needs. In addition, institutions have an interest in mitigating the potential economic hardships placed on health care providers directly, and the public in general, from the institutions' eligible students receiving medical services and then not being able to pay for those services.

(5) To meet these basic medical needs of their students, and reduce any potential negative impact on local health care providers and the public, many institutions have established student health centers. Other than perhaps treating a visitor on campus occasionally on an emergency basis, student health centers provide health care services only to eligible students at institutions, and, in some cases, to other eligible recipients. Providing health care services or arranging for health care services for students is not the primary purpose of institutions of higher education; it is only incidental to the institutions' primary purpose, which is to educate those that matriculate with the institution. Student health centers are not established to enable the institutions of higher education to make a profit from providing health care services at the student health center.

(6) An institution is either a state institution under the direct control of, and supervised by, the Board, or it must be accredited by a regional accreditation organization. In order to be accredited, an institution must meet strict accounting standards, and be able to demonstrate it is financially solid. An institution must therefore comply with the strict accounting and financial requirements of the Board, or of a regional accrediting entity, which would include the need to reflect on the financial statements of the institution the liability for any risks the institution assumes, or costs the institutions may incur, for its student health center. Any shortfall in providing health care

services at the student health center would become the obligation of the institution. The institution can and must protect itself from financial shortfalls that could cause the providers to be left unpaid, and the students without health care services at the student health center; the institution does this by fixing the institution's liability either by employing the health care providers, or by contracting with health care providers for a fixed fee for the number of hours the health care provider is at the student health center, regardless of the number of patients/students the health care provider might see during that time. Since only limited health care services are provided at the student health center, there is little or no likelihood the institution will need to cover expenses such as major surgery, or extended hospital stays.

R590-239-5. Rule and Findings.

(1) Unless exempted from regulation by statute or by this rule, a student health center is a limited health plan, as defined in Chapter 8 of the Utah Insurance Code, and must comply with the provisions of the Utah Insurance Code.

(2) Health insurance made available to an institution's students through an insurer is not exempt from provisions of the Utah Insurance Code under this rule, even if:

(i) use of the institution's student health center is an integral part of the health care coverage offered to the institution's students; or

(ii) the health insurance offered to the institution's students requires initial treatment for any illness or injury be at the institution's student health center.

(3) Pursuant to Subsection 31A-1-103(3)(d)(i), the commissioner finds that student health centers established by institutions do not require regulation for the protection of the interests of the residents of this state and that student health centers are exempt from regulation under the Utah Insurance Code.

R590-239-6. Enforcement Date.

The commissioner will begin enforcing this rule 45 days from the rule's effective date.

R590-239-7. Severability.

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 such provision to other persons or circumstances shall not be affected thereby.

KEY: health insurance exemption
April 9, 2007 31A-1-103
Notice of Continuation April 4, 2017 31A-2-201

R590. Insurance Administration.
R590-248. Mandatory Fraud Reporting Rule.
R590-248-1. Authority.

This rule is promulgated pursuant to Section 31A-2-201(3)(a), which authorizes rules to implement the Insurance Code and 31A-31-110, which authorizes a rule to provide a process by which a person shall report a fraudulent insurance act.

R590-248-2. Purpose and Scope.

(1) The purposes of this rule are to:

(a) describe the required elements in a mandatory fraud report; and

(b) establish a reporting process for fraud reports.

(2) This rule applies to:

(a) all insurers doing the business of insurance in Utah; and

(b) all auditors employed by a title insurer doing the business of title insurance in Utah.

R590-248-3. Mandatory Elements of a Fraud Report.

A mandatory fraud report shall:

(1) be in writing;

(2) provide information in detail relating to:

(a) the fraudulent insurance act; and

(b) the perpetrator of the fraudulent insurance act; and

(3) state whether the person submitting the report of a fraudulent insurance act also reported the fraudulent insurance act in writing to:

(a) the attorney general;

(b) a state law enforcement agency;

(c) a criminal investigative department or agency of the United States;

(d) a district attorney; or

(e) the prosecuting attorney of a municipality or county; and

(4) state the agency to which the person reported the fraudulent insurance act.

R590-248-4. Mandatory Fraud Reporting Process.

(1) The following persons shall report a fraudulent insurance act to the commissioner if the person has a good faith belief on the basis of a preponderance of the evidence that a fraudulent insurance act is being, will be, or has been committed by:

(a) a person other than the person making the report:

(b) an insurer; or

(c) an auditor that is employed by a title insurer.

(2) An auditor employed by a title insurer shall report a fraudulent act to the title insurer and the title insurer shall report the fraudulent act in accordance with this subsection.

(3) An insurer shall submit mandatory fraud reports electronically.

(4) An insurer shall report a fraudulent insurance act by:

(a) submitting a report to the commissioner using the National Insurance Crime Bureau (NICB) fraud reporting system; or

(b) submitting a report directly to the commissioner using email sent to fraud@utah.gov.

R590-248-5. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

R590-248-6. Enforcement Date.

The commissioner will begin enforcing this rule 45 days from the rule's effective date.

R590-248-7. 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: insurance, mandatory fraud reporting
April 7, 2017 31A-2-201
Notice of Continuation December 23, 2013 31A-31-110

R590. Insurance, Administration.
R590-262. Health Data Authority Health Insurance Claims Reporting.
R590-262-1. Authority.

This rule is promulgated pursuant to Subsection 31A-22-614.5(3)(a) to coordinate with the provision of Subsection 26-1-37(2)(b) and Utah Department of Health rules R428-1 and R428-15.

R590-262-2. Purpose and Scope.

(1) This rule establishes requirements for certain entities that pay for health care to submit data to the Utah Department of Health.

(2) This rule allows the data to be shared with the state's designated secure health information master index person index, Clinical Health Information Exchange (cHIE), to be used:

(a) in compliance with data security standards established by:

(i) the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936: and

(ii) the electronic commerce agreements established in a business associate agreement;

(b) for the purpose of coordination of health benefit plans; and

(c) for the enrollment data elements identified in Utah Administrative Rule R428-15, Health Data Authority Health Insurance Claims Reporting.

(3)(a) This rule applies to an insurer offering:

(i) a health benefit plan; or

(ii) a dental plan.

(b) This rule does not apply to:

(i) an insurer that as of the first day of the reporting period:

(A) covers fewer than 2,500 individual Utah residents; or

(B) provides administrative services for fewer than 2,500 individual Utah residents covered under self-funded employee plans;

(ii) a fully insured employer group or self-funded employee plan whose primary place of business is outside the state of Utah and no more than 25% of the employees are residents of Utah;

(iii) a long-term care insurance policy; or

(iv) an income replacement policy.

(c) Except as provided in Subsection (4), this rule does not require a person to provide information concerning a self-funded employee plan.

(4)(a) The submission of health care claims data by an insurer on behalf of a self-funded employee plan is considered mandatory if and only if the self-funded employee plan opts-in under R590-262-7.

(b) An insurer is not obligated to submit data on behalf of a self-funded employee plan that fails to respond to opt-in requests required in R590-262-7.

R590-262-3. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purpose of this rule:

(1) "Claim" means a request or demand on an insurer for payment of a benefit.

(2) "Health care claims data" means information consisting of, or derived directly from, member enrollment, medical claims, and pharmacy claims that this rule requires an insurer to report.

(3) "Insurer" means:

(a) a person engaged in the business of offering a health benefit plan or a dental plan, including a business under an administrative services organization or administrative services contract arrangement;

(b) a third party administrator that collects premiums or settles claims for health care insurance policies;

(c) a governmental plan as defined in Section 414(d), Internal Revenue Code;

(d) a non-electing church plan as described in Section 410 (d), Internal Revenue Code; or

(e) a licensed professional employer organization that is acting as an administrator of a health care insurance policy.

(4) "Office" means the Office of Health Care Statistics within the Utah Department of Health, which serves as staff to the Utah Health Data Committee.

(5) "Reporting period" means a calendar year.

(6)(a) "Self-funded employee plan" means an employee welfare benefit plan as defined in 29 U.S.C. Section 1002(1) whose health coverage is provided other than through an insurance policy.

(b) Self-funded employee plan does not include:

(i) a governmental plan as defined in Section 414 (d), Internal Revenue Code;

(ii) a non-electing church plan as described in Section 410 (d), Internal Revenue Code; or

(iii) the Public Employees' Benefit and Insurance Program created in Section 49-20-103.

(7) "Technical specifications" means the technical specifications document published by the Health Data Committee describing the variables and formats of the data that are to be submitted as well as submission directions and guidelines.

R590-262-4. Reporting Requirements.

(1) Each insurer shall submit enrollment, medical claims, and pharmacy data described in R428-15-3 and R590-262-5, where Utah is the patient's primary residence, for services provided in or out of the state of Utah.

(2) Each insurer shall permit the Utah Department of Health to redisclose the enrollment and eligibility information with the state designated entity for the purpose of coordination of benefits.

(3) Each insurer shall submit monthly health care claims data. Each monthly submission is due no later than the last day of the following month.

R590-262-5. Reporting Process.

Submission procedures and guidelines are described in detail in the technical specifications published by the Health Data Committee. The health care claims data shall be formatted and submitted according to the technical specifications.

R590-262-6. Required Data Elements.

(1) The enrollment, medical claims, dental claims, and pharmacy data elements are described in detail in the technical specifications published by the Health Data Committee. Each insurer shall submit data for all fields contained in the submission specifications if the data are available to the insurer.

(2) Each insurer must submit the enrollment files, provider files, professional medical claims, institutional medical claims, and pharmacy claims data elements as required in R428-15.

R590-262-7. Voluntary Opt-In for Self-Funded Employee Plans.

(1)(a) Each insurer providing claim administration services for an employer who maintains a self-funded employee plan shall provide an employer a copy of the APCD Self-funded Employee Health Plan Opt-In form for purposes of determining whether an employer agrees to opt-in to submission of its self-funded employee plan's health care claims data as described in this rule.

(b) An insurer may use a form that they have developed for multi-state use instead of the form referenced in Subsection (1)(a) if the form is substantially similar and is approved by the Office in advance.

(c) Each insurer shall provide the APCD Self-funded Employee Health Plan Opt-In form:

(i) by December 15, 2016 for existing clients; or

(ii) within 15 days after claims administration services are retained and it is determined the employer meets the requirements of this section, for clients retained after December 1, 2016.

(2)(a) Except as provided in Subsections (b) and (c), an opt-in is effective for the reporting period in which it is signed and all future reporting periods. An employer may not opt-in for a partial reporting period.

(b) An opt-in signed by an employer and received by an insurer before March 1, 2017 shall be effective for the claims adjudicated in 2016 and not previously submitted to the Office, if otherwise required by this rule.

(c) An employer that has opted-in may opt-out for subsequent reporting periods by notifying the insurer in writing at least 30 days before the beginning of the next reporting period.

(3) For a self-funded employee plan whose employer has made an affirmative election for the submission of health care claims data, the insurer shall:

(a) include the self-funded employee plan data as part of the insurer's data submission otherwise required by this rule; and

(b) for plans that opt-in before March 1, 2017 as provided in Subsection (2)(b), include claims adjudicated in 2016 that were not previously submitted to the Office.

(4) Each insurer shall file with the Office, annually by January 31 of each year the following for the prior calendar year:

(a) a list of the self-funded employee plans whose employer made an affirmative election for the submission of their health care claim data;

(b) a list of employers who previously filed an opt-in request and have elected to opt-out for future reporting periods as provided under Subsection (2)(c); and

(c) a certification from an officer of the insurer that the insurer has taken reasonable efforts to provide the form to all known required employers; and

(d) a list identifying the employers to whom the form was provided and their contact information.

(5) The APCD Self-funded Employee Health Plan Opt-In form is for use only with self-funded employee plans and does not affect the mandatory reporting otherwise required by this rule.

(6) Nothing in this section requires an insurer to submit claims processed before the insurer was contracted to provide services.

R590-262-8. Third-party Contractors.

The Office may contract with a third party to collect and process the health care claims data and will prohibit it from using the data in any way but those specifically designated in the scope of work.

R590-262-9. Insurer Registration.

Each insurer shall register with the Office by completing the registration online at http://health.utah.gov/hda/apd/ no later than 30 days after becoming subject to this rule and annually thereafter by no later than September 1.

R590-262-10. Testing of Files.

Insurers that become subject to this rule shall submit to the Office a dataset for determining compliance with the standards for data submission no later than 90 days after the first date of becoming subject to the rule.

R590-262-11. Rejection of Files.

The Office or its designee may reject and return any data submission that fails to conform to the submission requirements. Paramount among submission requirements are: First Name, Last Name, Member ID, Relationship to Subscriber, Date of Birth, Address, City, State, Zip Code, Sex, which are key data fields that the insurer must submit for each enrolled member and claim. An insurer whose submission is rejected shall resubmit the data in the appropriate, corrected format to the Office, or its designee within ten state business days of notice that the data does not meet the submission requirements.

R590-262-12. Replacement of Data Files.

An insurer may replace a complete dataset submission if no more than one year has passed since the end of the month in which the file was submitted. However, the Office may allow a later submission if the insurer can establish exceptional circumstances for the replacement.

R590-262-13. Provider Notification.

(1) The following notification must be provided to a person that receives shared data, "This shared data is provided for informational purposes only. Contact the insurer for current, specific eligibility, or benefits coverage determination."

(2) The notification in this Section shall be provided in coordination with provider participation in the master index patient index and the cHIE programs.

R590-262-14. Limitation of Liability.

(1) A person furnishing information of the kind described in this rule is immune from liability and civil action if the information is furnished to or received from:

(a) the commissioner of the Insurance Department, the executive director of the Department of Health, or their employees or representatives;

(b) federal, state, or local law enforcement or regulatory officials or their employees or representatives; or

(c) the insurer that issued the policy connected with the data set.

(2) As provided in Section 26-25-1, any insurer that submits data pursuant to this rule cannot be held liable for having provided the required information to the Office.

R590-262-15. Exemptions and Extensions.

(1) The Office may grant exemptions or extensions from reporting requirements in this rule under certain circumstances.

(2) The Office may grant an exemption to an insurer when the insurer demonstrates that compliance imposes an unreasonable cost.

(a) An insurer may request an exemption from any particular requirement or set of requirements of this rule. The insurer must submit a request for exemption no less than 30 calendar days before the date the insurer would have to comply with the requirement.

(b) The Office may grant an exemption for a maximum of one calendar year. An insurer wishing an additional exemption must submit an additional, separate request.

(3) The Office may grant an extension to an insurer when the insurer demonstrates that technical or unforeseen difficulties prevent compliance.

(a) An insurer may request an extension for any deadline required in this rule. For each deadline for which the insurer requests an extension, the insurer must submit its request no less than seven calendar days before the deadline in question.

(b) The Office may grant an extension for a maximum of 30 calendar days. An insurer wishing an additional extension must submit an additional, separate request.

(4) The insurer requesting an extension or exemption shall include:

(a) The insurer's name, mailing address, telephone number, and contact person;

(b) the dates the exemption or extension is to start and end;
(c) a description of the relief sought, including reference to specific sections or language of the requirement;
(d) a statement of facts, reasons, or legal authority in support of the request; and
(e) a proposed alternative to the requirement or deadline.

R590-262-16. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided in Section 31A-2-308.

R590-262-17. Enforcement Date.

The commissioner will begin enforcing this rule upon the rule's effective date.

R590-262-18. Severability.

If any provision of this rule or its application to any person or situation is held to be invalid, that 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: health insurance claims reporting
March 10, 2017 31A-22-614.5(3)(a)
Notice of Continuation March 6, 2017

R590. Insurance Administration.
R590-273. Continuing Care Provider Rule.
R590-273-1. Authority.

This rule is promulgated pursuant to:

(1) Section 31A-2-201, which authorizes the commissioner to make rules to implement the provisions of Title 31A;

(2) Subsection 31A-44-202(1) for the establishment of registration fee;

(3) Subsection 31A-44-202(2) for the registration process;

(4) Subsection 31A-44-203(1) for the establishment of a renewal fee;

(5) Subsection 31A-44-203(4) for the annual renewal process;

(6) Section 31A-44-314 for the establishment of a disclosure fee;

(7) Subsection 31A-44-401(3) to define financial hardship in the case of resident dismissal contract exceptions;

(8) Subsection 31A-44-402(2) to determine when actuarial reserves will be required;

(9) Subsection 31A-44-502(2)(d) to determine market value of land and infrastructure improvements in rehabilitation;

(10) Subsection 31A-44-503(4)(d) to determine market value of land and infrastructure improvements in liquidation;

(11) Subsection 31A-44-601(6)(f) to determine the conditions under which a lien will be superior to a property lease; and

(12) Subsection 31A-44-602(2)(b) to establish financial disclosure and market conduct rules including conditions for enforcement.

R590-273-2. Purpose and Scope.

(1) The purpose of this rule is to outline the operating requirements of a provider of continuing care where required by Title 31A, Chapter 44.

(2) Pursuant to Subsection 31A-44-104(5), a provider that begins marketing a continuing care facility project:

(a) on or before May 10, 2016, will not be subject to the provisions of this rule until May 10, 2017; or

(b) after May 10, 2016 will be subject to this rule 45 days after the effective date of the rule.

R590-273-3. Definitions.

(1) The definitions in Sections 31A-1-301 and 31A-44-102 apply to this rule.

(2) "Qualified actuary" means a member of the American Academy of Actuaries or the Society of Actuaries or a person recognized by the commissioner as having comparable training or experience.

R590-273-4. Registration.

Thirty days prior to entering into a continuing care contract or reservation agreement, a provider must complete and submit to the commissioner:

(1) the initial registration form, supporting documentation, and attachments, which shall be filed electronically with the commissioner; and

(2) payment of the initial registration fee in accordance with Rule R590-102 through the online payment portal at https://secure.utah.gov/ips/uidrenewal.

(3) Registration forms are posted at the department's webpage https://insurance.utah.gov/agent/agent-other/CCRC.php.

R590-273-5. Registration Renewal.

(1) A registered provider registration must be completed and submitted to the commissioner:

(a) the renewal registration form and attachments, which shall be filed electronically with the commissioner by September 30 of each year; and

(b) payment of the renewal registration fee in accordance with Rule R590-102 through the online payment portal at https://secure.utah.gov/ips/uidrenewal.

(2) Registration forms are posted at the department's webpage at https://insurance.utah.gov/agent/agent-other/CCRC.php.

R590-273-6. Financial Hardship Refund.

A continuing care facility resident is in a condition of financial hardship for purposes of Subsection 31A-44-401(3) if:

(1) the resident's regular monthly expenses exceed his or her regular monthly income; and

(2) the resident has net assets, over and above his or her entrance fee at the continuing care facility, of less than $25,000.

R590-273-7. Additional Actuarial Reserve.

(1) Pursuant to Subsection 31A-44-402(2), the commissioner may require the additional reserve fund described in Subsection 31A-44-402(1) if the commissioner determines it is necessary pursuant to Subsection 31A-44-204(1)(a).

(2) The additional reserve fund shall be determined by:

(a) a qualified actuary; or

(b) a person recognized by the commissioner as having comparable training or experience.

(3) The commissioner may require an independent actuarial review to determine the adequacy of the additional actuarial reserve.

(4) The provider will pay the reasonable costs of the actuarial review described in Subsection (3) pursuant to Subsection 31A-44-603(3).

R590-273-8. Market Value of Land and Infrastructure Improvements in Rehabilitation.

In determining the market value of land and infrastructure improvements under an order of rehabilitation pursuant to Section 31A-44-502(2)(d), the commissioner shall:

(1) Consider the most probable price as of a specified date, for which the land and infrastructure improvements owned in fee by the ground lessor should sell:

(a) after reasonable exposure in a competitive market;

(b) under all conditions requisite to a fair sale;

(c) with the buyer and seller each acting prudently, knowledgeably and for self-interest; and

(d) assuming neither buyer or seller is acting under duress.

(2) Disregard the existence or terms of the ground lease.

(3) Determine if a commercial appraisal is required to assign the market value.

R590-273-9. Market Value of Land and Infrastructure Improvements in Liquidation.

In determining the market value of land and infrastructure improvements under an order of liquidation pursuant to Subsection 31A-44-503(4)(d), the commissioner shall:

(1) Consider the most probable price as of a specified date, for which the land and infrastructure improvements owned in fee by the ground lessor should sell:

(a) after reasonable exposure in a competitive market;

(b) under all conditions requisite to a fair sale;

(c) with the buyer and seller each acting prudently, knowledgeably and for self-interest; and

(d) assuming neither buyer or seller is acting under duress.

(2) Disregard the existence or terms of the ground lease.

(3) Determine if a commercial appraisal is required to assign the market value.

R590-273-10. Lien Held by the Commissioner in Favor of a Resident or a Group of Residents.

Pursuant to Subsection 31A-44-601(6)(f), the amount of a lien on a provider's property that is superior to the lien created

by Subsection 31A-44-601(1) includes:

(1) all amounts used to pay fees and costs for architectural and engineering for the design of the facility;

(2) all amounts paid for engineering, environmental and similar studies, reports and surveys with respect to the facility;

(3) all amounts paid for appraisals, marketing and other reports and surveys in connection with the construction, acquisition or improvement of the facility;

(4) fees and costs paid to contractors, developers, brokers, salespersons and other employees and agents, including affiliates of provider;

(5) all fees, charges, assessments, taxes charged or imposed by any governmental unit, district or similar body having jurisdiction over the facility; and

(6) reimbursements to a provider or other owner of the facility for expenditures that would otherwise qualify under Subsection 31A-44-601(1) or this rule if paid directly from loan proceeds.

R590-273-11. Enforcement.

(1) Pursuant to Subsection 31A-44-602(2)(b) the commissioner may conduct an examination or investigation of a provider to determine compliance with Title 31A, Chapter 44, Part 6:

(a) to determine the financial solvency of a facility;

(b) to determine the adequacy of the additional actuarial reserve under R590-273-7;

(c) to verify a statement contained in a disclosure or actuarial statement;

(d) to act on a complaint against a provider or a facility;

(e) to obtain all documents requested by the commissioner; or

(f) to take any corrective action to enforce compliance.

(2) The commissioner may request corrective actions, including:

(a) suggest corrective business practices;

(b) restrict or prohibit behavior by the provider that is misleading, unfair or abusive;

(c) order that the provider cease and desist from committing any further violation;

(d) suspend, revoke, or non-renew a provider's registration;

(e) provide transparent information to compare continuing care contracts, providers, or facilities;

(f) disclosure of all terms and conditions of continuing care contracts and agreements;

(g) disclosure of any financial risks;

(h) promote certain communications between the residents and the provider;

(i) employ or hire examiners, hearing officers, clerks, and others to perform the commissioner's duties in Title 31A, Chapter 44; or

(j) appoint a receiver.

(3)(a) The commissioner shall have free access to all the books and papers relating to the business and affairs of the provider.

(b) The books and records required under Subsection 31A-44-603(2)(a) shall be available for the inspection by the commissioner during normal business hours from the date of the transaction for no less than three years, plus the current calendar year.

(4) Nothing in this section prohibits the commissioner from billing to the provider, the reasonable costs of any examination or investigation, including the cost of the review by an actuary.

(5) Nothing in this section prohibits the issuance of administrative forfeitures calculated under Section 31A-44-604.

R590-273-12. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under Sections 31A-2-308, 31A-44-604 and 31A-44-605.

R590-273-13. Enforcement Date.

The commissioner will begin enforcing this rule 45 days from the rule's effective date.

R590-273-14. Severability.

If any provision of this rule or its application to any person or situation is held to be invalid, that 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: insurance, continuing care facility
April 7, 2017

31A-44-202(2)
31A-2-201
31A-44-314
31A-44-401(3)
31A-44-402(2)
31A-44-502(2)(d)
31A-44-503(4)(d)
31A-44-601(6)(f)
31A-44-602(2)(b)
31A-44-203(4)

R694. Public Lands Policy Coordination Office, Administration.
R694-1. Archeological Permits.
R694-1-1. Authority.

These rules are authorized by Subsection 9-8-305(5).

R694-1-2. Purpose.

The purpose of these rules is to establish requirements for the issuance of survey and excavation permits for all lands in the State of Utah, and to insure compliance with permit provisions and the underlying rules and law.

R694-1-3. Definitions.

(a) Terms used in this rule are defined in Section 9-8-302.

(b) In addition:

(i) "Full-time professional experience" means work within a position requiring responsibility for progress and completion of a project involving archeological resources.

R694-1-4. Qualifications of Permit Holders.

(a) Permits will be issued to those individuals who qualify as a principal investigator, except for those who may otherwise qualify but who have had a permit suspended or revoked pursuant to Section R694-1-11.

(b) As authorized by Subsection 9-8-305(2)(b), in lieu of a graduate degree in anthropology, archeology or history, a person requesting a permit may submit evidence demonstrating the ability to design and execute a research project in anthropology, archeology or history, including the collection and analysis of information, presentation of results in an approved and reviewed format, and the subsequent curation of specimens.

(c)(i) As authorized by Subsection 9-8-305(2)(iii), applicants for a permit may submit evidence of training related to proper methodologies for field procedures, laboratory analysis and reporting within projects involving archeological resources.

(ii) An applicant for a permit wishing to submit evidence pursuant to Subsection R694-1-4(c)(i) must demonstrate that the training was of a sufficient duration and a sufficiently broad scope of subject matter to substitute for a full year of full time professional experience.

(d) Experience in Utah prehistoric or historic archeology shall include basic field, associated laboratory analysis and reporting work based within any portion of the general physiographic and cultural regions found within the state boundaries.

R694-1-5. Application for Permit to Survey.

(a) A person who wishes to obtain a permit to survey shall obtain and complete an application form and submit the form and all other information required by the form to the Public Lands Policy Coordination Office.

(b) Other required information may include:

(i) Projects initiated under previous permits issued by the State of Utah which remain incomplete as of the date of application.

(ii) The applicant's employer or the name of the applicant's business, if self-employed.

(iii) A copy of an agreement to curate with an authorized curation facility in the name of the applicant or the applicant's employer.

R694-1-6. Application for Permit to Excavate.

(a)(i) A person who wishes to obtain a permit to excavate shall complete an application form and submit the original and two copies of the form and all other information required by the form to the Public Lands Policy Coordination Office.

(ii) The application form shall require the applicant to provide the information required by Subsection 9-8-305(3)(a).

(b) The Public Lands Policy Coordination Office shall forward one copy of the form and all other information requested to the Antiquities Section and one copy to the agency.

(c) If the Public Lands Policy Coordination Office has delegated the authority to issue a permit to excavate to another state agency, pursuant to Section R694-1-8, a person who wishes to obtain a permit to excavate on the lands owned by that agency shall submit an application to that agency.

R694-1-7. Review of Permit Applications.

(a) The Public Lands Policy Coordination Office may, at its sole discretion, seek the advice of one or more principal investigators as part of the review of an application for a permit to survey or a permit to excavate.

(b) Principal investigators who are authorized to provide advice on permits must hold a valid permit issued by the Public Lands Policy Coordination Office and must volunteer for the task.

(c) The Public Lands Policy Coordination Office shall keep a list of those principal investigators who volunteer, and shall make use of their services on a rotational basis, except that the Office shall avoid using the advice of any particular volunteer if a conflict of interest would thereby arise.

(d)(i) The Public Lands Policy Coordination Office shall notify the applicant within 30 calendar days whether or not the application is approved.

(ii) This time may be extended if additional information is required from the applicant.

R694-1-8. Delegation of Authority to Issue a Permit to Excavate.

(a) An agency which owns land within the state of Utah may request the delegation of the authority to issue permits to excavate for the lands it owns.

(b) The agency shall request the delegation by letter signed by the agency's authorized representative.

(c) The letter shall contain the proposed terms and conditions of the delegation, which shall include the information required by Subsection 9-8-305(3)(c)(ii), and agreement with the following conditions:

(i) each person approved for a permit to excavate by the agency shall hold a valid permit to survey from the Public Lands Policy Coordination Office at all times prior to and including the expiration date of the permit, including any extensions; and

(ii) the agency shall consult with the Antiquities Section regarding the research design of the proposed project prior to issuing the permit, and

(iii) permits issued by the agency pursuant to delegation shall contain the provisions required by Subsection R694-1-10(a), and for purposes of compliance and enforcement of the provisions of R694-1-10(a), a permit issued by the agency shall be considered a permit issued by the Public Lands Policy Coordination Office, and

(iv) the agency shall refer issues about performance of work by the permit holder to the Public Lands Policy Coordination Office through the process described in Section R694-1-11, and shall agree to amend, suspend, or revoke a permit according to the final results of that process, and to reinstate a permit only with the concurrence of the Public Lands Policy Coordination Office after compliance with the provisions of Section R694-1-12, and

(v) the agency and the Public Lands Policy Coordination Office shall review the operations of the delegation agreement at least annually, and

(vi) the Public Lands Policy Coordination Office may revoke the delegation at any time without cause, as provided by Subsection 9-8-305(3)(d).

(d) The agency and the Public Lands Policy Coordination

Office shall formalize the terms of the delegation through a Memorandum of Understanding.

R694-1-9. Time Period for Permits.

(a) A Permit to Survey shall be effective for either

(i) three years from the date of issuance specified in the permit, or

(ii) for any other period of time

(A) as part of the response to an action initiated under Section R694-1-11, or

(B) for other administrative needs.

(b)(i) A Permit to Excavate shall be effective for the amount of time reasonably necessary to complete the research design's excavation, laboratory analysis, reporting and curation, as specified by a date of expiration in the Permit.

(ii) The time period of a Permit to Excavate may be extended, upon a showing of good cause to the Public Lands Policy Coordination Office, for a period of time to be specified by a new expiration date.

R694-1-10. Permit Provisions.

(a) The following provisions shall be included within each permit issued by the Public Lands Policy Coordination Office:

(i) Professional and Ethical Standards

(A) Permit holders shall comply with the individual provisions of the "Code of Conduct" and the "Standards of Research Performance" promulgated by the Register of Professional Archeologists.

(B) If any of the provisions of the Code or Standards is altered, superseded or otherwise affected in any manner by these rules or other law, the rules and law shall take precedence, and permit holders shall comply with the rule or law.

(ii) Persons Employed by the Principal Investigator to Assist in the Field or Laboratory

By engaging in any field or laboratory work under any permit issued by the Public Lands Office, the principal investigator shall insure that persons hired or otherwise engaged to perform such work, or supervise field or laboratory work in the principal investigator's absence, are fully qualified to perform such work, and shall comply with the "Code of Conduct" and "Standards of Research Performance" as required by Subsection R694-1-10(a)(i).

(iii) Principal Investigators who are Employed by Others

(Reserved.)

(iv) Survey Methodologies

(Reserved.)

(v) Report and Data Format and Standards

(A) Reports of projects undertaken pursuant to permits issued by the Public Lands Policy Coordination Office shall conform to the format and standards which are attached to and made an integral part of the permit.

(B) The Public Lands Policy Coordination Office may amend the format and standards at any time during the time period of a permit, however, the permit holder shall have the option to continue to use the original format and standards for projects which are well into the reporting phase.

(C) Reports for individual projects and sites must contain an identification number obtained from the Division of State History prior to the commencement of fieldwork.

(D) Reports for individual projects must list all individuals who served in a supervisory capacity on the project.

(vi) Completion of Reports in a Timely Manner

(A) Reports of projects undertaken pursuant to any permit issued by the Public Lands Policy Coordination Office shall be completed and submitted to the agency and the Division of State History in a timely manner.

(B)(1) An agency may establish the parameters of timely manner through an agreement with the Division of State History and the Public Lands Policy Coordination Office.

(2) If an agreement has been finalized, the permit shall reference the agreement as the requirement for submission of reports for projects involving that agency's lands.

(3) For purposes of the requirements of Subsection R694-1-10(a)(vi)(B)(1), the term agency shall include an agency or other entity of the federal government.

(vii) Curation of Specimens

(A) The holder of any permit issued by the Public Lands Policy Coordination Office shall either hold a valid agreement with an authorized curation facility, or be covered under the authority of a curation agreement held by the employer of the permit holder, at all times during the time period of the permit.

(B) The holder of any permit issued by the Public Lands Policy Coordination Office shall keep the Office notified of any changes to the expiration date of the curation agreement required by Subsection R694-1-10(a)(vii)(A), or a change in employment.

(C) All specimens collected pursuant to any permit issued by the Public Lands Policy Coordination Office shall be deposited with the appropriate curation facility in a timely manner.

(viii) Discovery of Human Remains

Any person working under the authority of any permit issued by the Public Lands Policy Coordination Office who discovers human remains shall cease further activity in the area and shall notify the landowner, the antiquities section, and the appropriate law enforcement agencies, as required by Sections 9-9-403 and 76-9-704.

(ix) Access to Sites and Site Records

The holder of any permit issued by the Public Lands Policy Coordination Office agrees to cooperate with the Office to allow authorized Office employees access, at any reasonable time, to field and workings and records for the purpose of assuring compliance with the law, rules or permit provisions, subject to the provisions of other law, regulation or rule.

(x) Compliance with Law, Rule, and Permit Conditions

(A) Any person working under the authority of a permit issued by the Public Lands Policy Coordination Office shall comply with all laws, rules and permit conditions.

(B) Failure to comply may result in amendments to or the suspension or revocation of the permit, in addition to any other penalties authorized by law or rule.

(xi) The holder of the permit shall keep the Public Lands Policy Coordination Office apprised of any changes in the permittee's employment or business address and phone number, and changes in other business information as the Office may require.

(b) Permits issued by the Public Lands Policy Coordination Office may include such other provisions as the Office may deem necessary based on an individual's application.

(c) Permits to excavate issued by the Public Lands Policy Coordination Office shall require that the permit holder also hold a valid permit to survey issued by the Public Lands Policy Coordination Office at all times prior to and including the expiration date of the permit to excavate, including any extensions.

R694-1-11. Amendment, Suspension or Revocation of Permits.

(a)(i) Permits may be amended, suspended or revoked pursuant to the terms of this rule.

(ii) Permits may be amended, suspended, or revoked for violations of law, rule or permit provisions, or upon a finding by the Public Lands Policy Coordination Office that a permit holder is unfit to hold a permit due to a judicial or administrative determination concerning the character or competence of the individual.

(b)(i) Any agency may file a petition with the Public Lands Policy Coordination Office concerning the work

performed under the provisions of any Permit to Survey or Permit to Excavate if the agency believes the work has been done in a manner which is contrary to law, rule or permit provisions.

(ii) The petition shall state with specificity the facts and circumstances involved and the law, rule or permit provision at issue, and shall be signed by the agency's authorized representative.

(iii) Each agency shall keep the Public Lands Policy Coordination Office informed of the name of the agency's authorized representative on an ongoing basis.

(c) The Public Lands Policy Coordination Office shall investigate the issues raised by the petition.

(d) The Public Lands Policy Coordination Office may initiate investigations into a permit holder's compliance with law, rule and permit provisions at its sole discretion, and may initiate a proceeding to amend, suspend or revoke a permit as a result of those investigations.

(e)(i) The Public Lands Policy Coordination Office may, at its sole discretion, seek the advice of one or more principal investigators as part of an investigation initiated by either petition or itself.

(ii) Principal investigators who are authorized to provide this advice must hold a valid permit issued by the Public Lands Policy Coordination Office and must volunteer for the task.

(iii) The Public Lands Policy Coordination Office shall keep a list of those principal investigators who volunteer, and shall make use of their services on a rotational basis, except that the Office shall avoid using the advice of any particular volunteer if a conflict of interest would thereby arise.

(f) The Public Lands Policy Coordination Office may choose to employ either informal or formal hearings as authorized by Subsection 63G-4-201(a)(v).

(g) The Public Lands Policy Coordination Office may resolve issues raised by a petition or by its own proceedings by

(i) dismissing the petition or otherwise terminating the proceedings, or

(ii) amending any of the provisions of an existing permit, or

(iii) imposing new conditions within an existing permit, or

(iv) suspending the permit, or

(v) revoking the permit, or

(vi) any other relief the Office may consider appropriate.

(h) The Public Lands Policy Coordination Office will immediately inform the Division of State History if a permit is suspended or revoked.

(i) The final notice of suspension or revocation shall state the reasons for the suspension or revocation.

R694-1-12. Reinstatement of Permits.

(a) The final notice of suspension or revocation from a proceeding held pursuant to Section R694-1-11 shall specify the conditions for reinstatement of the permit.

(b) The holder of the suspended or revoked permit may request reinstatement by submitting a letter to the Public Lands Policy Coordination Office indicating the reasons the reinstatement should be granted.

(c) The Public Lands Policy Coordination Office may request additional information.

(d) Reinstatement shall be granted at the sole discretion of the Public Lands Policy Coordination Office.

(e) A principal investigator who has had a permit suspended or revoked shall not be eligible for another permit until the principal investigator becomes eligible for reinstatement of the original permit.

R694-1-13. Waiver of Provisions.

(a) The Public Lands Policy Coordination Office may grant a waiver of the provisions of these rules, except for statutory provisions, in the interest of fairness, impossibility of performance, or other exigent or extenuating circumstances.

(b) This provision is to be employed to allow the Public Lands Policy Coordination Office to deal with generally unforseen circumstances, and should not be employed to grant broad scale general exceptions to the requirements of Rule R694-1.

R694-1-14. Confidentiality.

(Reserved.)

KEY: archeological permits
April 30, 2012 **9-8-305**
Notice of Continuation April 4, 2017

R746. Public Service Commission, Administration.
R746-313. Electrical Service Reliability.
R746-313-1. Authority.

(1) This rule establishes electric service reliability and continuity requirements as provided for in Utah Code Sections 54-3-1, 54-4-2 and 54-4-7.

R746-313-2. Definitions.

(1) "Customer average interruption duration index" ("CAIDI") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(2) "Electric company" means an electrical corporation or a distribution electrical cooperative that is also a public utility, as defined in Utah Code 54-2-1(16).

(3) "Form 7 - Information on Service Interruptions" means:

(a) Part G of the United States Department of Agriculture Rural Utilities Service Form 7 Financial and Statistical Report,

(b) Part H of the National Rural Utilities Cooperative Finance Corporation Form 7 Financial and Statistical Report, or

(c) their equivalents.

(4) "Governing Authority" means:

(a) for a distribution electrical cooperative as defined in Utah Code 54-2-1(6), its board of directors; and

(b) for an electrical corporation as defined in Utah Code 54-2-1(7), the Public Service Commission of Utah, otherwise referred to as the commission.

(5) "The Institute of Electrical and Electronics Engineers Standard 1366" ("IEEE 1366") means the 2012 edition of the IEEE Guide for Electric Power Distribution Reliability Indices.

(6) "Loss of power supply"

(a) "Loss of power supply - Distribution Substation" means the loss of the electrical power supply system due to an outage/failure of a distribution substation component.

(b) "Loss of power supply - Generation/Transmission" means the loss of the electrical power supply from the electric company's own electric generator or transmission system, including transmission lines and transmission substations, or from another electric company or electric corporation.

(7) "Momentary average interruption event frequency index" ("MAIFIe") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(8) "Major event day identification threshold value" ("T_{MED}") has the same meaning as in IEEE 1366 or RUS 1730A-119.

(9) "Operating area" means a geographic subdivision of an electric company's Utah service territory that functions under the direction of an electric company office and as a separate entity used for reliability reporting within the electric company. An operating area may also be referred to as regions, divisions, or districts and may also be a reliability reporting area.

(10) "Reliability" means the degree to which electric service is supplied without interruptions to customers.

(11) "Reliability indices" means the electric service interruption indices identified in IEEE 1366 or RUS 1730A-119, as applicable.

(12) "Reliability reporting area" means a grouping of one or more operating areas, for which the electric company calculates major event thresholds.

(13) "Reporting Period" means the 12-month period, based on the previous 365 days, or 366 days for leap years, for which an electric company is tracking and reporting reliability performance.

(14) "Rules" means the Electric Service Reliability rules R746-313-1 through 8.

(15) "RUS 1730A-119" means the United States Department of Agriculture Rural Utilities Service Bulletin 1730A-119 entitled "Interruption Reporting and Service Continuity Objectives for Electric Distribution Systems," dated March 24, 2009.

(16) "System average interruption duration index" ("SAIDI") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(17) "System average interruption frequency index" ("SAIFI") has the same meaning as in IEEE 1366 or RUS 1730A-119, as applicable.

(18) "System-wide" means pertaining to and limited to the electric company's customers in Utah.

R746-313-3. Purpose, Scope, Applicability and Exceptions.

(1) This rule establishes requirements for each electric company to monitor and report on electric service reliability.

(2) Unless otherwise approved, an electric company whose governing authority is the commission shall:

(a) follow the provisions of IEEE 1366 in the collection and analysis of interruption data and in the calculation and reporting of reliability indices as required by these rules. If there is a conflict between any provision in IEEE 1366 and the rules, the rules govern; and

(b) include both "distribution system" interruptions and "interruptions caused by events outside of the distribution system," as defined in IEEE 1366, in the electric company's record keeping, calculations, reporting, and filing as required by R746-313-4 through R746-313-8.

(3) Unless otherwise approved, an electric company whose governing authority is not the commission shall:

(a) follow the provisions of either IEEE 1366 or the RUS Bulletin 1730A-119 in the collection and analysis of interruption data and in the calculation and reporting of reliability indices as required by these rules. If a conflict exists between any provision in IEEE 1366 or RUS 1730A-119 and the rules, the rules govern; and

(b) include both "distribution system" interruptions and interruptions caused by events outside of the distribution system in the electric company's record keeping, calculations, reporting, and filing as required by the Electric Service Reliability Rules R746-313-4 through R746-313-8.

(4) The commission may, upon written request and for good cause shown, waive or modify any provision of these rules in accordance with R746-100-15, Deviation from Rules.

R746-313-4. Electric Service Reliability.

(1) An electric company must have a written reliability program.

(2) Within 3 months after the effective date of these rules an electric company whose governing authority is the commission must file for commission approval of reliability performance baselines for SAIDI and SAIFI reliability indices.

(3) The filing required by 746-313-4(2)must include, but is not limited to:

(a) the basis for the proposed SAIDI and SAIFI values; and

(b) identification of systems and description of internal processes to collect, monitor and analyze interruption data and events including:

(i) definitions of all parameters used to calculate the proposed standards and major event days, and the time-period upon which the proposed standards are based (e.g., 12-month rolling average, 365-day rolling average, annual average);

(ii) identification of all proposed deviations from IEEE 1366 used in the calculation of reliability indices and determination of major event days; and

(iii) a description of all data estimation methods used for the collection and calculation of SAIDI, SAIFI, CAIDI, and MAIFIe.

R746-313-5. Electric Service Interruption Records.

(1) Except as provided in subsection (4) of this Section:

(a) An electric company using predominantly non-automated methods for identifying outages and tracking reliability shall keep an accurate record of each sustained interruption of service that affects one or more customers.

(b) An electric company using an electronic outage management system for identifying electric service interruptions and/or tracking outages shall keep an accurate record of each interruption of service that affects one or more customers.

(2) Each record shall contain at least the following information:

(a) the operating area where the interruption occurred;

(b) the reference identification of the substation involved;

(c) the reference identification of the circuit involved;

(d) the date and time the interruption started or was reported. If the exact time is unknown, the beginning of an interruption is recorded as the earlier of an automatic alarm or the reported initiation time;

(e) the date and time service was restored;

(f) the duration of the interruption;

(g) the number of metering points affected by the interruption;

(h) the cause of the interruption;

(i) whether the interruption was planned or unplanned;

(j) the interrupting device that made the interruption, if known; and

(k) the component involved (e.g., transmission line, substation, overhead primary main, underground primary main, transformer, etc.).

(3) For interruptions where customers are not simultaneously restored, an electric company shall keep records that document the step-restoration operations.

(4) For major events where an electric company is unable to obtain accurate data, the electric company shall make reasonable estimates and explain these estimates in any report filed with its governing authority.

(5) An electric company shall retain the records associated with this rule in accordance with R746-310-10 Preservation of Records.

R746-313-6. Inquiries about Electric Service Reliability.

(1) A customer may request a report from its electric company about the reliability of the electric service provided to the customer's own meter which the electric company must provide at no cost within 20 business days of the request. If a customer requests one or more additional reliability reports for the same meter within one year of the date of the first request, the electric company may charge the customer the cost of preparing the report(s).

(2) For an electric company whose governing authority is the commission, the report to the customer must include:

(a) The name of the customer;

(b) The date of the request;

(c) The address where the meter is installed;

(d) The meter identification number;

(e) The general identification of the equipment serving the customer; and

(f) A chronological listing of interruptions to the customer including all associated interruption data required by R746-313-5(2) covering at least the 36 months preceding the date of the request, if available. If 36 months of data are not available, the chronological listing must include all available data.

(3) For an electric company whose governing authority is not the commission, the report to the customer must include:

(a) The name of the customer;

(b) The date of the request;

(c) The address where the meter is installed;

(d) The meter identification number;

(e) The general identification of the equipment serving the customer; and

(f) A chronological listing of interruptions on the feeder serving the customer's meter including all interruption data required by R746-313-5(2) covering at least the 12 months preceding the date of the request. If 12 months of data are not available, the chronological listing must include all available data.

(4) Other than those inquiries specified in R746-313-6(1), each electric company must have a written policy for consistent treatment of all other inquiries pertaining to electric reliability. At a minimum, the electric company must provide to the inquiring party, by electronic means, the electric company's most-recently filed report on electric service reliability required by R764-313-7.

R746-313-7. Reporting on Electric Service Reliability.

(1) An electric company must report deviations from the reliability performance baselines established in accordance with R746-313-4 within 60 days after the end of the month when the deviation(s) occurred.

(2) Beginning May 1, 2013, and by May 1 of each succeeding year, an electric company shall file with the commission a report on electric service reliability for the previous calendar year. The electric company must make electronic copies of the report available to the public upon request and may charge a reasonable cost for requested paper copies.

(3) For an electric company whose governing authority is the commission, the report on electric service reliability must contain at a minimum:

(a) the calculated SAIDI, SAIFI, CAIDI, and MAIFIe reliability indices for the reporting period. At a minimum, the electric company must report this information on a system-wide basis compared with the previous four years' performance and, for SAIDI, SAIFI, and CAIDI on an operating area compared with the previous four years' performance;

(b) an analysis of the system-wide and reliability reporting area sustained interruption causes compared to the previous four-year performance. Outages may be categorized using the following cause categories:

(i) Loss of Supply - Generation/Transmission;

(ii) Loss of Supply - Distribution Substation;

(iii) Distribution - Environment (e.g., unpreventable contamination, corrosion, airborne deposits, flooding, fire/smoke not related to faults or lightning);

(iv) Distribution - Equipment Failure;

(v) Distribution - Lightning;

(vi) Distribution - Operational;

(vii) Distribution - Planned Outages;

(viii) Distribution - Public;

(ix) Distribution - Vegetation;

(x) Distribution -Weather (other than lightning);

(xi) Distribution -Wildlife;

(xii) Distribution - Unknown; and

(xiii) Distribution - Other.

(c) a listing of the major events experienced during the reporting period and a listing of significant events as defined by the electric company, their cause, and their effect on reliability performance during the reporting period;

(d) comparisons of budgeted and actual maintenance spending, maintenance activities, capital spending, vegetation management spending and vegetation management activities;

(e) identification of areas whose reliability performance warrants additional improvement efforts.

(f) a listing of the T_{MED} values that will be used for each reliability reporting area for the forthcoming annual reporting period.

(g) a summary of the changes the electric company has made or will make pertaining to the collection, calculation, estimation, and reporting of electric service reliability

information and changes in reliability reporting areas and/or operating areas; and

(h) a map showing the reliability reporting areas and/or operating areas.

(4) For an electric company whose governing authority is not the commission, the report on electric service reliability must contain, at a minimum:

(a) The reliability indices listed in Form 7 - Information on Service Interruptions based upon the cause codes listed in RUS1730A-119 ; and

(b) A summary of any estimation methods and/or an explanation of any factors used in calculating reliability indices presented in the electric company's report on electric service reliability.

R746-313-8. Major Event Reporting by Electric Utilities.

(1) Major event reporting for an electric company whose governing authority is the commission. Within 30 business days after the conclusion of each event which an electric company determines satisfies the criteria for major event classification in accordance with IEEE 1366, the electric company shall file a major event report with the commission for its consideration. The major event report must include, at a minimum:

(a) a description of the major event, the interruption causes, and a summary of restoration efforts and factors that affected restoration of service;

(b) identification of reliability reporting area and geographic area affected;

(c) the total number of customers affected, and the number of customers without service at periodic intervals;

(d) the calculated SAIDI, SAIFI, and CAIDI impacts (i.e., Event SAIDI, SAIFI, and CAIDI) associated with the major event to customers for each reliability reporting area and system-wide; and

(e) restoration of service information including resources used and cost.

(2) Major event reporting for electric company whose governing authority is not the commission. Within a timely period after each event which an electric company determines satisfies the criteria for major event classification in accordance with IEEE 1366 or RUS 1730A-119, as applicable, the electric company shall provide a major event analysis to its governing authority.

KEY: reliability, IEEE 1366, SAIDI / SAIFI, major event

February 21, 2013 54-3-1

Notice of Continuation April 27, 2017 54-4-2

54-4-7

R746. Public Service Commission, Administration.
R746-400. Public Utility Reports.
R746-400-1. Scope and Applicability.

This rule is promulgated by Section 54-3-21 and applies to public utilities and telecommunications corporations operating in the state of Utah. This rule shall not limit the ability of the Commission, or the Division, to otherwise obtain information from these entities, as provided by other rules or statutes.

R746-400-2. Division Authority.

The Division shall ensure compliance with this rule, prepare and distribute report forms, collect and store the completed reports and information provided by reporting entities subject to in this rule.

R746-400-3. General Definitions.

For purposes of this rule, the terms listed below shall bear the following meanings:

A. "Reporting entity" means a public utility as defined in Section 54-2-1, and a telecommunications corporation as defined in Section 54-8b-2.

B. "Commission" means the Public Service Commission of Utah.

C. "Division" means the Division of Public Utilities within the Department of Commerce of the State of Utah.

R746-400-4. Reports to the Commission.

A. Report Form Purposes -- The Division shall design report forms that will provide information from reporting entities useful to the Commission and the Division in performing their statutory duties and to administer Commission supervised or directed programs. These forms shall include, but are not limited to, reports used to provide information on a reporting entity's monthly and annual operations, reports concerning an entity's gross revenues used to calculate the public utilities' regulation fee under Section 54-5-2, reports and supplements used to prepare the Commission's annual report to the Governor and Legislature required by Subsection 54-8b-2.5, reports used in the administration the State of Utah Universal Public Telecommunications Service Support Fund, lifeline programs, and telephone relay program.

B. Acceptable Report Forms --

1. The Division shall make report forms available to all reporting entities. Applicable report forms for any report shall be available at least 60 days prior to the date the report is due to be completed by a reporting entity. The Division shall design report forms that clearly state the due date for the report and shall provide, as needed, directions, definitions and other information that will assist a reporting entity in completing a report form.

2. The Division may accept a reporting entity's request that an alternative report form or document, used to furnish information to federal government agencies, other agencies of this or other states, or for the entity's other needs or uses, be used in lieu of all or part of a Commission report form. The Division may require that the alternative report form or document be supplemented with other or additional information in order to obtain the same information as sought in the Utah report form.

C. Report Certification and Corrections -- Each report shall be signed by a responsible officer of the public utility certifying that the report is true and correct. If a reporting entity learns that any portion of a filed report is incorrect, it shall file corrected pages as soon as possible with an explanation of the corrections. The utility shall file an electronic copy of the report, in addition to a paper copy, if the report is prepared electronically.

R746-400-5. Copies of Reports to Federal Government Agencies.

Upon request of the Division, each reporting entity shall provide the Division with a copy of any report filed with the following federal government agencies: Federal Energy Regulatory Commission, Federal Communications Commission, Rural Utility Services, Securities and Exchange Commission, and Surface Transportation Board. The reporting entity shall provide to the Division the requested reports within 10 days of receiving the Division's request.

R746-400-6. Copies of Reports to Shareholders and Audited Financial Reports.

A. Annual Report -- Each reporting entity shall provide the Division with a copy of any annual report sent to shareholders within 10 days of its issuance.

B. Audited Financial Statements -- Upon request of the Division, a reporting entity shall provide the Division with a copy of any audited financial statements, including the opinion statements of the auditor, if the statements are prepared for the reporting entity.

R746-400-7. Confidentiality.

A. Public Information -- Reports filed pursuant to this rule shall be considered public information unless otherwise provided.

B. Protected Documents -- If a reporting entity desires that any report, copy or document, or any portion thereof, required by this rule, be treated in any manner other than as public information, it shall comply with the provisions of the Government Records Access and Management Act, Title 63G, Chapter 2, and provide a written claim of confidentiality and the reasons supporting that claim. If the records, or portions thereof, are classified as protected under GRAMA, the Division shall maintain the confidential reports in a separate file and disclosure to anyone outside of the Commission, its staff, the Division, and the staff of the Committee of Consumer Services, shall only be as allowed by GRAMA.

KEY: public utilities, reports, rules and procedures

October 30, 2002	**54-2-1**
Notice of Continuation April 27, 2017	**54-8b-2**
	54-5-2
	63G-2-101

R850. School and Institutional Trust Lands, Administration.
R850-11. Procurement.
R850-11-100. Authorities.

This rule is authorized by Sections 6, 8, 10, and 12 of the Utah Enabling Act; Articles X and XX of the Utah Constitution, and Subsection 53C-1-201(3)(e).

R850-11-150. Purposes.

Subsection 53C-1-201(3)(e) permits the agency to be exempted from the Utah Procurement Code upon board approval and adoption of alternative procurement procedures. This rule provides alternative procurement procedures that the agency may follow when procuring any goods and services related to the administration of the agency or the management, development, leasing or sale of trust lands. Nothing in this rule shall be deemed to prevent the agency from procuring goods and services pursuant to the Utah Procurement Code or other applicable law whenever deemed advisable by the agency, or in circumstances where this rule is not applicable.

R850-11-200. Definitions.

For the purposes of this rule:

1. Provider: means an individual or firm engaged in the business of providing goods or services deemed necessary by the agency.

2. Professional Services: any professional services related to the administration of the agency or the management, development, leasing or sale of trust lands, including management consulting, accounting, auditing, engineering, land planning, marketing, environmental, geological, mining engineering, architectural, surveying, appraisal, archaeological, real estate brokerage, planning, or such other services as needed.

3. Legal Services: a licensed professional service provided by attorneys or law firms to address issues of law, whether litigation or otherwise.

R850-11-300. Professional or Legal Services.

1. The agency may from time to time request providers of professional or legal services to submit a statement of qualifications containing information that the agency deems relevant to the provider's ability to provide quality services and the provider's hourly rates. At least once annually, the agency will advertise statewide its intent to accept statements of qualifications, and will maintain a list of qualified providers with approved rates.

2. The purpose of prequalification is to provide the agency with basic information regarding providers for the agency's convenience. The agency is not required to solicit each or any prequalified provider for a particular service when it undertakes a procurement.

3. When the procurement of professional or legal services is estimated to cost less than $50,000, the agency may select the provider directly from either the list of providers who have submitted annual statements of qualifications, or from other qualified providers if necessary.

4. When the procurement is estimated to exceed $50,000, a written request for proposal (RFP) shall be prepared which describes the agency's requirements and sets forth the evaluation criteria for the procurement. Consideration shall be given to publishing the RFP in a newspaper of general circulation or otherwise advertising the RFP to elicit additional responses from potential providers. The agency shall select the provider offering, as determined in the discretion of the director, the best combination of price, expertise, and other relevant factors. The director shall make a written determination, supported by the following reasons, that the selected provider is best qualified to provide the particular services being procured by the agency:

(a) competence to perform the services as reflected by technical training and education, general experience, experience in providing the required services and the qualifications and competence of persons who would be assigned to perform the services;

(b) ability to perform the services as reflected by workload and the availability of adequate personnel, equipment, and facilities to perform the services expeditiously;

(c) past performance as reflected by the services of the firm with respect to factors such as responsiveness, control of costs, quality of work, and an ability to meet deadlines; and

(d) a determination that the provider's fees are reasonable.

5. The agency may in its discretion issue contracts for professional or legal services by competitive bid pursuant to R850-11-400 or R850-11-500 instead of utilizing the procedures in this section.

R850-11-400. Bidding Procedures - Other Procurements.

1. Competitive bids are not required for procurements under $3,000 unless the responsible agency staff member believes that the potential financial benefit to the trust beneficiaries from obtaining bids outweighs the staff time and costs associated with soliciting bids.

2. For procurements over $3,000 and less than $50,000, except for procurements of professional or legal services undertaken pursuant to R850-11-300, the responsible agency staff member shall seek to obtain no less than two competitive bids. Bids may be solicited and received by telephone or other means, but shall be noted in writing by the responsible agency staff member.

3. The provider offering the lowest bid shall be selected unless the director makes a written determination that a provider submitting a higher bid is better qualified to provide the particular services being procured by the agency.

4. Nothing in this rule shall prevent the agency from using existing statewide contracts for supplies, services and construction as set forth in R33-3-301(2).

R850-11-450. Bidding Procedures - Large Contracts.

1. For procurements anticipated to exceed $50,000, except for procurements of professional or legal services undertaken pursuant to R850-11-300, the agency shall prepare a written request for proposals (RFP) or invitation to bid describing information required by the agency in evaluating the proposal, which may include a description of the services required, a statement of the provider's experience and qualifications, any performance schedule or deadlines, billing rates, bid specifications, and other information relevant to the particular project.

2. The responsible agency staff member shall seek to obtain at least three written responses to the RFP. Consideration shall be given to publishing the RFP in a newspaper of general circulation or otherwise advertising the RFP to elicit additional responses from potential providers.

3. The provider offering the lowest bid shall be selected unless the director makes a written determination, supported by detailed reasons, that a provider submitting a higher bid is better qualified to provide the particular services being procured by the agency.

R850-11-500. Sole Source Procurements.

Where the agency has identified a provider that has special familiarity or qualifications with respect to a project, or that has previously worked on a related project, the agency may hire the provider without soliciting bids from other providers if the director finds in writing that hiring the particular provider is in the best interests of the trust beneficiaries, and that the provider's fee is reasonable.

R850-11-600. Real Estate Brokerage Services.

1. The agency is not required to solicit bids for real estate

brokerage services, and may list trust lands with a licensed Utah broker as it sees fit.

2. Where the agency has not listed a property with a broker, but has undertaken internal marketing efforts, the agency is authorized but not obligated to pay a commission or finder's fee no greater than the prevailing market rates in the area to real estate brokers who have previously registered their client as directed by the agency, and who are the procuring cause of:

(a) the sale of trust lands; or

(b) a development transaction entered into by the agency pursuant to R850-140.

3. Commission amounts will be determined in the discretion of the agency based on type of transaction, prevailing market conditions, and any other relevant factors.

R850-11-700. Debt and Equity Investments.

Debt and equity investments made by the agency shall be exempt from the Utah Procurement Code, provided that such investments are part of a development transaction reviewed by the board and entered into by the agency pursuant to R850-140.

R850-11-800. Documentation.

The agency will determine, based on the type of service requested and complexity of the project, the level of contractual documentation necessary in order to adequately protect the best interests of the trust. Formal contract documentation shall be subject to approval as to form by a representative of the attorney general's office.

R850-11-900. Bonding for Construction Services.

1. For construction services costing $50,000 or higher, the agency shall require the chosen provider to deliver to the agency a performance bond and a payment bond in amounts equal to 100% of the price specified in the contract and executed by a surety company authorized to do business in this state or in any other form satisfactory to the agency;

2. For construction services costing less than $50,000, the agency may require a performance bond and a payment bond as described in R850-11-700(1) if it determines that requiring such bonds is in the best interests of the trust.

R850-11-1000. Conflicts of Interest.

The agency shall not enter into any contract with a provider which violates or, on account of the factual circumstances or person involved, gives the appearance of a conflict of interest or a potential violation of the Utah Public Officer's and Employee's Ethics Act.

R850-11-1100. Appeals.

Appeals of agency procurement decisions shall be governed by 63G-6. All initial appeals shall be directed to the director of the agency, with a copy to the Director of the Division of Purchasing. The disposition of any appeal shall take into account the intended purpose of Subsection 53C-1-201(3)(a)(iv), which is to provide the agency with broad discretion and flexibility in procurement to facilitate businesslike management of trust lands.

KEY: government purchasing
January 21, 2016 53C-1-201(3)
Notice of Continuation April 24, 2017

R895. Technology Services, Administration.
R895-3. Computer Software Licensing, Copyright, Control, Retention, and Transfer.
R895-3-1. Purpose.

The purpose of this rule is to establish the State of Utah's position and its intent to:

(1) comply with computer software licensing agreements and applicable federal laws, including copyright and patent laws;

(2) define the methods by which the State of Utah (State) will control and protect computer software; and

(3) establish the State's right, title and interest in state-developed computer software, including the sale and transfer of such software under certain conditions.

R895-3-2. Application.

All state agencies of the executive branch of the State government shall comply with this rule, which applies to the use, acquisition and transfer of all computer software, regardless of the operating environment or source of the software.

R895-3-3. Authority.

This rule is issued by the Chief Information Officer under the authority of Section 63F-1-206 of the Technology Governance Act, and in accordance with Section 63G-3-201 of the Utah Rulemaking Act, Utah Code Annotated.

R895-3-4. Definitions.

As used in this rule:

(1) "Audit" means to review compliance with laws, rules and policies that apply to computer software and related documentation; and to report findings and conclusions.

(2) "Commercial computer software" means computer software that is sold, licensed, or leased in significant quantities to the general public at established market or catalog prices.

(3) "Computer program" means a set of statements or instructions used in an information processing system to provide storage, retrieval, and manipulation of data from the computer system and any associated documentation and source material that explain how to operate the program.

(4) "Computer software" means sets of instructions or programs structured in a manner designed to cause a computer to carry out a desired result.

(5) "Spot Audit" means a periodic audit described in (1) and conducted by a person or persons performing the State Software Controller function.

(6) "State agency" means any agency or administrative sub-unit of the executive branch of the State government except:

(a) the State Board of Education; and

(b) the Board of Regents and institutions of higher education.

(7) "State-developed computer software" means computer software and related documentation developed under contract with the State or by State employees under the conditions set forth in the Employment Inventions Act, Section 34-39-1 et seq., Utah Code Annotated.

R895-3-5. Compliance and Responsibilities: Software Licensing.

(1) Each state agency and its employees shall comply with computer software licensing agreements, state laws, federal contracts, federal funding agreements, and federal laws, including copyright and patent laws.

(2) All management personnel will discourage software piracy and take appropriate personnel action up to and including dismissal, against any employee who has been found to be in violation of software license agreements. Personnel action shall be in full accordance with the Department of Human Resource Management Rule R477-11-1 et seq., Utah Administrative Code.

(3) Each state agency shall:

(a) establish a software coordinating function that will work with the DTS software coordinator to provide responsibility and authority to manage software licenses, software licensing agreements, software inventory;

(b) Inform employees that are engaged in developing or controlling the distribution of software for the State, that any state-developed software is an asset owned by the State and controlled according to the terms of this rule.

(4) A state software controller function is established within the Department of Technology Services with the following responsibilities:

(a) coordinate all centralized software purchases;

(b) manage software licenses, software licensing agreements and software inventory for centralized software purchases;

(c) coordinate and provide information to employees who are responsible for the software controller function within each state agency;

(d) provide to employees notices of the state agency's software use policy at appropriate locations. Appropriate locations may include computing facilities, offices, lunchrooms or websites.

(e) keep and maintain an inventory of all state-owned computer software and software licensing agreements tracked by agency by:

(i) establishing accurate software inventories and maintaining them;

(ii) establishing a baseline inventory of software already purchased;

(iii) maintaining this inventory through annual inventory reviews that reconcile purchases against inventory;

(iv) acquiring and using auditing tools to assist in establishing the inventory baseline and performing the ongoing reconciliation;

(f) coordinate with DTS technical personnel to:

(i) dispose of software in accordance with the software license agreement;

(ii) remove from the storage media before disposing of a computer, all private, protected or controlled data as defined by the Government Records Access and Management Act, UCA 63G-2-101 et seq.

(g) Understand the conditions of computer software licensing agreements before purchasing computer software, and inform State employees, whose responsibility it is to monitor the State's compliance with computer software licensing agreements, of these conditions.

(h) coordinate statewide audits or spot audits as needed.

R895-3-6. Compliance and Responsibilities: Retention and Transfer of State-Developed Computer Software.

(1) Unless otherwise prohibited by federal law, regulation, contract or funding agreement, the State of Utah may retain the right, title and interest in any state-developed computer software. To do so, the agency shall:

(a) clearly define in all contracts that it controls the ownership rights for computer software development and related documentation; and

(b) mark all computer software and related documentation developed by employees of the State with the copyright symbol and year, and label "Utah State Government" on all media on which the computer software or documentation is stored and at the beginning of the computer software execution.

(2) The State of Utah may sell or otherwise transfer the right, title and interest in any state-developed computer software. In order to carry this out, state agency must do the following:

(a) Submit a request to the state software controller and

obtain approval from the Chief Information Officer prior to the sale or transfer of state-developed computer software. The agency's request shall include a copy of the transfer agreement and any other contractual information. A summary report of these requests will be provided to the Information Technology Policy and Strategy Committee. An example of a model transfer or sale of state-developed software agreement may be obtained from the Chief Information Officer.

(b) Clearly specify within the transfer documents whether the costs of development will be recovered from the receiver.

(c) Clearly specify within the transfer documents whether the costs associated with copying and sending the state-developed computer software will be recovered from the receiver.

(d) Clearly specify within the transfer documents that the receiver is responsible for acquiring any commercial computer software upon which the state-developed computer software may be dependent.

(e) Clearly specify within the transfer documents that no additional services, such as installation, training, or maintenance, will be provided unless the parties have agreed otherwise.

(f) Clearly specify within the transfer documents that the state-developed computer software is being transferred in "as is" condition, and that the State will not be held liable for any incidental or consequential damages under any circumstances.

(g) Retain a record of the transfer, and process it in accordance with the Government Records Access and Management Act, Section 63G-2-101 et seq., Utah Code Annotated.

(3) In accordance with the requirements of (2), the state may initiate an agreement to transfer state-developed computer software when reasons exist to share such software with another state or entity.

(4) The Chief Information Officer may measure compliance of a state agency and its employees with this rule by conducting periodic audits in accordance with Section 63F-1-206, Utah Code Annotated. In performing audits, the Chief Information Officer may utilize external auditors and an agency's internal auditor(s) when such resources are available and the use of such resources is appropriate.

KEY: computer software, licensing, copyright, transfer
October 22, 2012 **63F-1-206**
Notice of Continuation April 6, 2017 **63G-3-201**
34-39-1 et seq.
63G-2-101 et seq.

R986. Workforce Services, Employment Development.
R986-600. Workforce Innovation and Opportunity Act.
R986-600-601. Authority for Workforce Innovation and Opportunity Act (WIOA) and Other Applicable Rules.

(1) The Department provides services to eligible clients under the authority granted in the Workforce Innovation and Opportunity Act, (WIOA) 20 CFR 610 allowing states to select a one-stop operator through a sole source selection. Funding is provided by the federal government through the WIOA. Utah is required to file a State Plan to obtain the funding. A copy of the State Plan is available at Department administrative offices and on the Internet. The regulations contained in 20 CFR 603, 20 CFR 651 through 20 CFR 652, 20 CFR 676 through 20 CFR 678 (2016) are also applicable.

(2) The provisions of Rule R986-100 apply to WIOA unless expressly noted otherwise in these rules even though R986-100 refers to public assistance and WIOA funding does not meet the technical definition of public assistance. The residency requirements of R986-100-106 and the additional penalty under R986-100-118 do not apply.

R986-600-602. Workforce Innovation and Opportunity Act.

(1) The goal of WIOA is to increase a client's occupational skills, employment, retention and earnings; to decrease welfare dependency; support alignment of education and economic development; increase prosperity of clients, employers and community; and to improve the quality of the workforce and national productivity.

(2) WIOA is for clients who need assistance finding employment to achieve self-sufficiency.

(3) Services are available for the following groups: adults, dislocated workers, and youth.

R986-600-603. Youth Services.

(1) The goals of WIOA youth services are to reconnect out-of-school youth to education and employment, provide options for improving educational and skill competencies; to provide effective connections to employers; to ensure access to mentoring, training opportunities and support services; to provide incentives for achievement; and to provide opportunities for leadership, citizenship and community service.

(2) WIOA youth services may be available to;

(a) in School Youth, age 14 through 21, who are low income and who have one or more barriers including those that interfere with the ability to complete an educational program or to secure and hold employment,

(b) out of School Youth, age 16 through 24 and who have one or more barriers including: school dropout, attendance issues, offender, homeless, runaway, foster care, aged out of foster care, pregnant or parenting, or disabled, and

(c) out of School Youth, age 16 through 24, who are low income and who have one or more barriers including: Native American, child of incarcerated parent(s), substance abuse issues, victim of domestic violence, or refugee.

(3) An incentive may be paid to provide recognition of achievement to eligible youth.

R986-600-604. Adults, Youth, and Dislocated Workers.

The Department offers four levels of service for adults, youth and dislocated workers:

(1) basic career services;

(2) individualized career services;

(3) training services; and

(4) follow-up services that, if requested, may be provided after receiving individualized or training services for a minimum of 12 months for all youth; or for a maximum of 12 months following the adult's or dislocated worker's first date of unsubsidized employment.

R986-600-605. Basic Career Services.

Basic career services include:

(1) registration for services;

(2) providing the following informational resources:

(a) outreach, intake, and orientation to, and information about, available services, including resource and referral services;

(b) local, regional and national labor market information including job vacancy listings and occupations in demand and the skills necessary to obtain those jobs and occupations;

(c) performance measures with respect to the one-stop delivery system and

(d) performance information and program cost for eligible training providers and programs.

(3) job development;

(4) rapid response services;

(5) bonding;

(6) assessment of skill levels, aptitudes, abilities, and supportive service needs;

(7) job search and placement assistance, and where appropriate, career counseling and workshops;

(8) Referral to and coordination of activities with other programs and services within the one-stop delivery system and other community programs, and

(9) determining if a client is eligible for, and assistance in, applying for: WIOA funded programs, unemployment insurance benefits, financial aid assistance available for training and educational programs not funded under WIOA, food stamps (SNAP), other supportive services such as child care, medical services, and transportation.

R986-600-606. Individualized Career Services.

(1) Individualized career services available to clients consist of:

(a) an assessment as provided in R986-600-620;

(b) development of an employment plan as provided in R986-600-621;

(c) case management, career counseling and career planning;

(d) in depth testing and formal assessment;

(e) workforce preparation activities and prevocational services; and

(f) financial literacy services.

(2) The following individualized career services may be available to eligible adults, dislocated workers and youth:

(a) English language acquisition;

(b) out-of-area job search and relocation assistance;

(c) supportive services;

(d) unpaid internships; and

(e) employment internship opportunities.

(3) Additional individualized career services available to youth include:

(a) leadership development;

(b) mentoring;

(c) comprehensive guidance and counseling;

(d) entrepreneurial skills training;

(e) alternative school; and

(f) summer youth employment internship opportunities.

R986-600-607. Training Services.

Training services include basic education, employment related education and work site learning.

R986-600-608. Eligibility Requirements, General Definition.

(1) Basic career services are available to all clients. There are no eligibility requirements for basic career services offered by the Department.

(2) Eligibility requirements for individualized career services, may be determined before an adult, youth, or

dislocated worker can receive services.

(3) Eligibility requirements for training and follow-up services must be determined before an adult, youth or dislocated worker can receive services.

(4) A client is required to sign and date the training program agreement for the program in which he or she is enrolled.

R986-600-609. Citizenship and Employment Authorization Requirements.

A client seeking individualized career or training services must be a citizen of the United States or be employment eligible in the United States. Employment eligible is defined by the WIOA Act, section 188 (a)(5) as citizens and nationals of the US, lawfully admitted permanent resident aliens, refugees, asylees, parolees and other immigrants authorized by the U.S. Attorney General to work in the US.

R986-600-610. Selective Service Registration Requirements.

Male applicants and recipients who are 18 and older must be in compliance with Selective Service registration requirements to receive individualized career or training services.

R986-600-611. Factors Used for Determining Priority.

(1) Priority will be given to recipients of public assistance, other low income clients and individuals who are basic skills deficient for WIOA Adult individualized career and training services. Other criteria may be applied if funding is limited as determined by the Governor's State Workforce Development Board (SWDB).

(2) In the event WIOA Youth funds are limited, priority will be given to clients who have two or more barriers as determined by the SWDB.

(3) Veterans and covered persons, as determined by federal law, will receive priority over non-veterans.

R986-600-612. Eligibility for Individualized Career Services.

(1) Individualized career services are available to adults who:

(a) are unemployed and are determined by the Department to be in need of more individualized career services to obtain employment; or

(b) are employed and are determined by the Department to be in need of more individualized career services to obtain employment that leads to self-sufficiency. Self-sufficiency for WIOA Adult is defined as 100% of the Lower Living Standard Income Level (LLSIL) for the specified family size.

(2) Individualized career services are available to dislocated workers who are:

(a) unemployed and are determined by the Department to be in need of more individualized career services to obtain employment; or

(b) employed and are determined by the Department to be in need of more individualized career services to obtain employment that leads to self-sufficiency. Self-sufficiency for WIOA Dislocated Worker is defined as 80% of the client's layoff wage.

R986-600-613. Income Eligibility.

(1) Dislocated workers do not need to meet income eligibility requirements.

(2) Applicants for youth and adult programs must meet income eligibility requirements.

(3) A client is deemed to have met the income eligibility requirements for youth services, and adult services, if the client is;

(a) receiving, has received, or has been determined eligible to receive food stamps (SNAP) at any time during the six months prior to the application date. This does not apply if the client only received expedited food stamps;

(b) currently receiving financial assistance from the Department or TANF funds from another state;

(c) homeless;

(d) currently receiving SSI;

(e) in foster care; or

(f) basic skills deficient.

(4) If a client is not eligible under paragraphs (1) or (2) above, the client must meet the low income eligibility guidelines in this rule.

(5) Up to 5% of the youth clients served do not need to meet the income eligibility requirements but must have barriers as determined by the Department. A list of current, eligible barriers is available at the Department.

R986-600-614. How to Determine Who Is Included in the Family.

(1) Family size must be determined to establish income eligibility for adult and youth services. Family size is determined by counting the maximum number of family members in a single residence during the six months prior to the date of application, not including the current month. Family members included in the income determination:

(a) a husband and wife and dependent children;

(b) parent(s)or legal guardian(s) and dependent children;

(c) a husband and wife, if there are no dependent children, and

(d) two people living in a single residence who are not married but have children in common.

(e) dependent is defined as the client's statement that the child is claimable as an IRS dependent.

(2) A client can be considered a "family" of one, if the client is living alone or with a family member and has a disability that substantially limits one or more major life activities.

(3) The income of the parent or guardian is not counted for a client who is over the age of 19 and the parents cannot claim him or her as an IRS dependent.

R986-600-615. Assets.

Assets are not counted when determining eligibility for WIOA services but will be considered in determining whether the client has a need for WIOA funding.

R986-600-616. Countable Income.

(1) Countable income is total gross income from all sources with the exceptions listed below under "Excludable Income". If income is not specifically excluded, it is counted. Countable income, for WIOA purposes includes:

(a) gross wages and salaries including severance pay and payment of accrued vacation leave;

(b) net receipts from self-employment, including farming;

(c) pensions and retirement income including railroad and military retirement;

(d) strike benefits from union funds;

(e) workers' compensation benefits;

(f) alimony;

(g) any insurance, annuity, or disability, payments other than SSI or veterans disability,

(h) merit-based scholarships, fellowships, and assistantships;

(i) dividends;

(j) interest;

(k) net rental income;

(l) net royalties, including tribal payments from casino royalties;

(m) periodic receipts from estates or trusts;

(n) net gambling or lottery winnings;
(o) tribal payments;
(p) disaster relief employment wages;
(q) on the job training wages reimbursed by the Department;
(r) Social Security Retirement Benefits and Social Security Disability Income which does not include old-age retirement or SSI; and
(s) all training stipends not listed in R986-600-616(2) as excludable income.
(2) Excludable Income. Income that is not counted in determining eligibility:
(a) cash payments under a Federal, state or local public assistance program, including FEP, FEPTP, GA, RRP payment, or EA,
(b) SSI, Old-Age Retirement Benefits, and Survivor's Benefits paid by the Social Security Administration;
(c) payments received from any governmental entity for adoption assistance,
(d) child support;
(e) unemployment compensation;
(f) capital gains;
(g) veterans disability payments other than retirement;
(h) educational financial assistance including Pell grants, work-study and needs-based scholarship assistance;
(i) foster care payments,
(j) tax refunds,
(k) gifts,
(l) loans,
(m) lump-sum inheritances,
(n) one-time insurance payments or compensation for injury,
(o) earned income credit from the IRS,
(p) military service member income, including military pay, military allowances and stipends and military reserve pay;
(q) reparation payments, including German reparation payments, Radiation Exposure Compensation Act payments, and Black Lung Compensation payments;
(r) guardianship subsidies as paid by a governmental entity;
(s) employment internship opportunity wages reimbursed to the employer by the Department;
(t) stipends received from VISTA, Peace Corps, Foster Grandparents Program, Retired Senior Volunteer Program, Youth Works, Americorps, and Job Corp;
(u) non-cash benefits such as employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, federal noncash benefits programs such as Medicare, Medicaid, food stamps, school lunches and housing assistance; and
(v) other amounts specifically excluded by federal statute.

R986-600-617. How to Calculate Income.
(1) To determine if a client meets the income eligibility standards, all income from all sources of all family members during the six months prior to the application date is counted. If necessary, the Department can make a year-to-date estimate based on available records.
(2) The family is income eligible if the annual income meets the higher of:
(a) the poverty line as determined by the U. S. Department of Human Services, or
(b) 70% of the LLSIL as determined by the U. S. Department of Labor and available at the Department of Workforce Services.

R986-600-618. Dislocated Worker.
(1) A dislocated worker is a client who meets one of the following criteria:
(a)(i) has been laid off through no fault of his or her own, and
(A) is eligible for or has exhausted unemployment compensation entitlement, or
(B) has been employed for a duration sufficient to demonstrate attachment to the workforce, but is not eligible for unemployment compensation due to insufficient earnings or having performed services for an employer that were not covered under unemployment compensation law, and
(ii) is unlikely to return to the client's previous industry or occupation. 'Unlikely to return' means the client lacks the skills to re-enter the industry or occupation, or declares that he or she will not return to that industry or occupation.
(b) has received a notice of layoff;.
(c) Was self-employed (including employment as a farmer, a rancher, or a fisherman) but is unemployed as a result of general economic conditions in the community in which the client resides or because of natural disasters;
(d) Is a displaced homemaker. A WIOA displaced homemaker is a client who has been providing unpaid services to family members in the home and who:
(i) has been dependent on the income of another family member but is no longer supported by that income; and
(ii) is unemployed or underemployed and is experiencing difficulty in obtaining or upgrading employment;
(e) was laid off from military service and
(i) is eligible for or has exhausted unemployment compensation entitlement,
(ii) is unlikely to return to the previous industry or occupation, and
(iii) was discharged from the military service under conditions other than dishonorable; or
(f) is defined by the Department of Veteran Affairs as a covered person who left employment in order to relocate because of an assignment change of the military service member, and
(i) is eligible for or has exhausted unemployment compensation entitlement, or
(ii) has been employed for a duration sufficient to demonstrate attachment to the workforce but is not eligible for unemployment compensation due to insufficient earnings or having performed services not covered for unemployment compensation, and
(iii) is unlikely to return to the client's previous industry or occupations.
(2) The displacement must be no more than 24 months prior to the date of application.
(3) There are no income or asset requirements for dislocated worker eligibility.
(4) If the Department is providing services under a National Reserve Discretionary Grant, additional eligibility requirements must be met.

R986-600-619. Participation Requirements.
Payment of any and all financial assistance, individualized career and/or training services is contingent upon the client participating, to the maximum extent possible, in assessment and evaluation, and the completion of a negotiated employment plan.

R986-600-620. Participation in Obtaining an Assessment.
(1) When the Department determines that a client has a need for individualized career services, an employment counselor/case worker may be assigned to assess the needs of the client.
(2) When the Department determines a client has a need for training services an employment counselor will be assigned to assess the needs of the client.
(3) The client may be required to participate in testing or

completion of other assessment tools and may be referred to another person within the Department, another agency, or to a company or individual under contract with the Department to complete testing, assessment, and evaluation.

R986-600-621. Requirements of an Employment Plan.

(1) A client is required to sign and make a good faith effort to participate to the maximum extent possible in a negotiated employment plan.

(2) The goal of the employment plan is obtaining employment.

(3) An employment plan consists of activities designed to help a client become employed.

(4) The employment plan may require that the client:

(a) search for employment.

(b) participate in an educational program to obtain a high school diploma or its equivalent, if the client does not have a high school diploma;

(c) obtain education or training necessary to obtain employment;

(d) obtain medical, mental health, or substance abuse treatment;

(e) resolve transportation and child care needs;

(f) resolve any other barriers identified as preventing or limiting the ability of the client to obtain employment, and/or

(g) participate in rehabilitative services as prescribed by the state Office of Rehabilitation.

(5) The client must meet the performance expectations of each activity in the employment plan in order to remain eligible for certain individualized career or training services.

(6) The client must cooperate with the Department's efforts to monitor and evaluate the client's activities and progress under the employment plan, which may include providing ongoing information and or documentation relative to their progress and providing the Department with a release of information, if necessary to facilitate the Department's monitoring of compliance.

(7) The client agrees, as part of the employment plan, to cooperate with other agencies, or with individuals or companies under contract with the Department, as outlined in the employment plan.

(8) An employment plan may, at the discretion of the Department, be amended to reflect new information or changed circumstances.

R986-600-622. Additional Requirements of an Employment Plan for Youth.

(1) Employment plans for all youth must reflect intentions to assist with preparing for post-secondary education and/or employment; finding effective connections to the job market and employers, and understanding the links between academic and occupational learning.

(2) The goal of the youth program is to reconnect out-of-school youth to education and employment and assist in-school youth with completing education through:

(a) placement in employment or postsecondary education;

(b) attainment of a degree or certificate; and/or

(c) literacy and numeracy gains for out-of-school youth who are basic skill deficient.

R986-600-623. Individualized Career and Training Services as Part of an Employment Plan.

(1) A client's participation in training services is limited per exposure to the lesser of;

(a) 24 months which need not be continuous and which can be waived by a Department supervisor based on individual circumstances, or

(b) the completion of the education and training goals of the employment plan.

(2) Education and training will only be supported when the client meets appropriateness as provided in R986-600-624.

(3) Additional payments and/or services may be allowed under certain circumstances based on individual need provided they are necessary and appropriate to enable the client to participate in activities authorized under WIOA.

R986-600-624. Appropriateness for Training Services.

(1) To be eligible for training services, the client must:

(a) have met the funding priority requirements for individualized career services as listed in R986-600-611; and

(b) be deemed appropriate for training services by the Department. To be deemed appropriate, the client must:

(i) have been determined by the Department to be in need of training services,

(ii) have the skills and qualifications to successfully complete the selected training program,

(iii) select a program of training that is directly linked to employment opportunities in the area in which they plan to work, and

(iv) be unable to obtain grant assistance from other sources to pay the costs of such training or the other grant assistance is pending. If the client's PELL grant is pending when training services are provided, and later the PELL grant is awarded, the client must reimburse the Department for those training costs.

(2) A client who does not meet the requirements listed in subsection (1) of this section will be denied training services by the Department.

R986-600-625. Funding.

(1) When a client is approved for individualized career or training services, the Department will estimate the anticipated cost to the Department associated with those services and reserve that amount for accounting purposes. This amount may be revised and/or rescinded by the Department at any time without prior notice to the client.

(2) The Department issues an electronic benefit transfer card (card) to each eligible individualized career and/or training service client to pay for training, supportive services, and incentives.

(3) The client must prove that all funds received from the Department were spent as intended. Proof may require receipts. If a client is found to have been ineligible for funds, made unauthorized use of Department funds, or cannot prove how those funds were spent, the client will be responsible for repayment of the overpayment.

(4) Amounts remaining on the card after 30 days of inactivity are subject to expungement.

R986-600-626. The Right to Appeal a Denial of Services.

If an applicant or a client who is currently receiving services is denied services the client or applicant can request a hearing as provided in Rules R986-100-123 through R986-100-135.

R986-600-652. Initial Eligibility Requirements for Training Providers and Programs.

(1) Training providers must apply for a specific program/s, and be found eligible, to be included on the Utah Eligible Training Provider List (ETPL).

(2) The following training providers can apply to be included in the ETPL;

(a) post-secondary institutions,

(b) registered apprenticeship programs,

(c) other public or private providers of training services, or

(d) providers of adult education and literacy activities including English as a Second Language.

(3) Training provider requirements.

(a) All training providers seeking initial eligibility must have been in business as a training provider and have provided training to students for at least two years.

(b) Training providers, with the exception of government entities and basic education providers, must be registered with the Utah Division of Consumer Protection as a Post-Secondary Proprietary School. The only acceptable reasons for exemption from registration as a post-secondary proprietary school are for those schools governed by an accrediting body which oversees program instruction.

(4) Training providers must apply for eligibility for each training program they wish to have included on the ETPL.

(5) Training programs are defined as one or more courses or classes, or a structured regimen that leads to;

(a) an industry recognized post-secondary credential,

(b) employment,

(c) high school diploma or GED, or

(d) a measurable skill gain toward credential or employment.

(6) Training programs can be delivered in-person, online or in a blended approach.

(a) Online training is only eligible if it;

(i) is part of a curriculum where lessons are assigned, completed and returned,

(ii) requires students to interact with instructors, and

(iii) requires students to take periodic tests.

(b) Self-directed online training that is not instructor-led is not eligible.

(7) Training programs must submit performance data. that include data from at least one training class that has completed and/or graduated from the program and the students have been tracked for at least 3 months after completing the program. If a training program has not operated for at least three months after the first class has graduated, the provider must submit letters verifying the need for trained employees from at least three local businesses that hire employees that need the type of training offered.

(8) Out of state training providers that do not have a training location in Utah may apply to be on the Utah ETPL only if they maintain provider and program eligibility on the ETPL in the state where their main or corporate office is located.

(9) Utah may enter into reciprocal agreements with other states to utilize the ETPL from those states. The agreement allows Utah clients to select a training program from another state's ETPL.

(10) The Department will not pay for training costs that are incurred prior to the training program being found eligible.

(11) when applying and while on the ETPL, training providers must agree to abide by the Training Provider Terms and Conditions Agreement which is provided as part of the application process.

R986-600-653. Applying for Initial Training Provider and Program Eligibility.

(1) Training providers must submit the following information for each program for which they are seeking eligibility:

(a) training provider contact information,

(b) training program description and requirements,

(c) connection with in-demand industry sectors and occupations,

(d) license or accreditation, if applicable,

(e) equal opportunity grievance procedure,

(f) aggregate performance data for every graduating class in the last full school year for every student, and

(g) any other information, documentation and/or verification requested by the Department.

(2) The training provider will be notified once an eligibility decision is made. If an application is denied, the notification will include information on the appeals process as described in R986-600-659.

R986-600-654. Registered Apprenticeships.

(1) All U.S. Department of Labor (DOL) Registered Apprenticeships located in Utah are eligible to be included on the ETPL. In order to provide funding for classroom training, the registered apprenticeship sponsor must be listed on the ETPL.

(2) Registered apprenticeship program sponsors must request to be included on the list verbally, through email or hard copy.

(3) Registered apprenticeship sponsors must submit information on the sponsor, program and training provider. Registered apprenticeship sponsors are not required to submit performance standards.

(4) Any registered apprenticeship will be removed from the ETPL if it loses its registration voluntarily or involuntarily.

(5) If a registered apprenticeship program sponsor is determined to have provided inaccurate information or to have substantially violated any provision of WIOA, they will be removed from the ETPL.

R986-600-655. Informed Client Choice.

The ETPL contains information for a client to make an informed choice based on performance data, the connections the training has with in-demand occupations, and cost.

R986-600-656. Continued Eligibility Requirements for Training Providers and Programs.

(1) Training programs receive initial eligibility for up to one year. To remain on the ETPL, the training provider must complete an application for continued eligibility and submit it before the expiration of the last month of eligibility.

(2) Training providers must renew eligibility annually or more often as instructed by the Department.

(3) If a training provider already on the list adds a new program, it must apply for approval of that program. The renewal date for the new program will be coordinated with the provider's other program or programs so all programs for that provider renew at the same time.

(4) If any of the information provided in R986-600-653 changes, the provider must notify the Department.

R986-600-657. Applying for Continued Eligibility Training Provider and Program Eligibility.

(1) Training providers must certify that all the information previously provided for each program for which they are seeking continued eligibility is current and correct.

(2) As part of continued eligibility the provider must submit performance data by program for the last school year for every WIOA student enrolled in the program.

(3) The Department will also consider the provider's past compliance with the Training Provider Terms and Conditions Agreement when determining continued eligibility.

(4) Programs that do not meet the minimum standards or provide the required information by the renewal date will be removed from the ETPL. If a provider is unable to complete the renewal requirements, an extension may be granted if the delay is due to exceptional circumstances or circumstances that are beyond the provider's control. The request for an extension must be submitted 30 days before the renewal deadline or as soon as possible.

(5) Training provider will be notified of the decision on continued eligibility. If an application is denied, the notification will include information on the appeals process as described in R986-600-659

R986-600-658. Training Provider Terms and Conditions, Noncompliance.

(1) Training providers must agree to comply with the Training Provider Terms and Conditions Agreement. If a training provider does not follow the Terms and Conditions Agreement, the provider and all of its programs will be removed from the ETPL.

(2) If a training provider reports false or inaccurate information during the initial or continued eligibility process or substantially violates a provision of Title I of WIOA or its implementing regulations, including Equal Opportunity (EO) regulations, the training provider and all of its programs will be removed from the ETPL. The Department may also do an onsite visit to ensure compliance with WIOA and EO regulations.

(3) If a provider has been removed from the ETPL the Department will not pay for any additional training costs for any current or future clients until the training provider is eligible to reapply for ETPL initial eligibility.

(4) If a training provider has been removed from the ETPL, they will be notified if they will be eligible to reapply for initial eligibility and when they can submit a new application.

R986-600-659. Training Provider Right to Appeal.

(1) If a Training Provider or Program is denied eligibility; or the training provider and/or program has been removed from the ETPL due to non-compliance, they have the right to appeal the decision.

(3) Training providers must provide a written appeal to the Department within 30 days from the decision date.

(4) The SWDB will review the appeal and make a final decision.

(5) EO findings are reviewed by the Department executive director for a final decision.

(6) Training providers will be notified of the final decision.

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