

SOUTH CAROLINA STATE REGISTER DISCLAIMER

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SOUTH CAROLINA STATE REGISTER

PUBLISHED BY
THE LEGISLATIVE COUNCIL
of the
GENERAL ASSEMBLY

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Published May 22, 2009

Volume 33 Issue No. 5

This issue contains notices, proposed regulations, emergency regulations, final form regulations, and other documents filed in the Office of the Legislative Council, pursuant to Article 1, Chapter 23, Title 1, Code of Laws of South Carolina, 1976.

SOUTH CAROLINA STATE REGISTER

An official state publication, the *South Carolina State Register* is a temporary update to South Carolina's official compilation of agency regulations--the *South Carolina Code of Regulations*. Changes in regulations, whether by adoption, amendment, repeal or emergency action must be published in the *State Register* pursuant to the provisions of the Administrative Procedures Act. The *State Register* also publishes the Governor's Executive Orders, notices or public hearings and meetings, and other documents issued by state agencies considered to be in the public interest. All documents published in the *State Register* are drafted by state agencies and are published as submitted. Publication of any material in the *State Register* is the official notice of such information.

STYLE AND FORMAT

Documents are arranged within each issue of the *State Register* according to the type of document filed:

Notices are documents considered by the agency to have general public interest.

Notices of Drafting Regulations give interested persons the opportunity to comment during the initial drafting period before regulations are submitted as proposed.

Proposed Regulations are those regulations pending permanent adoption by an agency.

Pending Regulations Submitted to the General Assembly are regulations adopted by the agency pending approval by the General Assembly.

Final Regulations have been permanently adopted by the agency and approved by the General Assembly.

Emergency Regulations have been adopted on an emergency basis by the agency.

Executive Orders are actions issued and taken by the Governor.

2009 PUBLICATION SCHEDULE

Documents will be accepted for filing on any normal business day from 8:30 A.M. until 5:00 P.M. All documents must be submitted in the format prescribed in the *Standards Manual for Drafting and Filing Regulations*.

To be included for publication in the next issue of the *State Register*, documents will be accepted no later than 5:00 P.M. on any closing date. The modification or withdrawal of documents filed for publication must be made **by 5:00 P.M.** on the closing date for that issue.

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Submission Deadline	1/9	2/13	3/13	4/10	5/8	6/12	7/10	8/14	9/11	10/9	11/13	12/11
Publishing Date	1/23	2/27	3/27	4/24	5/22	6/26	7/24	8/28	9/25	10/23	11/27	12/25

REPRODUCING OFFICIAL DOCUMENTS

Documents appearing in the *State Register* are prepared and printed at public expense. Media services are encouraged to give wide publicity to documents printed in the *State Register*.

PUBLIC INSPECTION OF DOCUMENTS

Documents filed with the Office of the State Register are available for public inspection during normal office hours, 8:30 A.M. to 5:00 P.M., Monday through Friday. The Office of the State Register is in the Legislative Council, Fourth Floor, Rembert C. Dennis Building, 1000 Assembly Street, in Columbia. Telephone inquiries concerning material in the *State Register* or the *South Carolina Code of Regulations* may be made by calling (803) 212-4500.

ADOPTION, AMENDMENT AND REPEAL OF REGULATIONS

To adopt, amend or repeal a regulation, an agency must publish in the *State Register* a Notice of Drafting; a Notice of the Proposed Regulation that contains an estimate of the proposed action's economic impact; and, a notice that gives the public an opportunity to comment on the proposal. If requested by twenty-five persons, a public hearing must be held at least thirty days after the date of publication of the notice in the *State Register*.

After the date of hearing, the regulation must be submitted to the General Assembly for approval. The General Assembly has one hundred twenty days to consider the regulation. If no legislation is introduced to disapprove or enacted to approve before the expiration of the one-hundred-twenty-day review period, the regulation is approved on the one hundred twentieth day and is effective upon publication in the *State Register*.

EMERGENCY REGULATIONS

An emergency regulation may be promulgated by an agency if the agency finds imminent peril to public health, safety or welfare. Emergency regulations are effective upon filing for a ninety-day period. If the original filing began and expired during the legislative interim, the regulation can be renewed once.

REGULATIONS PROMULGATED TO COMPLY WITH FEDERAL LAW

Regulations promulgated to comply with federal law are exempt from General Assembly review. Following the notice of proposed regulation and hearing, regulations are submitted to the *State Register* and are effective upon publication.

EFFECTIVE DATE OF REGULATIONS

Final Regulations take effect on the date of publication in the *State Register* unless otherwise noted within the text of the regulation.

Emergency Regulations take effect upon filing with the Legislative Council and remain effective for ninety days. If the original ninety-day period begins and expires during legislative interim, the regulation may be refiled for one additional ninety-day period.

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3202		SR33-2	Requirements for Licensure as a Physical Therapist	2/11/09	LLR - Board of Physical Therapy Examiners
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3196		SR33-3	S.C. National Guard College Assistance Program	3/09/09	Commission on Higher Education
3207		SR33-3	Board of Veterinary Medical Examiners Chapter Revision	3/11/09	LLR - Bd of Veterinary Medical Examiners
3204		SR33-3	Licensing Standards for Continuing Care Retirement Communities	3/12/09	Department of Consumer Affairs
3199		SR33-4	South Carolina Trauma Care Systems	3/18/09	Department of Health and Envir Control
3206		SR33-4	Application, Renewal and Continuing Education	3/20/09	LLR - Board of Chiropractic Examiners
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3203			Telephone Utilities Offering Regulated Prepaid Local Exchange Services and Bonds	5/13/09	Public Service Commission
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4029			Assessment Program	5/13/09	State Board of Education
4027			Program for Assisting, Developing, and Evaluating Principal Performance (PADEPP)	5/13/09	State Board of Education
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4018			Board of Registration for Professional Engineers and Surveyors	5/16/09	LLR- Bd of Registration for Professional Engineers and Surveyors
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3222			Interruption of Service, Computation of Time, and Service Between Parties of Record	5/18/09	Public Service Commission
4039			Designation of Asian Citrus psyllid as Plant Pest and Quarantine	5/20/09	Clemson University-State Crop Pest Comm.
4001			Plum Pox Virus Quarantine	5/20/09	Clemson University-State Crop Pest Comm.
4013			Standards for Licensing Nursing Homes	5/20/09	Department of Health and Envir Control
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4032			Need-based Grants Program	5/22/09	Commission on Higher Education
4033			Palmetto Fellows Scholarship and Palmetto Fellows Scholarship Enhancement	5/22/09	Commission on Higher Education
4034			Determination of Rates of Tuition and Fees	5/22/09	Commission on Higher Education
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4020			PC&N (Stretcher Vans)	5/24/09	Public Service Commission
4017			Milk and Milk Products	5/27/09	Department of Health and Envir Control
3198			Solid Waste Management: Demonstration-of-Need	5/27/09	Department of Health and Envir Control
3221			Statewide Criminal Gang Database	5/29/09	State Law Enforcement Division

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4043		Amend and Add Regulations to Chapter 67 to Reflect Changes in Title 42 Necessitated by the Approval of Act 111 on June 25, 2007	1/25/10	Workers' Compensation Commission
4049		Use and Dissemination of Test Results	1/25/10	State Board of Education
4053	R27 SR33-5	Enforcement of Pilot Statutes and Maritime Homeland Security	2/09/10	Commissioners of Pilotage
4022		Riverbanks Parks Commission	2/10/10	Riverbanks Parks Commission
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4054		Registration of Immigration Assistance Services	3/06/10	LLR
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4058		Insurance Holding Company Systems	3/20/10	Department of Insurance
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4060		Life Insurance Disclosure	3/20/10	Department of Insurance
4061		Valuation of Investments	3/20/10	Department of Insurance
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In order by General Assembly review expiration date
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 South Carolina General Assembly Home Page: <http://www.scstatehouse.gov/regnsrch.htm>

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3184	Restructuring ATF Regulations - Pyrotechnic Safety	Labor, Commerce and Industry	Labor, Commerce and Industry
3202	Requirements for Licensure as a Physical Therapist	Medical, Military, Pub & Mun Affairs	Medical Affairs
3201	Mobile Dental Facilities and Portable Dental Operations	Medical, Military, Pub & Mun Affairs	Medical Affairs
3196	S.C. National Guard College Assistance Program	Education and Public Works	Education
3207	Board of Veterinary Medical Examiners Chapter Revision	Agriculture and Natural Resources	Labor, Commerce and Industry
3204	Licensing Standards for Continuing Care Retirement Communities	Medical, Military, Pub & Mun Affairs	Medical Affairs
3199	South Carolina Trauma Care Systems	Medical, Military, Pub & Mun Affairs	Medical Affairs
3206	Application, Renewal and Continuing Education	Medical, Military, Pub & Mun Affairs	Medical Affairs
3209	Operation of Public Pupil Transportation Services	Education and Public Works	Education
3214	Fire Prevention and Life Safety	Labor, Commerce and Industry	Labor, Commerce and Industry
3215	Fire Prevention and Life Safety for Special Occupancies	Labor, Commerce and Industry	Labor, Commerce and Industry
3216	Explosives	Labor, Commerce and Industry	Labor, Commerce and Industry
3217	Portable Fire Extinguishers and Fixed Fire Extinguishing Systems	Labor, Commerce and Industry	Labor, Commerce and Industry
3218	Liquefied Petroleum (LP) Gas	Labor, Commerce and Industry	Labor, Commerce and Industry
3219	Fireworks and Pyrotechnics	Labor, Commerce and Industry	Labor, Commerce and Industry
3220	Fire Prevention and Life Safety in Local Detention Facilities	Labor, Commerce and Industry	Labor, Commerce and Industry
3213	Annual Audited Financial Reporting Regulation	Labor, Commerce and Industry	Banking and Insurance
3208	Contact Information from Traffic Stops	Education and Public Works	Transportation
3205	Tax Credits for Fortification Measures	Ways and Means	Banking and Insurance
3197	Annual Reporting Requirements for Designated Eligible Telecommunications Carriers	Labor, Commerce and Industry	Judiciary
3203	Telephone Utilities Offering Regulated Prepaid Local Exchange Services and Bonds	Labor, Commerce and Industry	Judiciary
3210	Licensing of Onsite Wastewater System Master Contractors	Agriculture and Natural Resources	Medical Affairs
4004	Federal Government Construction Contracts	Ways and Means	Finance
3225	Hazardous Waste Management	Agriculture and Natural Resources	Medical Affairs
4005	Deed Recording Fee	Judiciary	Finance
3223	Adjustment of Bills and Representation	Labor, Commerce and Industry	Judiciary
3226	X-rays (Title B)	Medical, Military, Pub & Mun Affairs	Labor, Commerce and Industry
4036	Replacement of Life Insurance and Annuities	Labor, Commerce and Industry	Banking and Insurance
4035	Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values	Labor, Commerce and Industry	Banking and Insurance
4028	Charter School Appeals	Education and Public Works	Education
4029	Assessment Program	Education and Public Works	Education
4027	Program for Assisting, Developing, and Evaluating Principal Performance (PADEPP)	Education and Public Works	Education
4026	Procedures and Standards for Review of Charter School Applications	Education and Public Works	Education
4019	Occupational Safety and Health Act	Labor, Commerce and Industry	Medical Affairs
4041	Pilot and Apprentice Age Limitations; Short Branch Qualifications; Pilot Functions and Responsibilities; and Penalties	Labor, Commerce and Industry	Transportation
4018	Board of Registration for Professional Engineers and Surveyors	Labor, Commerce and Industry	Labor, Commerce and Industry
4016	Environmental Health Inspections and Fees	Agriculture and Natural Resources	Medical Affairs
3222	Interruption of Service, Computation of Time, and Service Between Parties of Record	Labor, Commerce and Industry	Judiciary
4039	Designation of Asian Citrus psyllid as Plant Pest and Quarantine	Agriculture and Natural Resources	Agriculture and Natural Resources
4001	Plum Pox Virus Quarantine	Agriculture and Natural Resources	Agriculture and Natural Resources
4013	Standards for Licensing Nursing Homes	Medical, Military, Pub & Mun Affairs	Medical Affairs
4040	Consumer Credit Counseling Requirements	Labor, Commerce and Industry	Banking and Insurance
4031	LIFE Scholarship & LIFE Scholarship Enhancement	Ways and Means	Education
4032	Need-based Grants Program	Ways and Means	Education
4033	Palmetto Fellows Scholarship and Palmetto Fellows Scholarship Enhancement	Ways and Means	Education
4034	Determination of Rates of Tuition and Fees	Ways and Means	Education
4030	Public Swimming Pools	Agriculture and Natural Resources	Medical Affairs
4020	PC&N (Stretcher Vans)	Labor, Commerce and Industry	Judiciary
4017	Milk and Milk Products	Agriculture and Natural Resources	Medical Affairs
3198	Solid Waste Management: Demonstration-of-Need	Agriculture and Natural Resources	Medical Affairs
3221	Statewide Criminal Gang Database	Judiciary	Judiciary
4042	Seasons, Bag Limits, Methods of Take and Special Use Restrictions on Wildlife Management Areas	Agriculture and Natural Resources	Fish, Game and Forestry
4043	Amend and Add Regulations to Chapter 67 to Reflect Changes in Title 42 Necessitated by the Approval of Act 111 on June 25, 2007	Labor, Commerce and Industry	Judiciary
4049	Use and Dissemination of Test Results	Education and Public Works	Education
4053	Enforcement of Pilot Statutes and Maritime Homeland Security	Judiciary	Transportation
4022	Riverbanks Parks Commission	Agriculture and Natural Resources	Fish, Game and Forestry

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4054	Registration of Immigration Assistance Services	Labor, Commerce and Industry	Labor, Commerce and Industry
4055	Illegal Aliens and Private Employment	Judiciary	Labor, Commerce and Industry
4058	Insurance Holding Company Systems	Labor, Commerce and Industry	Banking and Insurance
4059	South Carolina Reinsurance Facility Recoupment	Labor, Commerce and Industry	Banking and Insurance
4060	Life Insurance Disclosure	Labor, Commerce and Industry	Banking and Insurance
4061	Valuation of Investments	Labor, Commerce and Industry	Banking and Insurance
4062	Phytophthora ramorum Quarantine	Agriculture and Natural Resources	Agriculture and Natural Resources
4068	Funeral Service Practice Act		Judiciary

Resolution Introduced to Disapprove

4014	Environmental Protection Fees	Agriculture and Natural Resources	Medical Affairs
4015	Environmental Protection Fees	Agriculture and Natural Resources	Medical Affairs

Permanently Withdrawn

3166	SCDOT Chief Internal Auditor	Education and Public Works	Transportation
4003	Donors and Goods Given Away for Advertising Purposes	Ways and Means	Finance

Executive Order No. 2009-03

WHEREAS, the Congress and President of the United States enacted the American Recovery and Reinvestment Act of 2009 (“the Act”), which provides for the expenditure of \$500 billion in federal funds for infrastructure investment, health care and welfare programs, and other public works; and

WHEREAS, the Act entitles the State of South Carolina to \$2.84 billion in federal funds for various public projects and programs; and

WHEREAS, the Act directs much of the stimulus funds programmatically to state and local governmental entities without requiring the approval or oversight of either the Governor or the General Assembly; and

WHEREAS, the expenditure of massive amounts of stimulus funds without oversight creates the possibility of government waste and fraud; and

WHEREAS, a coordinated effort to oversee and account for the expenditure of stimulus funds is fundamental to ensuring that taxpayer money is spent with efficiency and integrity; and

WHEREAS, pursuant to S.C. Code Ann. § 1-3-10, public officers have a duty to “immediately furnish to the Governor, in such form as he may require, any information desired by him in relation to their respective affairs or activities,” a directive that is consistent with the constitutional authority found in Article IV, Section 17, of the South Carolina Constitution, which provides that “[a]ll state officers, agencies, and institutions within the Executive Branch shall, when required by the Governor, give him information in writing upon any subject relating to the duties and functions of their respective offices.”

NOW, THEREFORE, I hereby establish the South Carolina Stimulus Oversight, Accountability, and Coordination Task Force (“Task Force”). The Task Force shall coordinate efforts among state and local governmental entities to maintain transparency, accountability, efficiency, and consistency with the Act in the spending of stimulus funds. In addition, the Task Force shall consult with the Senate Finance Committee and the House Ways and Means Committee to prevent annualizations and ensure that stimulus funds are not used to fund existing obligations or programs that are currently funded in the Annual Appropriations Act. The Task Force shall be comprised of the following officials or their designee:

- (1) South Carolina Comptroller General, who shall serve as the Chair of the Task Force;
- (2) South Carolina State Auditor, who shall exercise all powers provided pursuant to Title 11, Chapter 7, of the South Carolina Code of Laws to ensure that the accounting of all stimulus funds complies with state and federal law and other applicable government accounting standards and who shall assist the Comptroller General in his role as Chair of the Task Force; provided, however, that the State Auditor shall not perform any task which would jeopardize his independence as required by S.C. Code Ann. § 11-7-45;
- (3) South Carolina Treasurer;
- (4) South Carolina Superintendent of Education;
- (5) Secretary of the South Carolina Department of Transportation;
- (6) Director of the South Carolina Department of Health and Human Services;
- (7) Director of the Department of Social Services;
- (8) Secretary of the South Carolina Department of Commerce;
- (9) Chief of the State Law Enforcement Division;
- (10) Director of the Department of Public Safety;
- (11) Director of the Department of Natural Resources;
- (12) Commissioner of the Department of Health and Environmental Control;
- (13) Director of the Office of Economic Opportunity;

6 EXECUTIVE ORDERS

- (14) Executive Director of the Budget and Control Board;
- (15) Director of the South Carolina Energy Office;
- (16) Executive Director of the South Carolina State Housing Finance and Development Authority;
- (17) Director of the Budget and Control Board's Office of State Budget; and
- (18) Other public officials receiving or applying for stimulus funds, as hereafter appointed by the Governor.

FURTHER, pursuant to Article IV, Section 17, of the South Carolina Constitution and S.C. Code Ann. § 1-3-10, I hereby order that all State and local governmental entities that apply for, receive, or otherwise administer programs receiving funds from the Act provide the Task Force with such documents as it deems necessary to ensure that stimulus funds are expended, awarded, or otherwise distributed prudently, ethically, efficiently, and consistent with state and federal law.

This Order shall take effect immediately.

**GIVEN UNDER MY HAND AND THE
THE GREAT SEAL OF THE STATE OF
SOUTH CAROLINA, THIS 20th DAY
OF MARCH, 2009**

MARK SANFORD
Governor

Executive Order No. 2009-04

WHEREAS, on April 22, 2009, a brush fire broke out along Highway 90 in Horry County and spread along both sides of Highway 22 and has burned over 15,000 acres, damaged or destroyed 140 homes, and caused the evacuation of over 2,500 residents in Horry County; and

WHEREAS, I have been advised that the wildfire in Horry County represents a threat to the safety, security, welfare and property of citizens and transients living in South Carolina, and that Horry County has exhausted its resources.

NOW, THEREFORE, by virtue of the power and authority vested in me as Governor, pursuant to the Constitution and Statutes of the State of South Carolina, I hereby declare that a State of Emergency exists in Horry County. I direct that the South Carolina Emergency Operations Plan be placed into effect. I further direct that all prudent preparations be taken at the individual, local, and state levels to protect against the possible effects of the wildfire, and that the South Carolina National Guard be placed on a standby status and, at the discretion of the Adjutant General, and in coordination with South Carolina Emergency Management Division, specified units of the National Guard be placed on active duty to assist civil authorities and to take all reasonable precautions as is necessary for the preservation of life and property.

FURTHER, Proclamations and Orders deemed necessary to ensure the fullest possible protection of life and property during this State of Emergency may be issued verbally by me, and thereafter published for dissemination within the succeeding twenty-four hour period.

This Order shall take effect immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 23rd DAY OF APRIL, 2009.

MARK SANFORD
Governor

Executive Order No. 2009-05

WHEREAS, by Executive Order 2009-04, a state of emergency for Horry County, South Carolina, was declared because a brush fire broke out along Highway 90 and spread along both sides of Highway 22, eventually burning almost 20,000 acres and damaging or destroying over 170 homes; and

WHEREAS, today the South Carolina Forestry Commission has determined that the brush fire is 100 percent contained.

NOW, THEREFORE, by virtue of the power and authority vested in me as Governor, pursuant to the Constitution and Statutes of the State of South Carolina, I declare that a state of emergency no longer exists and hereby declare that Executive Order 2009-04 is cancelled, rescinded, and from this date declared null and void.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 28th DAY OF APRIL 2009.

MARK SANFORD
Governor

8 NOTICES

BUILDING CODES COUNCIL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 6-9-40 of the 1976 Code of Laws of South Carolina, as amended, the Building Codes Council hereby adopts the latest edition of the following nationally recognized code: 2008 Edition of the National Electric Code, with two amendments.

The original promulgating authority for this code is:

National Fire Protection Association

1 Batterymarch Park

Quincy, Massachusetts 02269

The Building Codes Council specifically requested comments concerning sections of this edition, which may be unsuitable for enforcement in South Carolina and considered all submissions. Based upon the evidence presented to it, the Building Codes Council finds the following modifications will provide a reasonable degree of public health, safety and welfare, and will be suitable for enforcement in South Carolina.

Modifications:

The modified sections will now read:

Article 90.2(B)(5)b. Not Covered – Installations under the exclusive control of an electric utility where such installations

b. Are located in legally established easements, rights-of-way, or by other agreements either designated by or recognized by public service commissions, utility commissions, or other regulatory agencies having jurisdiction for such installations, or

Article 210.12(B) Arc-Fault Circuit-Interrupter Protection – Exception (c) A circuit serving no outlets within the bedroom except the smoke detector shall not be protected by an arc-fault protector.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PUBLIC NOTICE

In accordance with Section 44-7-200(C), Code of Laws of South Carolina, the public is hereby notified that a Certificate of Need application has been accepted for filing and publication May 22, 2009, for the following project(s). After the application is deemed complete, affected persons will be notified that the review cycle has begun. For further information, please contact Mrs. Sarah "Sallie" C. Harrell, Division of Planning and Certification of Need, 2600 Bull St., Columbia, SC 29201 at (803) 545-4200.

Affecting Aiken County

Establishment of a home health agency restricted to serve Aiken County

United Home Care, Inc. d/b/a United Home Care of Aiken County

North Augusta, South Carolina

Project Cost: \$21,150

Affecting Barnwell County

Construction for the addition of sixteen (16) nursing home beds, which will not participate in the Medicaid (Title XIX) Program for a total of sixty (60) nursing home beds
 Barnwell County Nursing Home
 Barnwell, South Carolina
 Project Cost: \$2,138,960

Affecting Berkeley County

Establishment of a Home Health Agency restricted to the provision of pediatric home health services in Berkeley County to children aged fourteen (14) years and younger
 Lowcountry Nursing Group, LLC d/b/a Interim Healthcare
 Charleston, South Carolina
 Project Cost: \$600

Affecting Charleston County

Acquisition of the DISC Radiologists Practice by Carolina Family Care (CFC), a wholly owned subsidiary of University Medical Associates (UMA), in order to provide MRI services on a 1.0T Magnetic Resonance Imaging (MRI) unit approved in NA-06-13 which is located at 1341 Old Georgetown Road, Suite C, Mt. Pleasant, South Carolina
 Carolina Family Care, Inc.
 Mount Pleasant, South Carolina
 Project Cost: \$869,495

Establishment of a Home Health Agency restricted to the provision of pediatric home health services in Charleston County to children aged fourteen (14) years and younger
 Lowcountry Nursing Group, LLC d/b/a Interim Healthcare
 Charleston, South Carolina
 Project Cost: \$2,700

Affecting Dorchester County

Establishment of a Home Health Agency restricted to the provision of pediatric home health services in Dorchester County to children aged fourteen (14) years and younger
 Lowcountry Nursing Group, LLC d/b/a Interim Healthcare
 Charleston, South Carolina
 Project Cost: \$600

Affecting Greenville County

Acquisition of Greenville Radiology, P.A., a radiology group and imaging center for the expansion of services as an outpatient imaging department of Greenville Hospital System, to include the relocation of a sixteen (16) slice Computed Tomography (CT) scanner from the Memorial Medical Office Building (MMOB) at Greenville Memorial Hospital; the facility will be located at 1210 West Faris Road in Greenville
 Greenville Memorial Hospital
 Greenville, South Carolina
 Project Cost: \$8,802,803

10 NOTICES

In accordance with S.C. DHEC Regulation 61-15, the public and affected persons are hereby notified that the review cycle has begun for the following project(s) and a proposed decision will be made within 60 days beginning May 22, 2009. "Affected persons" have 30 days from the above date to submit comments or requests for a public hearing to Mr. Les W. Shelton, Division of Planning and Certification of Need, 2600 Bull Street, Columbia, S.C. 29201. For further information call (803) 545-4200.

Affecting Charleston County

Expansion of radiation oncology services by the addition of one (1) linear accelerator to be used for specialized treatment including pediatric and total body irradiation
Medical University of South Carolina Medical Center
Charleston, South Carolina
Project Cost: \$62,000

Affecting Greenville County

Renovation for the addition of a fourth (4th) fixed cardiac catheterization laboratory located a modular building on the first floor adjacent to the existing cardiac catheterization area
St Francis Hospital, Inc. (ST. FRANCIS downtown)
Greenville, South Carolina
Project Cost: \$2,956,035

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PUBLIC NOTICE

Statutory Authority: 1976 Code Section 48-1-10 et seq.

The South Carolina Department of Health and Environmental Control (Department) is publishing this public notice to provide interested persons the opportunity to comment on the Department's response to meet obligations of the United States Environmental Protection Agency (EPA). Specifically, the Department proposes to address the requirements of the EPA regarding the Control Techniques Guideline (CTG) Rule, pursuant to Section 182(b)(2)(A) of the CAA. To be considered, comments must be received by June 22, 2009, the close of the drafting comment period.

The Department is also providing the public with the opportunity to request a public hearing on the issue. If requested, a public hearing will be held on Tuesday, June 30, 2009, at 1:00 p.m., in room 3141 of the Sims Building, 2600 Bull Street, Columbia, South Carolina. The public is invited to attend. However, pursuant to 40 CFR 51.102, if no request for a public hearing is received by the close of the comment period (June 22, 2009), the hearing will be cancelled. If the public hearing is cancelled, the Department will notify the public at least one week prior to the scheduled hearing via the "Scheduled Public Hearings" link on the Air Quality Regulation Development webpage at <http://www.scdhec.gov/environment/baq/regulatory.aspx>. Interested persons may also contact Maeve S. R. Mason, Regulatory Development Section, Bureau of Air Quality, at 2600 Bull Street, Columbia, SC 29201, or via phone at (803) 898-2230 for more information or to find out whether the public hearing will be held.

Synopsis:

The Clean Air Act (CAA) (section 183(e)) directs the EPA to list regulated categories of consumer and commercial products that account for at least 80 percent of the volatile organic compounds (VOC) emissions in areas that violate the National Ambient Air Quality Standards (NAAQS) for ozone. The CAA further directs EPA to divide the list of categories to be regulated into four groups.

The EPA published the initial list in the *Federal Register* on March 23, 1995. Since then, however, the EPA has revised the list several times, with the most recent being May 2006.

“CAA section 172(c)(1) provides that state implementation plans (SIPs) for nonattainment areas must include ‘reasonable available control measures (RACM),’ including RACT, for sources of emissions. CAA section 182(b)(2)(A) provides that for certain nonattainment areas, States must revise their SIPs to include RACT for each category of VOC sources covered by a CTG document issued between November 15, 1990, and the date of attainment” (72 FR 57218).

The EPA defines RACT as the lowest emission limitation that a particular source is capable of meeting by the application of control technology (i.e., devices, systems, process modification, or other apparatus or techniques that reduce air pollution) that is reasonably available considering technological and economic feasibility. The RACT requirement is meant to ensure that all moderate and above nonattainment areas, have in place all RACT for source categories covered by a CTG document and for major sources that are not subject to a CTG.

States must adopt control methods for sources in its nonattainment area(s) subject to a CTG. Alternatively, a State may also declare that there are no sources in its nonattainment area(s) subject to a RACT requirement, and therefore, the requirement to adopt a rule for those sources does not apply.

On April 30, 2004, the EPA designated and classified a portion of York County, South Carolina within the Rock Hill Fort Mill Area Transportation Study (RFATS) Metropolitan Planning Organization (MPO) as a moderate nonattainment area for the 8-hour ozone NAAQS as part of the Charlotte-Gastonia-Rock Hill, North Carolina – South Carolina nonattainment area. As a result of this designation, the Department is required to amend the SIP, in accordance with the requirements of the CAA, as amended (42 U.S.C. 7401 et seq.). On August 31, 2007, the Department submitted a Reasonably Available Control Technology (RACT)/Reasonably Available Control Measures (RACM) SIP and the Rock Hill-Fort Mill Area Transportation Study (RFATS) 8-Hour Ozone Attainment Demonstration (SIP Amendment) for the Charlotte/Gastonia/Rock Hill (York County, SC) 8-hour ozone nonattainment area to the EPA which addressed the CTGs that had been promulgated up to that point (May 2006). Since then, additional CTGs have been promulgated.

On July 14, 2008, (as a result of the 2006 revisions) a final CTG for the Group IV (Miscellaneous Metal Product Coatings, Plastic Parts Coatings, Auto and Light-Duty Truck Assembly Coatings, Fiberglass Boat Manufacturing Materials, and Miscellaneous Industrial Adhesives) sources was published in the *Federal Register* (73 FR 40230). The CAA section 182(b)(2) provides that any CTG issued after 1990 specify the date by which States are required to submit a SIP revision. For the Group IV sources (the subject of this Notice), the EPA provides that States should submit their SIP revisions within one year of the date that the CTGs are finalized, or July 14, 2009.

The Department has reviewed its permit files and emissions inventory and has determined that there are no stationary sources or emitting facilities located in the York County ozone nonattainment area that are subject to the following Group IV CTG category sources as defined by the aforementioned *Federal Register* Notice. Pending any comments received, a letter to this effect will be sent to the EPA.

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Category	North American Industry Classification System Code	Examples of affected entities
Miscellaneous metal and plastic parts coatings.	331, 332, 333, 334, 336, 482, 811	Facilities that manufacture and repair fabricated metal, machinery, computer and electronic equipment, transportation equipment, rail transportation equipment.
Auto and light-duty truck assembly coatings.	336111, 336112, 336211	Automobile and light-duty truck assembly plants, producers of automobile and light-duty truck bodies.
Fiberglass boat manufacturing materials.	336612	Boat building facilities.
Miscellaneous industrial adhesives	316, 321, 326, 331, 332, 333, 334, 336, 337, 339, 482, 811	Facilities that manufacture and repair leather and allied products, wood products, plastic and rubber products, fabricated metal machinery, computer and electronic equipment, transportation equipment, furniture and related products, rail transportation equipment, and facilities involved in miscellaneous manufacturing.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

PUBLIC NOTICE

Public Notice #09-535-GP-N
May 22, 2009

The SCDHEC, Bureau of Air Quality (BAQ), does hereby give notice of authorization being granted to the following sources who have requested coverage under General Conditional Major Operating Permit (GCMP-03) "Hot Mix Asphalt Plants." This general permit was previously opened for a 30 day public comment period on September 1, 2006, with issuance on February 01, 2007. Pursuant to South Carolina Regulation 61-62.1, Section II G(7)(a)&(b), the Department may now grant coverage to those qualified sources seeking to operate under the terms and conditions of this general permit. The authorization of each facility's coverage shall be a permit action for purposes of administrative review.

In accordance with the provisions of the Pollution Control Act, Sections 48-1-50(5) and 48-1-110(a), the 1976 Code of Laws of South Carolina, as amended, and Regulation 61-62 "Air Pollution Control Regulations and Standards," these sources are hereby granted permission to discharge air contaminants into the ambient air. The BAQ authorizes the operation of these sources in accordance with the plans, specifications and other information submitted by each facility in the General Conditional Major Permit application. Facilities operating under this permit seek to limit their potential to emit to below the thresholds which define a major source by complying with the federally enforceable conditions contained in this permit. Permit coverage is subject to and conditioned upon the terms, limitations, standards, and schedules contained in or specified on said permit.

Interested persons may review the general permit, materials submitted by the applicant, and any written comments received, during normal business hours, at the following location: SCDHEC, BAQ, 2600 Bull Street, Columbia, South Carolina, 29201.

This notice is given pursuant to the requirements of South Carolina Regulation 61-62.1, Section II G(7)(c). Comments and questions concerning any of the following individual facility's coverage under this permit should be directed to: Ms. Elizabeth Basil, Director, Engineering Services Division, BAQ, SC DHEC, 2600 Bull Street, Columbia, South Carolina, 29201 at (803) 898-4123.

AIKEN COUNTY

T B Asphalt Inc
1579 Edgefield Hwy
Aiken SC

GREENVILLE COUNTY

Banks Brothers Asphalt Paving
1460 N Hwy 25
Travelers Rest SC

HORRY COUNTY

Southern Asphalt Inc
3470 Mt Pisgah Rd
Conway SC

WORKERS' COMPENSATION COMMISSION

NOTICE

The South Carolina Workers' Compensation Commission is considering a change to its Hospital Inpatient Payment System to include a carve out for implantable devices. Under this proposal, payments would continue to be determined by DRG, diagnosis related groups. For those discharges involving an implantable device, payment would be made based on the DRG assignment and the cost of the implant. While specifics of this proposal have not been established, the Commission is seeking comments on the possibility of such a change.

The present hospital payment system for inpatient care was established in 1997 and revised in 2006. It is based on diagnosis related groups, a classification which assigns inpatient claims based on diagnoses, procedures performed, complications, co-morbidities, signs and symptoms and discharge status. A DRG payment system is prospective in nature in that the price is set prior to services being rendered. Payment is based on the diagnosis related group the claim is assigned and determined by the resource needs for the average patient for that diagnosis group. Also included in this determination is length of stay and intensity of services. The DRG classifications used are those developed by the Centers for Medicare and Medicaid Services for the Medicare program. The maximum allowable payment is the Medicare payment rate plus 40%.

All comments and recommendations are welcomed and can be submitted to the Medical Services Division, South Carolina Workers' Compensation Commission, Post Office Box 1715, Columbia, South Carolina 29202-1715. To allow time for full consideration, comments must be submitted by July 31, 2009. A public hearing also will be held to receive comments. The public hearing will be held Wednesday, July 22, 2009 at 10:00 am at the offices of the Commission, 1333 Main Street, Columbia, South Carolina.

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WORKERS' COMPENSATION COMMISSION

NOTICE

The South Carolina Workers' Compensation Commission is in the process of reviewing and revising the *Medical Services Provider Manual* (fee schedule). The fee schedule sets the maximum allowable fees physicians and other medical providers may be paid for authorized services provided to a workers' compensation patient. It does not include fees for hospital inpatient and outpatient services, services which are included in a separate fee schedule.

The next edition of the *Medical Services Provider Manual* will be a complete revision and include updates to payment policies, billing policies, evaluation and management services, anesthesia, surgery, radiology, pathology and lab services, medicine and injections, physical medicine, special reports and services, and supplies and durable medical equipment. All procedural codes and prices will be updated.

Since 1995 the *Medical Services Provide Manual* has been based on the Center for Medicare & Medicaid Services resource based relative value scale, RBRVS. RBRVS establishes a relative value for most medical services and is a well recognized and established method for determining price based on the work involved, the expense associated with providing that service, and malpractice insurance costs. RBRVS attempts to ensure that fees are based on the resources used to provide each service and utilizes one of the most systematic methods for setting prices. The relative value of each procedure is multiplied by a conversion factor to arrive at the maximum allowable payment. The current conversion factor is \$52.00. Medicare's conversion factor for 2009 is \$36.0666.

All comments and recommendations are welcomed and can be submitted to the Medical Services Division, South Carolina Workers' Compensation Commission, Post Office Box 1715, Columbia, South Carolina 29202-1715. To allow time for full consideration, comments must be submitted by June 30, 2009. A public hearing also will be held to receive comments. The public hearing will be held Friday, June 19, 2009 at 10:00 am at the offices of the Commission, 1333 Main Street, Columbia, South Carolina.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61

Statutory Authority: 1976 Code Sections 13-7-10 et seq.

Notice of Drafting:

The Department of Health and Environmental Control proposes to amend R.61-63, Radioactive Materials (Title A) to adopt federal amendments. Interested persons may submit comments in writing to Richard A. Haynes, PE, Director, Division of Waste Management, S.C. Department of Health and Environmental Control, 2600 Bull Street, Columbia, S.C. 29201. To be considered, comments must be received by 5:00 p.m. on June 26, 2009, the close of the drafting comment period.

Synopsis:

The Nuclear Regulatory Commission (USNRC) promulgates amendments to 10 CFR 30, 40, 70 and 71 throughout each calendar year.

Recent amendments include requirements for the National Source Tracking System (RATS-ID 2006-2 & 2006-3), published in the *Federal Register* on November 8, 2006 at 71 FR 65585, the Expanded Definition of Byproduct Material (RATS-ID 2007-3), published on October 1, 2007 at 72 FR 55864, and Occupational Dose Records, Labeling Containers, and Total Effective Dose Equivalent (RATS-ID 2008-1), published on December 4, 2007 at 72 FR 68043.

The Department intends to amend R.61-63, Radioactive Materials (Title A) to maintain conformity with federal requirements and ensure compliance with federal standards as required by Section 274 of the Atomic Energy Act of 1954. In addition, minor corrections and clarifications may be made to achieve conformity with prior federal regulations.

Legislative review of these amendments will not be required.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61

Statutory Authority: 1976 Code Sections 44-7-110 et seq.

Notice of Drafting:

The Department of Health and Environmental Control proposes to amend specific sections of Regulation 61-84, Standards For Licensing Community Residential Care Facilities. This current Notice of Drafting cancels, replaces and supercedes the proposed revisions noticed in a previous Notice of Drafting that was published in the State Register on May 23, 2008. Interested persons may submit written comments on the proposed revisions as listed below to Dennis L. Gibbs, Director, Division of Health Licensing, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina 29201. To be considered, all comments must be received no later than 5:00 p.m. on June 22, 2009, the close of the drafting comment period.

Synopsis:

The Department proposes to amend and is soliciting comments on specific sections of Regulation 61-84, to be limited to the revision/update of those sections relating to:

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- (1) definitions, *i.e.*, proposed new definitions on airborne infection isolation, blood assay for Mycobacterium tuberculosis (BAMT), contact investigation, incident, latent TB infection (LTBI), private sitter, quarterly and risk assessment; revision of definitions: annual, local transportation , and peak hours (Section 101);
- (2) non-departmental publications referenced in this regulation (Section 102.B);
- (3) compliance with structural standards (Section 103.D);
- (4) the living quarters in the facility for individuals other than residents (Section 103.G);
- (5) application completion (Section 103.J);
- (6) the fiscal responsibilities of the proposed facility licensee and facility licensee (Section 103.K);
- (7) license fees (Section 103.L);
- (8) department reports availability (Section 202.E);
- (9) conditions affecting the determination of enforcement action (Section 302.E);
- (10) determination of monetary penalty amounts (Section 302.F);
- (11) appeal procedure for enforcement actions (Section 302.G);
- (12) facility responsibilities for written policies and procedures (Section 401.A);
- (13) a criminal background check for direct care staff (Section 501.B);
- (14) administrator licensing law (Section 502.A);
- (15) facility staff provision of care (Section 503.B);
- (16) staff training documentation and verification (Section 504.A);
- (17) staff provision of resident recreational activities (Section 504.B);
- (18) private sitters for residents (proposed new Section at 506);
- (19) facility compliance with reporting of incidents (Section 601);
- (20) change of administrator reporting responsibilities (Section 604);
- (21) time period for notes of observation (Section 701.B.6);
- (22) age of resident photograph (Section 701.B.10);
- (23) resident assessment documentation requirements (Section 702);
- (24) criteria for resident admission and retention (Section 801.B&C);
- (25) documentation requirements for statement of resident rights and grievance procedures (Section 901.A.8);
- (26) resident finances fiscal management documentation (Section 902.H);

- (27) resident use of telephone (Section 1001.L);
- (28) content of resident physical examination (Section 1101.A);
- (29) medication and first aid items availability (Section 1201.A);
- (30) medication and treatment orders (Section 1202);
- (31) time period for physician signing verbal orders (Section 1202.B);
- (32) documentation of treatments (Section 1203.A);
- (33) clarification of unit dose system (Section 1205.B);
- (34) refrigeration of medications (Section 1206.A.);
- (35) documentation of controlled substances (Section 1206.C);
- (36) menu approvals for medically prescribed diets (Section 1306.A);
- (37) facility staff use of alcohol-based hand sanitizers (Section 1309.A);
- (38) counties affected by letter of agreement for sheltering facilities (Section 1401.B.1.c);
- (39) documentation of continuity of essential services (Section 1403);
- (40) resident fire response training (Section 1503.C);
- (41) tuberculin skin testing for residents and staff (Section 1702);
- (42) health screening for facility pets (Section 1705. B);
- (43) kitchen firefighting equipment (Section 2201.D);
- (44) non-combustible or flame retardant materials (Section 2207.D);
- (45) facility ‘no smoking’ areas (Section 2207.E);
- (46) ‘smoking’ and ‘non-smoking’ areas signage (Section 2207.F);
- (47) mirrors in resident rooms (Section 2702.J);
- (48) use of bar soap in shared bathrooms (Section 2704.D);
- (49) facility telephones for resident use (Section 2715.A); and
- (50) barriers to natural or manmade bodies of water on or adjacent to the facility property (Section 2717.A).

Additionally, changes may be proposed throughout the regulation to improve its overall quality, *i.e.*, stylistic changes and language clarifications. The table of contents will be updated, and other minor corrections may be proposed as needed.

Legislative review of this amendment is required.

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DEPARTMENT OF INSURANCE

CHAPTER 69

Statutory Authority: 1976 Code Sections 1-23-110, 38-3-110 and 38-57-10 et seq.

Notice of Drafting:

The South Carolina Department of Insurance proposes to promulgate a regulation that will set forth standards to protect purchasers of life insurance and annuities from improper or misleading insurance sales practices in the marketing or sales of life insurance and annuities. Interested persons may submit comments in writing to: Rachel Harper, South Carolina Department of Insurance, 1201 Main Street, Suite 1000, Columbia, South Carolina 29201 or P.O. Box 100105, Columbia, South Carolina 29202. To be considered, comments must be received no later than 5:00 p.m. on June 24, 2009, the close of the drafting comment period.

Synopsis:

The South Carolina Department of Insurance proposes to promulgate a regulation that will set forth the standards to protect purchasers of life insurance and annuities from misleading and improper use of specific designations or titles in the marketing or sales of life insurance and annuities. It makes it an unfair and deceptive act or practice for an insurance producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that the insurance producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale or purchase of a life insurance or annuity product. This regulation shall be based upon the NAIC Model Regulation on the Use of Senior-Specific designations in the sale of life insurance and annuities.

The proposed regulation will require legislative review.

DEPARTMENT OF NATURAL RESOURCES

CHAPTER 123

Statutory Authority: 1976 Code Section 50-15-70

Notice of Drafting:

The Department of Natural Resources proposes to repeal regulations 123-151 and draft new regulations to implement the alligator management program pursuant to amendments made to Chapter 15 of Title 50 of SC Code of Laws. The new regulations will prescribe and implement the Depredation, Private Lands and Hunting Season programs for alligators.

Interested persons may submit comments to D. Breck Carmichael, Jr., Deputy Director, Wildlife & Freshwater Fisheries Division, S.C. Department of Natural Resources, Post Office Box 167, Columbia, SC 29202.

Synopsis:

The General Assembly passed amendments to Chapter 15 of Title 50 to provide for an alligator hunting season and to make changes to existing programs. The proposed regulation will clearly describe the process and requirements for participants in the harvest of alligators in SC.

Document No. 4075
BOARD OF COSMETOLOGY
CHAPTER 35

Statutory Authority: 1976 Code Sections 40-1-70 and 40-13-60

Chapter 35. Requirements of Licensure in the Field of Cosmetology

Preamble:

To satisfy the requirements of licensure in the field of cosmetology, Regulations 35-1 through 35-5, Regulations 35-8 through 35-10, Regulations 35-13, 35-15 through 35-16, 35-20, and Regulations 35-23 through 35-26 must be revised and updated in conformance with the current Board of Cosmetology Practice Act. Regulations 35-7, 35-11, 35-12 and 35-22 will be deleted.

Section-by-Section Discussion:

Regulation 35-1.

Updates provisions to reflect terminology change from manicuring to nail technology; increases surety bond for school owners (protection for students who prepay tuition). Streamlines process for application review.

Regulation 35-2.

Simplifies provisions for equipping schools and references current building, health and fire codes.

Regulation 35-3.

Revises provision for minimum curriculum for a school of cosmetology, nail technology, or esthetics. Courses include threading; reduces hours to match statutory requirements.

Regulation 35-4.

Revises provision for instructors, qualifications, and applications. Defines specific educational and licensure requirements for instructors in methods of teaching as well as Student Instructor Training Program and curriculum requirements.

Regulation 35-5.

Revises provision for instructor examinations and reexaminations to facilitate use of national examinations.

Regulation 35-7.

Deleted in its entirety.

Regulation 35-8.

Revises provision for recognition of instructors licensed in other states.

Regulation 35-9.

Revises provision for license renewal for instructors.

20 PROPOSED REGULATIONS

Regulation 35-10.

Revises provision for general rules for the operation of cosmetology schools. Clarifies requirements for record retention, transcript submittal, training/class schedules, credit hours transfer, and school and student standards. Grade passage requirements are determined by individual schools.

Regulation 35-11.

Deleted in its entirety. Public school programs meet requirements of 35-1 and do not need additional regulation.

Regulation 35-12.

Deleted in its entirety to reflect use of national examinations.

Regulation 35-13.

Simplifies recognition by endorsement of out of state licenses.

Regulation 35-15.

Revises provision for licensure of cosmetology, nail technology, and esthetics salons. Simplifies applications, temporary permits, inspections, changes in location, changes in name and/or owner, salon closure and salon renewal.

Regulation 35-16.

Revises provision for salon equipment requirements, eliminating obsolete minimum requirements and salon specific equipment. Revision reflects current EPA and OSHA standards for disinfectants.

Regulation 35-20.

Revises provision for inspection of sanitation and safety for salons and schools, including residential salons. Provides for specific physical facilities' requirements, cleanliness standards, and instruments and supplies. Prohibits presence of animals in salons. Provides disinfecting requirements for instruments and supplies and prevention of infectious diseases.

Regulation 35-22.

Deleted in its entirety.

Regulation 35-23.

Revises provision for continuing education requirements to reflect changes in statute. Provides specific contact hours required and licensure status.

Regulation 35-24.

Revises provision for continuing education programs. Maintains University of South Carolina, Division of Continuing Education, as the certifying agent.

Regulation 35-25.

Revises provision for fees pursuant to S.C. Code Section 40-1-50.

Regulation 35-26.

Revises provision for minimum requirements for crossover between licensed cosmetologists and Master Hair Care Specialists.

Notice of Public Hearing and Opportunity for Public Comment:

Should a hearing be requested pursuant to Section 1-23-110(A)(3) of the 1976 Code, as amended, such a hearing will be conducted at the Administrative Law Judge Court at 9:00 a.m. on Thursday, July 9, 2009. Written comments may be directed to Eddie L. Jones, Administrator, South Carolina Board of Cosmetology, Post Office Box 11329, Columbia, South Carolina 29211-1329, no later than 5:00 p.m., June 25, 2009. If a qualifying request pursuant to Section 1-23-110(A)(3) is not timely received, the hearing will be canceled.

Preliminary Fiscal Impact Statement:

There will be no cost incurred by the State or any of its political subdivisions.

Statement of Need and Reasonableness:

These regulations are amended in conformance with Cosmetology Practice Act.

DESCRIPTION OF REGULATION:

Purpose: The board is updating the regulations to reflect amendments to the practice act (S.C. Code 40-13-10 et seq.) and simplify existing regulations. Proposed changes include requirements for board notification of school closings and for transfer of student records, for issuance of a cosmetology instructor's license for all locations, and for approval of persons with specialized training or education to teach cosmetology. Other changes include an increase of hours in the nail technician and esthetics curriculums, and an increase of bond fees as well as changes to the fee schedule.

Legal Authority: 1976 Code Sections 40-13-60 and 40-1-70.

Plan for Implementation: The revised regulations will take effect upon approval by the General Assembly and upon publication in the State Register. LLR will notify licensed operators of the revised regulations and post the revised regulations on the agency's web site.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS THEREIN AND EXPECTED BENEFITS:

The proposed regulations will prevent conflict between existing regulations and newer legislation. The proposed regulations will standardize the terminology used to refer to licensed nail technicians and to the nail technology taught and practiced. These changes will aid the licensees in understanding their responsibilities to the public.

The proposed regulations reflect current knowledge on sanitizers and will eliminate potential conflict between these regulations and the occupational safety and health standards of the state.

22 PROPOSED REGULATIONS

DETERMINATION OF COSTS AND BENEFITS:

There is no cost incurred by the state.

UNCERTAINTIES OF ESTIMATES:

There are no uncertainties of estimates concerning the regulations.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

These regulations will have no effect on the environment. These regulations contribute to the board's function of protecting public health in the state of South Carolina.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED:

There will be no detrimental effect on the environment and public health of this State if these regulations are not implemented.

Statement of Rationale:

These regulations are repealed and updated in conformance with the current Board of Cosmetology Practice Act.

Text:

The full text of this regulation is available on the South Carolina General Assembly Home Page: <http://www.scstatehouse.net/regnsrch.htm>. Full text may also be obtained from the promulgating agency.

Document No. 4076
DEPARTMENT OF NATURAL RESOURCES
CHAPTER 123
Statutory Authority: 1976 Code Section 50-15-70

123-150. Non-Game and Endangered Species
123-150.2. Birds, Fish, Reptiles, Amphibians and Mammals

Preamble:

The South Carolina Department of Natural Resources is proposing to update the Non-Game and Endangered Species list for South Carolina. The following is a section-by-section summary of the proposed changes and additions:

These proposed regulatory changes amend Regulations 123-150 and 123-150.2 in Chapter 123.

Section-by Section Discussion

In Regulation 123-150 the American Peregrine Falcon, Arctic Peregrine Falcon, and Southern Bald Eagle are deleted from the list.

In Regulation 123-150.2 the Bald Eagle and American Peregrine Falcon are added to the state list of Non-game Wildlife in Need of Management.

Notice of Public Hearing and Opportunity for Public Comment:

Should a hearing be requested pursuant to Section 1-23-110(A)(3) of the 1976 Code, as amended, such hearing will be conducted at 1000 Assembly Street on July 8, 2009, at 10:00 am in room 335, third floor, Rembert C. Dennis Building. Written comments may be directed to D. Breck Carmichael, Jr., Deputy Director, Wildlife & Freshwater Fisheries Division, Department of Natural Resources, Post Office Box 167, Columbia, SC 29202.

Preliminary Fiscal Impact Statement:

This amendment of Regulations 123-150 and 123-150.2 will not result in any fiscal impact to the state or the department.

Statement of Need and Reasonableness:

The statement of need and reasonableness was determined based on staff analysis pursuant to S.C. Code Sections 1-23-115(C) (1) through (3) and (9) through (11).

DESCRIPTION OF THE REGULATION:

Purpose: These regulations amend Chapter 123-150 and 123-150.2 to clarify and update conservation status and taxonomic changes for selected species in order to comply with changes in Federal law or regulation.

Legal Authority: Under Section 50-15-40 of the S.C. Code of Laws, the Department of Natural Resources has jurisdiction to review and amend the list of Non-Game Wildlife and Endangered Species in South Carolina.

Plan for Implementation: Once the regulation has been amended, the public will be notified through news releases and other Department media outlets and publications.

DETERMINATION OF NEED AND REASONABLENESS OF THE REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS:

The conservation status of wildlife species in South Carolina may change as a result of modification to the United States' List of Endangered Native Fish and Wildlife involving species indigenous to the State. The taxonomic status of wildlife species in South Carolina may change as a result of current research. As such the department is obligated to track and assess these changes and reflect them in proposed regulatory changes. The benefit of such actions to the state is an updated list of non-game wildlife and endangered species that is reflective of current conservation and taxonomic status changes.

DETERMINATION OF COSTS AND BENEFITS:

Implementation of the proposed regulation will not require any additional costs to the state.

UNCERTAINTIES OF ESTIMATES:

Staff does not anticipate any increased costs with the promulgation of this regulation. Accordingly, no costs estimates and the uncertainties associated with them are provided.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

The promulgation of this regulation will not have any impacts on public health. Environmental impacts will be positive since the proposed regulation will result in improved conservation and management for the affected species.

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DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED:

No detrimental impact on public health or the environment will occur if this proposed regulation is not implemented. Failure to implement this regulation will prevent positive benefits to public.

Statement of Rationale:

Rationale for the formulation of these regulations is based on changes to the endangered species list of the U.S. Fish and Wildlife Service as published in the federal register: American peregrine falcon delisted with a status of recovered 64 FR46541 46558, August 25, 1999; Arctic peregrine falcon delisted with a status of recovered 59 FR 50796 50805, October 5, 1994 and bald eagle delisted with a status of recovered 72 FR 37345 37372, July 9, 2007.

Text:

The full text of this regulation is available on the South Carolina General Assembly Home Page: <http://www.scstatehouse.net/regnsrch.htm>. Full text may also be obtained from the promulgating agency.

Document No. 4077
ALCOHOLIC BEVERAGES, BEER AND WINE
CHAPTER 7
Statutory Authority: 1976 Code Sections 12-4-320 and 61-2-60

7-202., 7-401.1., and 7-700. Premises

Preamble:

The South Carolina Department of Revenue is considering promulgating SC Regulation 7-202 to revise the definition of “premises” for purposes of licenses for beer, wine, and liquor issued pursuant to Title 61, Chapters 4 and 6. The Department of Revenue is also considering repealing SC Regulations 7-401.1 and 7-700, which contain the current definitions of “premises.” On repeal, SC Regulation 7-401.1 will be designated as “Reserved.” The Notice of Drafting was published in the February 27, 2009 edition of the State Register.

Section-by-Section Discussion

Proposed SC Regulation 7-202, which includes four subsections, will provide a unified definition of premises, with general guidelines appropriate for all license holders. The regulation will also provide specific guidelines appropriate for specific types of premises, i.e., the premises of retail liquor dealers and the premises of nonprofit organizations licensed to sell alcoholic liquor by the drink. These general and specific guidelines are consistent with other regulations or longstanding Department of Revenue policy, or both. In addition, a subsection addressing certain facilities that may constitute the premises for a license to sell liquor by the drink, including golf courses, fishing piers, and resort complexes, will incorporate and make public longstanding Department of Revenue policy as modified in accordance with recent amendments to S.C. Code Ann. Sections 61-6-20(2) and 61-6-1610.

With the promulgation of SC Regulation 7-202, SC Regulations 7-401.1 and 7-700, which contain the current definitions of premises, will become obsolete. Therefore, the South Carolina Department of Revenue is considering repealing SC Regulations 7-401.1 and 7-700. On repeal, SC Regulation 7-401.1 will be designated as “Reserved.”

Notice of Public Hearing and Opportunity for Public Comment:

All comments concerning this proposal should be mailed to the following address by 5:00 p.m. on June 22, 2009: S.C. Department of Revenue, Legislative Services - Mr. Meredith Cleland, P.O. Box 125, Columbia, South Carolina 29214.

The Department of Revenue has scheduled a public hearing before the Administrative Law Court in the Edgar Brown Building (Suite 224) on the Capitol Complex (1205 Pendleton Street) in Columbia, South Carolina for Tuesday, September 15, 2009 at 10:00 a.m. if the requests for a hearing meet the requirements of S.C. Code Ann. Section 1-23-110(A)(3). The public hearing, if held, will address a proposal by the Department to promulgate SC Regulation 7-202 concerning the definition of “premises” for purposes of licenses for beer, wine and liquor issued pursuant to Title 61, Chapters 4 and 6, and to repeal SC Regulations 7-401.1 and 7-700. The Department will be asking the Administrative Law Court, in accordance with S.C. Code Ann. Section 1-23-111, to issue a report that the proposal to promulgate SC Regulation 7-202 and to repeal SC Regulations 7-401.1 and 7-700 is needed and reasonable.

Preliminary Fiscal Impact Statement:

There will be no impact on state or local political subdivisions expenditures in complying with this proposed legislation. There will be no impact on general fund collections.

Statement of Need and Reasonableness:

DESCRIPTION OF REGULATION: 7-202. Premises

Purpose: To promulgate SC Regulation 7-202 to provide a unified definition of premises, with general guidelines appropriate for all license holders. Two of the regulation subsections will provide specific guidelines appropriate for specific types of premises, i.e., the premises of retail liquor dealers and the premises of nonprofit organizations licensed to sell alcoholic liquor by the drink. These guidelines are consistent with other regulations or longstanding Department of Revenue policy, or both. In addition, a subsection addressing certain facilities that may constitute the premises for a license to sell liquor by the drink, including golf courses, fishing piers and resort complexes, will incorporate and make public longstanding Department of Revenue policy as modified in accordance with recent amendments to S.C. Code Ann. Sections 61-6-20(2) and 61-6-1610. With the promulgation of SC Regulation 7-202, SC Regulations 7-401.1 and 7-700, which contain the current definitions of premises, will become obsolete. Therefore, the South Carolina Department of Revenue is considering repealing SC Regulations 7-401.1 and 7-700. On repeal, SC Regulation 7-401.1 will be designated as “Reserved.”

Legal Authority: S.C. Code Ann. Sections 12-4-320 and 61-2-60.

Plan for Implementation: After approval by the General Assembly and publication in the State Register, SC Regulation 7-202 would be effective upon publication in the State Register. The repeal of SC Regulations 7-401.1 and 7-700 would be effective at the same time.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS:

The promulgation of SC Regulation 7-202 is needed to provide a unified definition of premises, with general and specific guidelines that are consistent with other regulations or longstanding Department of Revenue policy, or both, as modified by recent amendments to S.C. Code Ann. Sections 61-6-20(2) and 61-6-1610. The

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promulgation of SC Regulation 7-202 is reasonable in that it represents longstanding Department policy that is consistent with applicable statutes and regulations. The repeal of SC Regulations 7-401.1 and 7-700, which contain the current definitions of premises, is both needed and reasonable inasmuch as these regulations will become obsolete with the promulgation of SC Regulation 7-202.

DETERMINATION OF COSTS AND BENEFITS:

There will be no impact on state or local political subdivisions expenditures from the promulgation of SC Regulation 7-202 and repeal of SC Regulations 7-401.1 and 7-700. There will be no impact on general fund collections. Promulgation of SC Regulation 7-202 and repeal of SC Regulations 7-401.1 and 7-700 will benefit the State and taxpayers by providing a unified definition of premises with general and specific guidelines, thus ensuring that longstanding Department of Revenue policies are made public and brought up to date in accordance with recent statutory amendments.

UNCERTAINTIES OF ESTIMATES:

None.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

None.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF REGULATION IS NOT IMPLEMENTED:

None.

Statement of Rationale:

SC Regulation 7-202 will provide a unified definition of premises, with general guidelines appropriate for all license holders. Two of the regulation subsections will provide specific guidelines appropriate for specific types of premises, i.e., the premises of retail liquor dealers and the premises of nonprofit organizations licensed to sell alcoholic liquor by the drink. The general and specific guidelines are consistent with other regulations or longstanding Department of Revenue policy, or both. In addition, a subsection addressing certain facilities that may constitute the premises for a license to sell liquor by the drink, including golf courses, fishing piers, and resort complexes, will incorporate and make public longstanding Department of Revenue policy as modified in accordance with recent amendments to S.C. Code Ann. Sections 61-6-20(2) and 61-6-1610. With the promulgation of SC Regulation 7-202, SC Regulations 7-401.1 and 7-700, which contain the current definitions of premises, will become obsolete. Therefore, the South Carolina Department of Revenue is considering repealing SC Regulations 7-401.1 and 7-700. On repeal, SC Regulation 7-401.1 will be designated as "Reserved."

The promulgation of SC Regulation 7-202 and repeal of SC Regulations 7-401.1 and 7-700 are needed to provide a unified definition of premises with general and specific guidelines, thus ensuring that longstanding Department of Revenue policies are made public and brought up to date in accordance with recent statutory amendments.

Text:

The full text of this regulation is available on the South Carolina General Assembly Home Page: <http://www.scstatehouse.net/regnsrch.htm>. Full text may also be obtained from the promulgating agency.

Document No. 4078
SECRETARY OF STATE
 CHAPTER 113

Statutory Authority: 1976 Code Sections 30-6-10 to 30-6-70

113-300 to 113-400. Uniform Real Property Recording Act

Preamble:

The General Assembly passed Act 210 of 2008 (South Carolina Code Section 30-6-10, et seq.) creating the Uniform Real Property Electronic Recording Act. The Act provides that the Secretary of State shall promulgate regulations to adopt standards to implement this chapter based upon the recommendations of the Electronic Recording Committee.

The purpose of these standards are as follows:

- A. To keep the standards and practices of registers in South Carolina in agreement with the standards of national standard-setting bodies, such as the Property Records Industry Association (PRIA), and in agreement with nationally accepted best practices in electronic real property recording.
- B. To keep the technology used by registers in South Carolina compatible with technology used by recording offices nationally that have enacted the Uniform Real Property Electronic Recording Act.
- C. To keep the standards and practices of registers in South Carolina in agreement with professional standards and best practices in electronic records management.
- D. To ensure accessibility of electronic instruments filed and recorded by a register as public records.
- E. To manage and retain real property records in accordance with established records management standards for electronic records.

Notice of Drafting was published in the South Carolina *State Register* on February 27, 2009.

Section by Section Discussion

- 113-300 This section defines the terminology used throughout the regulations.
- 113-310 This section provides an overview of the intent of the regulations.
- 113-320 This section sets forth the three models for electronic filing of documents.
- 113-330 This section sets forth the requirements for the Memorandum of Understanding between the parties who elect to file electronically and the register who will receive the electronic filing.
- 113-340 This section outlines the procedures to follow to ensure the authenticity and integrity of the electronically filed document.
- 113-350 This section outlines the procedures to follow when the filer is prepared to submit the document to the register.
- 113-360 This section outlines the requirements for the electronic recording of the document.
- 113-370 This section describes the types of document formats that may be filed electronically.

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- 113-380 This section describes how documents will be indexed in the county register's offices.
- 113-390 This section describes the process for the payment of fees and provisions for providing the filer with a receipt.
- 113-400 This section outlines the provisions for the preservation of the documents filed electronically within the register's offices.

Notice of Public Hearing and Opportunity for Public Comment:

Should a hearing be requested pursuant to Section 1-23-110(A)(3) of the S.C. Code, as amended, such hearing will be held on August 21, 2009 in the Department of Parks, Recreation and Tourism Conference Room, located on the second floor of the Edgar Brown Building, Room 252, 1205 Pendleton Street, State House Grounds, Columbia, South Carolina. Persons desiring to make oral comments at the hearing are asked to provide written copies of their presentation for the record. If a qualifying request pursuant to Section 1-23-110(A) (3) is not timely received, the hearing will be canceled.

Interested persons are also provided an opportunity to submit written comments on the proposed regulations by writing to the Secretary of State's Office, Melissa Dunlap, Chief of Staff & General Counsel, 1205 Pendleton Street, Suite 525, Columbia, SC 29201. Comments must be received no later than 5:00 PM on June 22, 2009.

Preliminary Fiscal Impact Statement:

No state funding is requested. The fiscal impact on local counties that choose to allow electronic recording is indeterminate. The Act does not require local government entities to incur any costs since participation in electronic recording is voluntary. If a county chooses to allow electronic recording of documents it would need to purchase specific hardware that would enable it to receive documents for recording, indexing and returning a copy of the documents once the recording is completed. Local Registers may experience reduced costs as a result of electronic recording. These savings would be in the scanning, copying and mailing costs currently associated with filings. Additionally, there would be a more efficient method of identifying and correcting errors in documents.

Statement of Need and Reasonableness:

The Secretary of State is required, pursuant to Act No. 210 of 2008, to promulgate regulations to adopt standards for uniform electronic recording of real property as recommended by the Electronic Recording Committee.

DESCRIPTION OF REGULATIONS:

Purpose: To provide uniform statewide standards for the electronic recording of documents related to real property.

Legal Authority: 1976 Code 30-6-10 et seq.

Plan for Implementation: The new regulations will take effect upon approval of the General Assembly and upon publication in the *State Register*. The new regulations will be available on the agency's website.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS:

The proposed regulations will set forth standards for local county registers to follow to implement the standards for uniform real property recording in the state.

DETERMINATION OF COSTS AND BENEFITS:

There will be no additional cost incurred by the State or its political subdivisions.

UNCERTAINTIES OF ESTIMATES:

There are no uncertainties of estimates concerning the regulations.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

These regulations will have no negative effect on the environment. These regulations will set forth uniform standards for electronic recording of real property documents in the state. There will be a reduction in paper usage.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED:

There will be no detrimental effect on the environment and public health of this State if these regulations are not implemented.

Statement of Rationale:

Promulgation of these regulations is necessary in order to carry about the provisions of 2008 Act No. 210.

Text:

The full text of this regulation is available on the South Carolina General Assembly Home Page: <http://www.scstatehouse.net/regnsrch.htm>. Full text may also be obtained from the promulgating agency.

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Filed: April 28, 2009 3:34pm

Document No. 4074

DEPARTMENT OF NATURAL RESOURCES

CHAPTER 123

Statutory Authority: 1976 Code Sections 50-11-2200 and 50-11-2210

123-200, 123-201, 123-203 and 123-205. Regulation of Real Property Owned by Department

Emergency Situation:

These emergency regulations amend and supersede South Carolina Department of Natural Resources Regulation Numbers 123-200, 123-201 (the definition of hunting), 123-203 (the introductory paragraph and subsections D, E (item (13) is added), H, K, L(1), and Q and by adding subsections T through BB) and 123-205 (D(2), V(1), W(1) and (6), and X(1), and by adding OO and PP). These regulations set use restrictions for DNR-owned and leased property. Since DNR properties are open year round, it is necessary to file these regulations as emergency to allow immediate public use.

Text:

ARTICLE 5.5

REGULATION OF REAL PROPERTY OWNED BY DEPARTMENT

123-200. Regulations Applicable to Real Property Owned or leased as a Wildlife Management Area by the Department of Natural Resources.

Applicability and Scope.

A. The purpose of this regulation is to govern the conduct and activities of visitors to all lands owned or leased by the Department of Natural Resources. This regulation applies to all lands, structures, and property owned or leased by the Department of Natural Resources, including but not limited to wildlife management areas, heritage preserves, boat landings, and game preserves or reserves.

B. Regulations for the establishment of open and closed seasons, bag limits, and methods for hunting and taking wildlife on all Department owned wildlife management area lands, and for the protection, preservation, operation, maintenance, and use of wildlife management area lands not owned by the Department are stated in R.123-40. The regulations below will apply to Department owned or leased wildlife management area lands in addition to R.123-40. In case of any conflict with R.123-40, this regulation will prevail.

C. Nothing contained in these regulations shall interfere in any manner with the use and management of lands by a state agency in charge of these lands in the functions of the agency as authorized by law. The Department or emergency personnel may undertake any of these activities for enforcement, emergencies or management purposes.

123-201. Definitions.

For purposes of this regulation:

“Hunting” means the act of trying to find, seek, obtain, pursue, or diligently search for wildlife for sport, regardless of whether wildlife is taken or not. The act of seeking wildlife or the pursuit of wildlife as sport, such as but not limited to raccoon hunting and training hunting dogs shall be deemed hunting. Any person accompanying a hunter or hunters and participating in a hunt in any regard shall be deemed to be hunting.

123-203. General Regulation.

This section shall apply to all Department land, owned or leased except as provided in any regulation for Heritage Preserves in 123-204 or specific Department land designated in 123-205.

D. Rock climbing or rappelling is prohibited on all Department land.

E. Operation of motorized, nonmotorized vehicles, all terrain vehicles, and off road vehicles.

The operation of motorized vehicles is allowed subject to the following restrictions or conditions:

(13) Operating a motor vehicle in watercourses other than at fording sites is prohibited.

H. Horse riding.

(1) The riding of horses is permitted on Department land only in areas specifically designated for horse riding.

(2) The Department may restrict the number of horses and horse trailers on any Department land and may require permits on specific areas. Restrictions shall be posted at the offices and/or entrances to Department lands or in published brochures.

(3) The owner of any horse brought onto Department property is responsible for providing proof of current Coggins and health certificates for out of state horses.

(4) The owner of any horse brought onto Department property is responsible for the payment of any expense for the removal of injured or dead horses.

(5) No horse may be left unattended.

(6) Only pelletized feed may be used, no hay.

(7) Access to a Department property by horseback is limited to a designated public entrance. A public entrance is a day-use parking area or a designated trailhead. For ride-on users (without vehicles or trailers) only, entrance is allowed where a designated horse road or firebreak intersects a public or private road.

(8) When not being ridden, horses must be led by halter or reins or must be confined in a trailer. A person may not use a portable corral or an electric fence and must confine a horse to a hitching rail or trailer tie.

(9) Within a day-use parking area, horses must be kept at a flat walk.

(10) The Department may require a person with an unruly horse, which is causing a disturbance or safety hazard, to remove the horse from Department property.

K. Consumption of alcohol.

Public drunkenness is not allowed on Department land. The consumption or display of any beverage containing alcohol while operating or riding as a passenger in any motorized or non-motorized vehicle is not allowed. Alcoholic beverages may be consumed by a person of lawful age only while actually camping at a designated campsite. The consumption of alcoholic beverages or possession of open containers of alcoholic beverages on lands designated for hunting is prohibited.

L. Gathering, damaging, or destroying plants, animals, fungi, rocks, minerals, fossils, artifacts, or ecofacts.

(1) No person may gather, collect, deface, remove, damage, disturb, destroy, or otherwise injure in any manner whatsoever the plants, animals (except lawful hunting), fungi, rocks, minerals, fossils, artifacts, or ecofacts on any Department owned land and US Forest Service, US Corp of Engineers and Santee Cooper lands in WMA, including but not limited to any tree, flower, shrub, fern, moss, charcoal, plant remains, or animal remains on any Department land and wildlife management areas. The Department may authorize the collection of certain material upon issuance of a permit as provided in 123-207.

Q. Abuse of Department land.

Abusing, damaging, defacing, or destroying land or any improvements on Department land is unlawful. Abuse of lands and improvements includes, but is not be limited to:

T. Geocaching is not allowed on Department land.

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U. Conducting commercial activity or using the area for commercial gain is prohibited, except by permit. Commercial activity includes, but is not limited to activities such as selling, buying, leasing or peddling goods, merchandise or services to the public. This restriction applies to the rental of horses for use on Department property.

V. Staging or participating in "paint ball", "airsoft" or similar games is prohibited.

W. Entering a closed area, or unauthorized entry is prohibited.

X. Launching or landing parachutes or parasails or aircraft including models or remotely piloted aircraft and similar devices is prohibited except for law enforcement or emergencies.

Y. Placing structures in the WMA, except permitted stands and blinds is prohibited.

Z. Obstructing or creating a hazard to land or water traffic or obstructing a watercourse is prohibited.

AA. Posting bills, signs or other notices is prohibited.

BB. Abandoning vehicles or other equipment is prohibited.

123-205. Regulations Applicable to Specific Properties.

D. Bear Island

(2) Managed wetlands will be open for wildlife observation, bird watching, photography or nature study during daylight hours (1/2 hour before sunrise to 1/2 hour after sunset) from February 9 through October 31 each year except during special hunts and events regulated by DNR.

V. Samworth WMA

(1) Managed wetlands will be open for wildlife observation, bird watching, photography or nature study during daylight hours (1/2 hour before sunrise to 1/2 hour after sunset) from February 9 through October 31 each year. Between November 1 and February 8 these activities will be restricted to designated areas on Butler Creek and the Big Pee Dee River. All public use of this type will be by foot travel only after arriving by watercraft.

W. Santee Coastal Reserve

(1) The Santee Coastal Reserve will be open during daylight hours (1/2 hour before sunrise to 1/2 hour after sunset) for public use year round except during annually scheduled hunts. Notice of the hunts will be issued annually. Managed wetlands will be open for wildlife observation, bird watching, photography or nature study during daylight hours (1/2 hour before sunrise to 1/2 hour after sunset) from February 9 through October 31 each year except during special hunts and events regulated by DNR.

(6) The hiking/biking trail will also be available during open periods, however, it will be closed between the dates of November 1 through February 8.

X. Santee-Delta WMA

(1) Managed wetlands will be open for wildlife observation, bird watching, photography or nature study during daylight hours (1/2 hour before sunrise to 1/2 hour after sunset) from February 9 through October 31 each year. Between November 1 through February 8 these activities will be restricted to designated areas marked by signs. All public use of this type will be by foot travel only.

OO. Botany Bay Plantation WMA

(1) Horseback riding by permit only, on roads open to vehicular traffic and areas specifically designated for horse riding. No groups larger than ten (10) horses. All dikes are closed to horseback riding. No horseback riding during scheduled deer, turkey and hog hunting except Sunday. Free permits are available at kiosks. Permit must be in possession while riding and data cards completed and returned to the kiosks upon leaving the area.

(2) No camping is allowed.

(3) All terrain vehicles are prohibited except those permitted by SCDNR for special management activities.

(4) The Fig Island shell rings are closed to all public access except organized scientific, management or educational activities permitted by the SCDNR.

(5) Access to the beach is by foot, bicycle or boat; no horses or dogs are allowed on the beach or the causeway to the beach. No collection, removal or possession of shells, fossils, driftwood or cultural artifacts is permitted except that youth (17 years of age and younger) may collect one quart of shells per day.

(6) Sea Cloud Landing on Ocella Creek and all other designated access points are restricted to non-trailer watercraft.

(7) All hunters, fishermen and visitors must obtain and complete a day use pass upon entering the area and follow all instructions on the pass.

(8) Botany Bay Plantation WMA is open to public access during daylight hours (1/2 hour before sunrise to 1/2 hour after sunset) except during special hunts and events regulated by DNR.

(9) Shorebased fishing, shrimping, and crabbing, is allowed only on the front beach and in designated areas only.

(10) SCDNR reserves the right to close specific areas as needed for management purposes.

(11) Botany Bay Plantation WMA is closed on Tuesdays to all public access except for designated hunts and other Department organized activities.

PP. Belfast WMA

(1) Belfast WMA is open to public access during daylight hours (1/2 hour before sunrise to 1/2 hour after sunset) except for special hunts and events regulated by DNR.

(2) Public visitation is not allowed during scheduled deer or turkey hunts.

(3) Vehicular access is limited to designated main roads. These roads may be closed if conditions or weather warrant.

Statement of Need and Reasonableness:

Periodically additional lands are made available to the public through the Wildlife Management Area Program. Since existing regulations only apply to specific wildlife management areas, new regulations must be filed to establish seasons, bag limits and methods of hunting and taking of wildlife and general public use on these new WMAs as well as expanding use opportunities on existing WMAs. Amendments are needed to allow additional opportunity. Because public use is year round on Department WMAs it is necessary to file these regulations as emergency so they take effect immediately.

Fiscal Impact Statement:

This amendment of Regulations 123-200, 123-201, 123-203 and 123-205 will result in increased public use opportunities that should generate additional State revenue through local expenditures by the public. The local economy should benefit from sales of supplies, food and overnight accommodations. Sales taxes on these items will also directly benefit government.

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Document No. 4052
CLEMSON UNIVERSITY
STATE CROP PEST COMMISSION
CHAPTER 27

Statutory Authority: 1976 Code Section 46-9-40

27-77. Light Brown Apple Moth Quarantine

Synopsis:

The State Crop Pest Commission has previously designated the Light Brown Apple Moth (LBAM) (*Epiphyas postvittana*) as a plant pest. The proposed quarantine will focus on the most effective method of preventing the introduction of the pest into the State by giving greater effect to state and federal quarantines at point of origin.

The Notice of Drafting was published in the South Carolina *State Register* on September 26, 2008.

Instructions:

This is a new regulation, designated as Regulation 27-77. Insert the new regulation in numerical order in the South Carolina Rules and Regulations, under new article 6D, as indicated below.

Text:

Article 6D

Light Brown Apple Moth Quarantine

27-77. Light Brown Apple Moth Quarantine

1. A state-wide quarantine is hereby imposed for the light brown apple moth (LBAM), (*Epiphyas postvittana*).
2. Regulated articles as cited below may not be moved into or within South Carolina from:
 - a. Any area under federal quarantine for light brown apple moth (LBAM), (*Epiphyas postvittana*).
 - b. Any area under state quarantine for light brown apple moth (LBAM), (*Epiphyas postvittana*), regulated by the plant regulatory agency of the state concerned.
3. Regulated Articles:
 - a. The light brown apple moth (*Epiphyas postvittana*) in any living stage.
 - b. All host plants for light brown apple moth.
 - c. Any other product, articles, or means of conveyance of any character whatsoever, not covered by the above, when it is determined by a quarantine officer of a state or federal plant pest regulatory agency that they present a hazard of spreading the light brown apple moth.
 - d. A complete listing of host material may be found at http://www.aphis.usda.gov/plant_health/plant_pest_info/pest_detection/downloads/praeostvittanapra.pdf
4. The movement of host material into South Carolina from areas under federal quarantine for light brown apple moth (LBAM), (*Epiphyas postvittana*), is prohibited unless the host material and the surrounding area in the sending state are treated in strict accordance with the recommendations of the USDA APHIS Technical Working Group for Light Brown Apple Moth (June 8, 2007), including both judicious insecticide application and mating disruption. Host material shipped into South Carolina must be clearly labeled as having been so treated.

Fiscal Impact Statement:

No additional state funding is requested. The Commission estimates that no additional costs will be incurred by the State and its political subdivisions in complying with the proposed revisions.

Statement of Rationale:

This regulation is necessary to enhance the ability of the Commission to prevent the introduction and spread of Light Brown Apple Moth (*Epiphyas postvittana*) into the State, while minimizing administrative burdens on ornamental nursery operators and agriculture generally.

Document No. 3213

DEPARTMENT OF INSURANCE

CHAPTER 69

Statutory Authority: 1976 Code Sections 38-3-110, 38-13-80, 38-90-150 and 38-90-630

69-70. Annual Audited Financial Reporting Regulation

Synopsis:

Pursuant to S.C. Code Ann. Section 38-13-80 (2002) the South Carolina Department of Insurance (“Department”) requires insurers to file an annual audited financial report. By March first of each year, every insurer shall file with the Department a statement showing the business standing and financial condition of the insurer on December thirty-first of the preceding year. The statement is to be prepared in accordance with the Annual Statement Instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners (“NAIC”). Effective January 1, 2010, the instructions for completing the Annual Audited Financial Report will be removed from the annual statement instructions because regulators and interested parties have determined that requirements for the Annual Audited Financial Report should be adopted by law or regulation through the legislative process. The proposed regulation incorporates revisions made by the NAIC to its Annual Financial Reporting Regulation, which requires insurers and designated entities to comply with certain best practices related to auditor independence, corporate governance, and internal controls over financial reporting.

Instructions:

Add Regulation 69-70, Annual Audited Financial Reporting Regulation, as drafted below, to the South Carolina Code of Regulations.

Text:

Section 1. Authority

This regulation is promulgated by the Director of Insurance (Director) of the South Carolina Department of Insurance (Department) pursuant to Section 38-3-110 of the South Carolina Code of Laws.

Section 2. Purpose and Scope

A. The purpose of this regulation is to improve the Department’s surveillance of the financial condition of insurers, as defined in Section 3, by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) Communication of Internal Control Related Matters Noted in an Audit, and (3) Management’s Report of Internal Control over Financial Reporting.

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B. Every insurer shall be subject to this regulation. Insurers having direct premiums written in this state of less than \$1,000,000 in any calendar year and less than 1,000 policyholders or certificateholders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the Director makes a specific finding that compliance is necessary for the Director to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of \$1,000,000 or more will not be so exempt.

C. Foreign or alien insurers filing the Audited Financial Report in another state, pursuant to that state's requirement for filing of Audited Financial Reports, which has been found by the Director to be substantially similar to the requirements herein, are exempt from Sections 4 through 13 of this regulation if:

(1) A copy of the Audited Financial Report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the Director in accordance with the filing dates specified in Sections 4, 11 and 12, respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

(2) A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the Director within the time specified in Section 10.

D. Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements and the Report is filed with the commissioner of the other state within the time specified.

E. This regulation shall not prohibit, preclude or in any way limit the Director from ordering or conducting or performing examinations of insurers under the rules and regulations of the Department and the practices and procedures of the Department.

Section 3. Definitions

A. The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

(1) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

(2) "Affiliate" of a specific person or a person "affiliated" with a specific person means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the specific person.

(3) "Audit Committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The Audit Committee of any entity that controls a group of insurers may be deemed to be the Audit Committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to Section 14(A)(5) for exercising this election. If an Audit Committee is not designated by the insurer, the insurer's entire board of directors shall constitute the Audit Committee.

(4) "Audited Financial Report" means and includes those items specified in Section 5 of this regulation.

(5) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

(6) "Independent board member" has the same meaning as described in Section 14(A)(3).

(7) "Insurer" includes any captive insurer, special purpose financial captives insurer, health maintenance organization, title insurer, fraternal organization, burial association, other association, corporation, partnership, society, order, individual, or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance or surety business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships, and corporations.

(8) “Group of insurers” means those licensed insurers included in the reporting requirements of Title 38, Chapter 21 - Insurance Holding Company Regulatory Act, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(9) “Internal control over financial reporting” means a process effected by an insurer’s board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and includes those policies and procedures that:

(a) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(b) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(c) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation.

(10) “SEC” means the United States Securities and Exchange Commission.

(11) “Section 404” means Section 404 of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.) and the SEC’s rules and regulations promulgated thereunder.

(12) “Section 404 Report” means management’s report on “internal control over financial reporting” as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3(A)(1).

(13) “SOX Compliant Entity” means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.): (i) the pre-approval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934) (15 USC Section 78a et seq.); (ii) the Audit Committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934 (15 USC Section 78a et seq.)); and (iii) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Section 4. General Requirements Related to Filing and Extensions for Filing of Annual Audited Financial Reports and Audit Committee Appointment

A. All insurers shall have an annual audit by an independent certified public accountant and shall file an Audited Financial Report with the Director on or before June 1 for the year ended December 31 immediately preceding. The Director may require an insurer to file an Audited Financial Report earlier than June 1 with ninety days advance notice to the insurer.

B. Extensions of the June 1 filing date may be granted by the Director for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the Director of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the Director to make an informed decision with respect to the requested extension.

C. If an extension is granted in accordance with the provisions in Section 4B, a similar extension of thirty days is granted to the filing of Management’s Report of Internal Control over Financial Reporting.

D. Every insurer required to file an annual Audited Financial Report pursuant to this regulation shall designate a group of individuals as constituting its Audit Committee, as defined in Section 3. The Audit Committee of an entity that controls an insurer may be deemed to be the insurer’s Audit Committee for purposes of this regulation at the election of the controlling person.

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Section 5. Contents of Annual Audited Financial Report

A. The annual Audited Financial Report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flow, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the insurer's state of domicile.

B. The annual Audited Financial Report shall include the following:

- (1) Report of independent certified public accountant.
- (2) Balance sheet reporting admitted assets, liabilities, capital and surplus.
- (3) Statement of operations.
- (4) Statement of cash flow.
- (5) Statement of changes in capital and surplus.

(6) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 38-13-80 of the South Carolina Code of Laws with a written description of the nature of these differences.

(7) The financial statements included in the Audited Financial Report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Director, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an Audited Financial Report, the comparative data may be omitted.

Section 6. Designation of Independent Certified Public Accountant

A. Each insurer required by this regulation to file an annual Audited Financial Report, within sixty days after becoming subject to the requirement, shall register with the Director in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this regulation. Insurers not retaining an independent certified public accountant on the effective date of this regulation shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first Audited Financial Report is to be filed.

B. The insurer shall obtain a letter from the accountant and file a copy with the Director stating that the accountant is aware of the provisions of the insurance code and the regulations of the insurance department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express an opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance department, specifying such exceptions as the accountant may believe appropriate.

C. If the accountant who was the insurer's accountant for the immediately preceding filed Audited Financial Report is dismissed or resigns, the insurer shall notify the Director within five business days of this event. The insurer shall also furnish the Director with a separate letter within ten business days of the above notification stating whether in the twenty-four months preceding the event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which, if not resolved to the satisfaction of the former accountant, would have caused the accountant to make reference to the subject matter of the disagreement in connection with the opinion. The disagreements required to be reported in response to this section include those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer also in writing shall request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for the disagreement; and the insurer shall furnish the responsive letter from the former accountant to the Director together with its own.

Section 7. Qualifications of Independent Certified Public Accountant

A. The Director shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

B. Except as otherwise provided in this regulation, the Director shall recognize an independent certified public accountant as qualified as long as the accountant conforms to the standards of the profession, as contained in the AICPA Code of Professional Conduct and the regulations of the South Carolina Board of Accountancy, or similar code.

C. A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Chapter 27 of Title 38 of the South Carolina Code of Laws, the mediation or arbitration provisions shall operate at the option of the statutory successor.

D. The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same insurer or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the Director for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty days before the end of the calendar year. The Director may consider the following factors in determining if the relief should be granted:

(1) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(2) Premium volume of the insurer; or

(3) Number of jurisdictions in which the insurer transacts business.

E. The insurer shall file, with its annual statement filing, the approval for relief from Subsection D with the states that it is licensed in or doing business in and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

F. The Director shall not recognize as a qualified independent certified public accountant or accept any annual Audited Financial Report prepared in whole or in part by any person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Section 1961 et seq., or any dishonest conduct or practices under federal or state law;

(2) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this regulation; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation.

G. The Director, pursuant to statute, may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual Audited Financial Report made pursuant to this regulation and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation.

H. The Director shall not recognize as a qualified independent certified public accountant or accept an annual Audited Financial Report prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(1) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(2) Financial information systems design and implementation;

(3) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

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(4) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

(a) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(b) The insurer has competent personnel (or engages a third-party actuary) to estimate the reserves for which management takes responsibility; and

(c) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(5) Internal audit outsourcing services;

(6) Management functions or human resources;

(7) Broker or dealer, investment adviser, or investment banking services;

(8) Legal services or expert services unrelated to the audit; or

(9) Any other services that the Director determines, by regulation, are impermissible.

I. In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit their own work, and cannot serve in an advocacy role for the insurer.

J. Insurers having direct written and assumed premiums of less than \$100,000,000 in any calendar year may request an exemption from Subsection H. The insurer shall file with the Director a written statement discussing the reasons why the insurer should be exempt from these provisions. An exemption may be granted if the Director finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer.

K. A qualified independent certified public accountant who performs the audit may engage in other non-audit services, including tax services, that are not described in Subsection H or that do not conflict with Subsection I, only if the activity is approved in advance by the Audit Committee, in accordance with Subsection L.

L. All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be pre-approved by the Audit Committee. The pre-approval requirement is waived with respect to non-audit services if the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity or:

(1) The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;

(2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; and

(3) The services are promptly brought to the attention of the Audit Committee and approved prior to the completion of the audit by the Audit Committee or by one or more members of the Audit Committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the Audit Committee.

M. The Audit Committee may delegate to one or more designated members of the Audit Committee the authority to grant the pre-approvals required by Subsection L. The decisions of any member to whom this authority is delegated shall be presented to the full Audit Committee at each of its scheduled meetings.

N. The Director shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the Director for relief from the above requirement on the basis of unusual circumstances.

O. The insurer shall file, with its Annual Statement filing, the Director's letter granting relief from Subsection N with the states in which it is licensed or doing business and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 8. Consolidated or Combined Audits

A. An insurer may make written application to the Director for approval to include in its Audited Financial Report audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

- (1) Amounts shown on the consolidated or combined Audited Financial Report shall be shown on the worksheet;
- (2) Amounts for each insurer subject to this section shall be stated separately;
- (3) Noninsurance operations may be shown on the worksheet on a combined or individual basis;
- (4) Explanations of consolidating and eliminating entries shall be included; and
- (5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual Statements of the insurers.

Section 9. Scope of Audit and Report of Independent Certified Public Accountant

Financial statements furnished pursuant to Section 5 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with Auditing (AU) Section 319 of the AICPA Professional Standards, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 16, the independent certified public accountant should consider (as that term is defined in Statements on Auditing Standards (SAS) No. 102 of the AICPA Professional Standards, Defining Professional Requirements in Statements on Auditing Standards or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Section 10. Notification of Adverse Financial Condition

A. The insurer required to furnish the annual Audited Financial Report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its Audit Committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Director as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the South Carolina Code of Laws as of that date. An insurer that has received a report pursuant to this paragraph shall forward a copy of the report to the Director within five business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the Director. If the independent certified public accountant fails to receive the evidence within the required five business day period, the independent certified public accountant shall furnish to the Director a copy of its report within the next five business days.

B. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with Subsection A.

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C. If the accountant, subsequent to the date of the Audited Financial Report filed pursuant to this regulation, becomes aware of facts that might have affected his or her report, the Director notes the obligation of the accountant to take such action as prescribed in AU 561 of the AICPA Professional Standards, Subsequent Discovery of Facts Existing at the Date of the Auditor's Report.

Section 11. Communication of Internal Control Related Matters Noted in an Audit

A. In addition to the annual Audited Financial Report, each insurer shall furnish the Director with a written communication as to any unremediated material weaknesses in its Internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty days after the filing of the annual Audited Financial Report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined in SAS No. 112 of the AICPA Professional Standards, Communicating Internal Control Related Matters Identified in an Audit, or its replacement) as of December 31 immediately preceding (so as to coincide with the Audited Financial Report discussed in Section 4(A)) in the insurer's Internal control over financial reporting identified by the accountant during the course of the audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

B. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

C. The insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant. The information should be made available to the examiner conducting a financial examination for review and kept in a manner as to remain confidential.

Section 12. Accountant's Letter of Qualifications

A. The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual Audited Financial Report, a letter stating:

(1) That the accountant is independent with respect to the insurer and conforms to the standards of their profession as contained in the AICPA's Code of Professional Conduct and pronouncements of its Financial Accounting Standards Board and the South Carolina Board of Accountancy, or similar code;

(2) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this regulation shall be construed as prohibiting the accountant from utilizing such staff as deemed appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

(3) That the accountant understands the annual Audited Financial Report and that its opinion thereon will be filed in compliance with this regulation and that the Director will be relying on this information in the monitoring and regulation of the financial position of insurers;

(4) That the accountant consents to the requirements of Section 13 of this regulation and that the accountant consents and agrees to make available for review by the Director, or the Director's designee or appointed agent, the workpapers, as defined in Section 13;

(5) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and

(6) A representation that the accountant is in compliance with the requirements of Section 7 of this regulation.

Section 13. Definition, Availability and Maintenance of Independent Certified Public Accountants Workpapers

A. Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of insurer documents and schedules or commentaries prepared or obtained by the independent certified

public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

B. Every insurer required to file an Audited Financial Report pursuant to this regulation, shall require the accountant to make available for review by Department examiners, all workpapers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department or at any other reasonable place designated by the Director. The insurer shall require that the accountant retain the audit workpapers and communications until the Department has filed a report on examination covering the period of the audit but no longer than seven years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the Department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the department.

Section 14. Requirements for Audit Committees

A. This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

(1) The Audit Committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the Audited Financial Report or related work pursuant to this regulation. Each accountant shall report directly to the Audit Committee.

(2) Each member of the Audit Committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection (A)(5) of this Section and Section 3(A)(C).

(3) In order to be considered independent for purposes of this section, a member of the Audit Committee may not, other than in his or her capacity as a member of the Audit Committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the Audit Committee and be designated as independent for Audit Committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(4) If a member of the Audit Committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the Director, may remain an Audit Committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(5) To exercise the election of the controlling person to designate the Audit Committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Director by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(6) The Audit Committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit Committee in accordance with the requirements of SAS No. 114 of the AICPA Professional Standards, The Auditor's Communication with those Charged with Governance, or its replacement, including:

(a) All significant accounting policies and material permitted practices;

(b) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(c) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

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(7) If an insurer is a member of an insurance holding company system, the reports required by Subsection (A)(6) may be provided to the Audit Committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit Committee.

(8) The proportion of independent Audit Committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
\$0 - \$300,000,000	Over \$300,000,000 - \$500,000,000	Over \$500,000,000
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The Director has authority afforded by state law to require the insurer's board to enact improvements to the independence of the Audit Committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than \$500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit Committees with at least a supermajority of independent Audit Committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

(9) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than \$500,000,000 may make application to the Director for a waiver from the Section 14 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 14 with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 15. Conduct of Insurer in Connection with the Preparation of Required Reports and Documents

A. No director or officer of an insurer shall, directly or indirectly:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

B. No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

C. For purposes of Subsection B, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the Director, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer's Audit Committee.

Section 16. Management's Report of Internal Control over Financial Reporting

A. Each insurer required to file an Audited Financial Report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of \$500,000,000 or more shall prepare a report of the insurer's or group of insurers' Internal Control Over Financial Reporting, as these terms are defined in Section 3. The report shall be filed with the Director along with the Communicating Internal Control Related Matters Identified in an Audit described under Section 11. Management's Report of Internal Control Over Financial Reporting shall be as of December 31 immediately preceding.

B. Notwithstanding the premium threshold in Subsection A, the Director may require an insurer to file Management's Report of Internal Control Over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in S.C. Code Ann. Sections 35-5-120, 38-9-150, 38-9-360, and 38-9-440.

C. An insurer or a group of insurers that is

- (1) directly subject to Section 404;
- (2) part of a holding company system whose parent is directly subject to Section 404;
- (3) not directly subject to Section 404 but is a SOX compliant entity; or
- (4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX compliant entity;

may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section's requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (i) a Section 16 report, or (ii) the Section 404 Report and a Section 16 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

D. Management's Report of Internal Control Over Financial Reporting shall include:

- (1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;
- (2) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;
- (3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;
- (4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;
- (5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management shall not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting;
- (6) A statement regarding the inherent limitations of internal control systems; and
- (7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

E. Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection D, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

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(1) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

(2) Management's Report on Internal Control over Financial Reporting, required by Subsection A , and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Director.

Section 17. Exemptions

Upon written application of an insurer, the Director may grant an exemption from compliance with any provision or requirement of this regulation if the Director finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten days from a denial of an insurer's written request for an exemption from this regulation, the insurer may request in writing a hearing, pursuant to statute, on its application for an exemption. The hearing shall be held in accordance with the statutes of the Department pertaining to administrative hearing procedures.

Section 18. Canadian and British Companies

A. For Canadian and British insurers, the annual Audited Financial Report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

B. For such insurers, the letter required in Section 6B shall state that the accountant is aware of the requirements relating to the annual Audited Financial Report filed with the Director pursuant to Section 4 and shall affirm that the opinion expressed is in conformity with those requirements.

Section 19. Effective dates

A. Unless otherwise noted, the requirements of this regulation shall become effective for the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers not required to file a report because its total written premium is below the threshold that subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file the report. Likewise, an insurer acquired in a business combination shall have two calendar years following the date of acquisition or combination to comply with the reporting requirements.

B. The requirements of Section 7D shall become effective for audits of the year beginning January 1, 2010 and thereafter.

C. The requirements of Section 14 shall become effective on January 1, 2010. An insurer or group of insurers that is not required to have independent Audit Committee members or only a majority of independent Audit Committee members (as opposed to a supermajority) because the total direct written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one calendar year following the date of acquisition or combination to comply with the independence requirements.

Section 20. Severability Provision

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Fiscal Impact Statement:

There will be no increased costs to the state or its political subdivisions.

Statement of Rationale:

The purpose of this regulation is to improve the Department's surveillance of the financial condition of insurers by requiring an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants. The audit will incorporate certain best practices related to auditor independence, corporate governance and internal control over financial reporting. It requires insurers with certain levels of premium writings to have a majority (50%) or a supermajority (75%) of its Audit Committee members to be independent members of its Board of Directors. It requires insurers with \$500 million or more in direct and assumed premiums annually to prepare management's assessment of internal controls over financial reporting. The regulation is based upon the NAIC model regulation and will become an accreditation standard January 1, 2010.

Document No. 4071

DEPARTMENT OF INSURANCE**CHAPTER 69**

Statutory Authority: 1976 Code Sections 1-23-110 et seq., 38-3-110, and 38-71-530

69-46. Medicare Supplement Insurance

Synopsis:

The amendments to the Medicare Supplement Insurance Regulation will bring the regulation into compliance with recently enacted federal laws, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the federal Genetic Information Nondiscrimination Act of 2008 (GINA). Federal law requires that states adopt regulations containing these newly enacted federal standards so that the states may continue to regulate these products.

The proposed regulation is exempt from legislative review as it is being promulgated to comply with federal law.

Notice of drafting for the proposed regulation was published in the *State Register* on November 28, 2008.

Instructions: Amend Regulation 69-30 by striking the existing regulation in its entirety and inserting the language below.

Text:

69-46. Medicare Supplement Insurance.

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Section 1. Purpose

The purpose of this regulation 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; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the director under S.C. Code Sections 38-3-110(2), 38-71-530(b) and 1-23-10 *et seq.*

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this regulation shall apply to:

- (1) All Medicare Supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and
- (2) All certificates issued under group Medicare Supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation 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 thereof, of the labor organizations.

Section 4. Definitions

For purposes of this regulation:

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 sixty-three (63) days.

F. "Creditable coverage"

(1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55 Title 10 of the United States Code (TRICARE);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool, including the South Carolina Health Insurance Pool;

(h) A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) A public health plan as defined in federal regulations; and

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

(a) Coverage only for accident or disability income insurance, or any combination of accident and disability income insurance;

(b) Coverage issued as a Supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

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(4) "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

- (a) Coverage only for a specified disease or illness; and
- (b) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

- (a) Medicare Supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
- (b) Coverage supplemental to the coverage provided under Chapter 55 Title 10 of the United States Code; and
- (c) Similar supplemental coverage provided to coverage under a group health plan.

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 that 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. "Medicare Supplement policy" means a group or individual policy of accident and sickness 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. §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. "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 §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 May 1, 1992.

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 May 1, 1992 and with an effective date for 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 for 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.

Section 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 that 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 nofault 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.

Section 6. Policy Provisions

A. Except for permitted preexisting condition clauses as described in Section 7A(1), Section 8A(1), and Section 8.1A(1) of this regulation, 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 Sections 7A(4), (5) and (7), and 8A(4) and (5), of this regulation, 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.

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(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 drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Section 7. Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to May 1, 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 regulation.

(1) A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) 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 (6) months before the effective date of coverage.

(2) A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, 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 cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the director 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 Paragraph (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 Section 8.1B of this regulation.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificateholder the conversion opportunities described in Subparagraph (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.

(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 ninety percent (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 (3) 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];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) 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.

Section 8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After May 1, 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 May 1, 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 regulation.

(1) A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (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 six (6) months before the effective date of coverage.

(2) A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, 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.

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(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 Section 8A(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 Section 8A(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 paragraph.

(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 twenty-four (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 ninety (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 reinstated as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (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 reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(d) Reinstatement of coverages as described in Subparagraphs (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, reinstatement 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 Standardized plan (as described in Section 9 of this regulation) to a 2010 Standardized plan (as described in Section 9.1 of this regulation), the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age. 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 must be filed with the director.

(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 preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized 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 Benefit Plans A to 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 one hundred percent (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 (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.

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 regulation.

(1) Medicare Part A Deductible: Coverage for all of 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 of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (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.

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(5) One Hundred Percent (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 fifty percent (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 fifty percent (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 eighty percent (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 sixty (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)(a) Preventive Medical Care Benefit: 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 Subparagraph (b) and patient education to address preventive health care measures;

(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 one hundred percent (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 (4) hours in a twenty-four hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations.

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(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 (7) 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;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) 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 one hundred percent (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 one hundred percent (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 one hundred percent (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 fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (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 Subparagraph (j);

(g) Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (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 Subparagraph (j);

(h) Except for coverage provided in Subparagraph (i) below, coverage for fifty percent (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 Subparagraph (j) below;

(i) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent (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.

(2) Standardized Medicare Supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Paragraphs (1)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs (1)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph (1)(j), but substituting \$2000 for \$4000.

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Section 8.1 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 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 standards. No issuer may offer any 1990 Standardized Medicare Supplement benefit plan for sale on or after the effective date of these 2010 Standardized Medicare Supplement benefit plan standards in this state. Benefit standards applicable to Medicare Supplement policies and certificates issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of Section 8 of this regulation.

A. General Standards. The following standards apply to Medicare Supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare Supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (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 six (6) months before the effective date of coverage.

(2) A Medicare Supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, 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 Section 8.1A(5)(e) of this regulation, 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 Section 8.1A(5)(c) of this regulation; 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 twenty-four (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 ninety (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 reinstated as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (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 certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

(d) Reinstatement of coverages as described in Subparagraphs (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 and 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 one hundred percent (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 (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) Hospice Care: 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, and N as provided by Section 9.1 of this regulation.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

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(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 one hundred percent (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 eighty percent (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 sixty (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.

Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After May 1, 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 Section 8B of this regulation.

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9G and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C, or 8D 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 Section 8B of this regulation.

(2) Standardized Medicare Supplement benefit plan "B" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).

(3) Standardized Medicare Supplement benefit plan "C" shall include only the following: The core benefit as defined in Section 8B of this regulation, 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 Sections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare Supplement benefit plan "D" shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare Supplement benefit plan "E" shall include only the following: The core benefit as defined in Section 8B of this regulation, 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 Sections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare Supplement benefit plan "F" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(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 Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(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 twelve-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 Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (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 Sections 8C(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 Section 8B of this regulation, 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 Sections 8C(1), (2), (6) and (8) respectively. The outpatient 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 Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (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 Sections 8C(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 Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (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 Sections 8C(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 Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (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 Sections 8C(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 Section 8D(1).

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(2) Standardized Medicare Supplement benefit plan “L” shall consist of only those benefits described in Section 8D(2).

G. New or Innovative Benefits: An issuer may, with the prior approval of the director, 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.

Section 9.1 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 issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of Section 9 of this regulation.

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 Section 8.1B of this regulation.

(2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) of this regulation), 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 A(1) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.

C. Benefit plans 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 regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, “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 of this section, 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 Section 8.1B of this regulation.

(2) Standardized Medicare Supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

(3) Standardized Medicare Supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

(4) Standardized Medicare Supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

(5) Standardized Medicare Supplement regular Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6), respectively.

(6) Standardized Medicare Supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(a) The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, 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 regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 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 twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

(7) Standardized Medicare Supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (5), and (6), respectively.

(8) Standardized Medicare Supplement 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 one hundred percent (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 one hundred percent (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 one hundred percent (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 fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (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 Subparagraph (j);

(g) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (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 Subparagraph (j);

(h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (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 Subparagraph (j);

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(i) Part B Preventive Services: Coverage of one hundred percent (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 one hundred percent (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 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 Paragraphs 9.1E(8)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph 9.1E(8)(j), but substituting \$2000 for \$4000.

(10) Standardized Medicare Supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(2), (3) and (6) of this regulation, respectively.

(11) Standardized Medicare Supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with copayments in the following amounts:

(a) the lesser of twenty dollars (\$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 fifty dollars (\$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 director, 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 must 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.

Section 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 director within which an issuer is authorized to offer a Medicare Select policy.

C. The director 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 director finds that the issuer has satisfied all of the requirements of this regulation.

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 director.

E. A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. 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 twenty-four (24) hours per day and seven (7) days per week.

(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 paragraph 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.

(7) Any other information requested by the director.

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 director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the director at least quarterly.

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:

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(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.

(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 each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director 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 (6) 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 paragraph, 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 paragraph, 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.

Section 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 (6) 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 subsection 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 (6) 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 (6) 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 (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Section 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 paragraphs:

(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.

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(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 agent 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 under Section 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 an agent 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 subparagraph (a) is terminated by the enrollee during any period within the first twelve (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).

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (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).

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: (i) the date the individual receives a notice of termination or cessation of all Supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(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 (63) days after the date the 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: (i) 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 (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) 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 and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the 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 the date that is sixty-three (63) 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 paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) 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 Section 12B(5);

(2) In the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For purposes of Subsections B(5) and B(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 paragraph 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) Section 12B(1), (2), (3) and (4) 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 Subparagraph (b), Section 12B(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 Paragraph (1);

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare Supplement policy with an outpatient prescription drug benefit, a Medicare Supplement policy described in this subparagraph is:

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(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) Section 12B(6) shall include any Medicare Supplement policy offered by any issuer;

(4) Section 12B(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 of this section 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 of this section 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 Section 12A. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

Section 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.

Section 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 seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

(b) 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) Administrative 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.

(3) For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 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 May 1, 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 Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with July 22, 2005 to date; and
- (c) The appropriate loss ratio requirement from Subsection 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 director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare Supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (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 May 1, 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 April 28, 1996. The first report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds 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 thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates. An issuer of Medicare Supplement policies and certificates issued before or after the effective date of May 1, 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 for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected 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 (3) years. 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 director, in accordance with the applicable filing procedures of this state:

(1)(a) 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.

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(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 director, the director 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 director 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 this regulation 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 director.

Section 15. Filing and Approval of Policies and 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 with and approved by the director in accordance with filing requirements and procedures prescribed by the director.

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 director 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 with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

D.(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval 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 director, up to four (4) 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 agent 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 Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the director. 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 twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall 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 Subparagraph (a) shall not file for approval 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 (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director 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 Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, 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 director may approve a change to the differential that is in the public interest.

F. (1) Except as provided in Paragraph (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 Section 14, subsection B.

(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.

Section 16. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent 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 percent 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 must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall 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 finders fees.

Section 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.

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(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 paragraph 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 thirty (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 CMS and in a type size no smaller than 12 point type. Delivery of the *Guide* shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare Supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgement 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 thirty (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 director. 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 acknowledgement of receipt of the outline from the applicant; and

(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 twelve (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 twelve (12) point type. All plans A-L 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 following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale after June 1, 2011.

Basic Benefits:

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance.

A	B	C	D	E	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1860] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

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K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50%Part A Deductible	75%Part A Deductible	50%Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$[4140]; paid at 100% after limit reached	Out-of-pocket limit \$[2070]; paid at 100% after limit reached		

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale after June 1, 2011.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

[for agents:]

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

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

Review the application carefully before you sign it. Be certain that all information has been properly recorded. [Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1D of this regulation.][Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

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PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[992] All but \$[248] a day All but \$[496] a day \$0 \$0	\$0 \$[248] a day \$[496] a day 100% of Medicare eligible expenses \$0	\$[992](Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[124] a day \$0	\$0 \$0 \$0	\$0 Up to \$[124] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[131] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[131] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[131] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN B
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[992](Part A deductible)	\$0
61 st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used:	All but \$[496] a day	\$[496] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100 th day	All but \$[124] a day	\$0	Up to \$[124] a day
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/ coinsurance for out- patient drugs and inpatient respite care	Medicare copayment/ coinsurance \$0	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN B

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

Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN B
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[992](Part A deductible)	\$0
61 st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[124] a day	Up to \$[124] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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**PLAN C
PARTS A & B**

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maxi- mum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[992] (Part A deductible)	\$0
61st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day \$0	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[124] a day	Up to \$[124] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for out- patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN D

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

Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN D
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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**PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1860] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE, **] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91st day and after: While using 60 Lifetime reserve days Once lifetime reserve days Are used: Additional 365 days Beyond the additional 365 days	All but \$[992] All but \$[243] a day All but \$[496] a day \$0 \$0	\$[992] (Part A deductible) \$[243] a day \$[496] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0**** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101 st day and after	All approved amounts All but \$[124] a day \$0	\$0 Up to \$[124] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare Copayment/ coinsurance	\$0

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

*Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$1860] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE,*] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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**PLAN F or HIGH DEDUCTIBLE PLAN F
PARTS A & B**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE,* *] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$[131] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1860] DEDUCTIBLE,* *] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

**PLAN G
MEDICARE (PART A)---HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[992] (Part A deductible)	\$0
61st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used:	All but \$[496] a day	\$[496] a day	\$0
—Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[124] a day	Up to \$[124] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN G

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

Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN G
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4140] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[496](50% of Part A deductible)	\$[496](50% of Part A deductible)
61 st thru 90th day	All but \$[248] a day	\$[248] a day	\$0♦
91st day and after: —While using 60 lifetime reserve days	All but \$[496] a day	\$[496] a day	\$0
—Once lifetime reserve days are used: —Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[124] a day	Up to \$[62] a day	Up to \$[62]♦ a day
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	50%	50%♦
Additional amounts	100%	\$0	\$0

<p>HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</p>	<p>50% of copayment/coinsurance</p>	<p>50% of Medicare copayment/coinsurance♦</p>
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*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN K
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

**** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<p>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts****</p> <p>Preventive Benefits for Medicare covered services</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 75% or more of Medicare approved amounts</p> <p>Generally 80%</p>	<p>\$0</p> <p>Remainder of Medicare approved amounts</p> <p>Generally 10%</p>	<p>\$[131] (Part B deductible)****</p> <p>♦ All costs above Medicare approved amounts</p> <p>Generally 10%♦</p>
<p>Part B Excess Charges (Above Medicare Approved Amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All costs (and they do not count toward annual out-of-pocket limit of [\$4140])*</p>

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BLOOD			
First 3 pints	\$0	50%	50%◆
Next \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)**** ◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* **This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4140] per year.** However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN K
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[131] of Medicare Approved Amounts*****	\$0	\$0	\$[131] (Part B deductible)◆
Remainder of Medicare Approved Amounts	80%	10%	10%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2070 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[992]	\$[744] (75% of Part A deductible)	\$[248] (25% of Part A deductible) ◆
61st thru 90th day	All but \$[248] a day	\$[248] a day	\$0
91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days	All but \$[496] a day \$0	\$[496] a day 100% of Medicare eligible expenses	\$0 \$0***
—Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21 st thru 100th day	All but \$[124] a day	Up to \$[93] a day	Up to \$[31] a day◆
101st day and after	\$0	\$0	All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%◆ \$0

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HOSPICE CARE You must meet Medicare’s requirement, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance♦
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*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN L
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

**** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2070])*
BLOOD First 3 pints	\$0	75%	25%♦
Next \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦

CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2070] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*****	\$0	\$0	\$[131] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[992] All but \$[248] a day All but \$[496] a day \$0 \$0	\$[496] (50% of Part A deductible) \$[248] a day \$[496] a day 100% of Medicare eligible expenses \$0	\$[496] (50% of Part A deductible) \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[124] a day \$0	\$0 Up to \$[124] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirement, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN M
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

**** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)****
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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**PLAN M
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*****	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

**PLAN N
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[992] All but \$[248] a day All but \$[496] a day \$0 \$0	\$[992] (Part A deductible) \$[248] a day \$[496] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[124] a day \$0	\$0 Up to \$[124] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare’s requirement, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsuran ce for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN N

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

**** Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physi- cian’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)****
Remainder of Medicare Approved Amounts	Generally 80%	Balance other than up to [\$20] per office visit and up to [\$50] per emergency room visit The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [\$20] per office visit and up to [\$50] per emergency room visit The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[131] of Medicare Approved Amounts****	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN N
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[131] of Medicare Approved Amounts*****	\$0	\$0	\$[131] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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.), disability income policy; or other policy identified in Section 3B of this regulation, 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 twelve (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 Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

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Section 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 agent containing such questions and statements may be used.

[Statements]

(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 reinstated 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 reinstated 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 reinstated 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 reinstated 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]

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 your 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

If yes,

(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?

START ___/___/___ END ___/___/___

(If you are still covered under the other policy, leave "END" blank.)

B. Agents 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 (5) years that 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 agent, 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 agent, except where the coverage is sold without an agent, 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 twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

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SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (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 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, AGENT [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

(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 Mailers.]
- Other. (please specify) _____

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting 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 Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

F. Paragraphs 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.

Section 19. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare Supplement advertisement intended for use in this state whether through written, radio or television medium to the Director of Insurance of this state for review or approval by the Director to the extent it may be required under state law.

Section 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 agents or other 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.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in S.C. Code Sections 38-57-10 et seq, 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 agent 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 regulation.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare Supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a 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.

Section 22. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information 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 must be grouped by individual policyholder.

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Section 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 (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Section 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 preexisting 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 the 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 preexisting 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.

Section 25. Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 26. Effective Date

This regulation shall be effective upon publication in the *State Register*.

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APPENDIX A
 MEDICARE SUPPLEMENT REFUND CALCULATION FORM
 FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

Line		(a) Earned Premium ³	(b) Incurred Claims ⁴
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues ⁵		
	c. Net (for reporting purposes = 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (<i>see worksheet for Ratio 1</i>)		
8.	Experienced Ratio Since Inception (<i>Ratio 2</i>) Total Actual Incurred Claims (line 3, col. b) _____ Total Earned Prem. (line 3, col. a)-Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
 2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans.
 3 Includes Modal Loadings and Fees Charged.
 4 Excludes Active Life Reserves.
 5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios".

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing Exhibit _____

Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	
-----	--	--

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name - Please Type

Title - Please Type

Date

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REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+ ⁶		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(1 + n)/(k + m)$: _____

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).

⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

⁶To include the earned premium for all years prior to as well as the 15th year prior to the current year.

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REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing Exhibit _____

Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+ ⁶		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(1 + n)/(k + m)$: _____

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).

⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

⁶ To include the earned premium for all years prior to as well as the 15th year prior to the current year.

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APPENDIX B
FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare Supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and

Date of

Certificate #

Issuance

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

APPENDIX C
DISCLOSURE STATEMENTS

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

1. Section 1882 (d) of the federal Social Security Act, 42 U.S.C. 1395ss, prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare Supplement policy to a person that already has a Medicare Supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously. [Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

[outpatient prescription drugs if you are enrolled in Medicare Part D]

other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

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[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

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

hospitalization

physician services

[outpatient prescription drugs if you are enrolled in Medicare Part D]

other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

[outpatient prescription drugs if you are enrolled in Medicare Part D]

other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

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

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[Original disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

Before You Buy This Insurance

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

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

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

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

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

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

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

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

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

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

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

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[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions

listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

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

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

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

[Alternative disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

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

Before You Buy This Insurance

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

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[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

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

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department.

Fiscal Impact Statement:

There will be no increased costs to the state or its political subdivisions.

Rationale:

Promulgation of this regulation is crucial to maintaining the Department's ability to regulate the Medicare Supplement insurance products and market. The federal Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Genetic Information Nondiscrimination Act of 2008 (GINA) each require passage of the regulation so that states may continue to regulate the Medicare Supplement Insurance Market. The regulation includes additional consumer protections and disclosures when Medicare Supplement Insurance products are marketed and sold.

Document No. 3216
DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL
 CHAPTER 71
 Statutory Authority: 1976 Code Sections 23-9-60 and 23-36-10 et seq.

71-8302. Explosives

Synopsis:

The Office of State Fire Marshal is updating, revising, and reformatting SCRR 71-8302 regarding Explosives. The new SCRR 71-8302 complies with Federal Bureau of Alcohol Tobacco and Firearms requirements, uses a standardized format, simplifies wording, removes obsolete language and clarifies licensing and permitting requirements for the storage, handling, and use of explosives.

Instructions:

Delete the current regulations 71-8302 Explosives (71-8302.1 through 71-8302.25) in their entirety. Replace with Subarticle 3 - Explosives (71-8302.1 through 71-8302.8) as printed below.

Text:

SUBARTICLE 3
 EXPLOSIVES

71-8302. Explosives.

71-8302.1. General.

A. The purpose of this regulation is to provide reasonable safety and protection to the public, public property, private property, and operators from the manufacture, transportation, handling, use, and storage of explosives in South Carolina.

B. This regulation shall apply to the manufacture, transportation, handling, use, and storage of explosives in South Carolina.

C. This regulation does not apply to the sale or storage of fireworks as regulated by the Board of Pyrotechnic Safety.

71-8302.2. Codes and Standards.

A. NFPA 495 governs the use of explosives. All references to NFPA 495 found in these regulations refer to the edition adopted in SCRR 71-8300.2 and are modified by the following regulations as shown below.

71-8302.3. Licensing and Permitting Fees.

A. All applications for licenses, tests, or permits must be accompanied by the appropriate fees.

B. The Office of State Fire Marshal is responsible for all administrative activities of the licensing program. The State Fire Marshal shall employ and supervise personnel necessary to effectuate the provisions of this article and shall establish fees sufficient but not excessive to cover expenses, including direct and indirect costs to the State for the operation of this licensing program. Fees may be adjusted not more than once each two years, using the method set out in South Carolina Code 40-1-50(D).

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C. Fees shall be established for the following:

1. Application
2. Background Check
3. Testing
4. Licensing
5. Permitting
6. Inspection
7. Renewal

D. All fees are due at time of application for licenses, background checks, permits, testing, inspection or renewal.

E. Applications for blasting permits shall be submitted to the Office of State Fire Marshal for approval 48 hours before the start of blasting operations. Applications submitted less than 48 hours before the start of blasting operations will be subject to a \$200.00 special processing fee.

F. All fees paid to the Office of State Fire Marshal are nonrefundable.

71-8302.4. Licenses and Permits.

A. Classification of Licenses and Permits

Class	Category	Blasting Permitted
1. A	Unlimited	All types of blasting
2. B	General aboveground	All phases of blasting operations in quarries, open pit mines, and aboveground construction
3. C	General underground	All phases of blasting operations in underground mines, shafts, tunnels, and drifts
4. D	Demolition	All phases of blasting in demolition projects
5. E	Seismic	All phases of blasting in seismic prospecting
6. G	Special	Special blasting as described on the permit

B. Licenses

1. No person shall be granted a license who has not successfully completed a written examination administered by the Office of State Fire Marshal covering the applicable codes, state laws and regulations for the license classification for which they are applying.

2. Any applicant who fails the written examination is allowed one (1) re-test after a minimum seven (7) day waiting period. Any applicant who fails the re-test shall wait at least six (6) months before reapplying.

3. Licenses are not transferable.

4. The State Fire Marshal may accept determination of relief from disability incurred by reason of a criminal conviction that has been granted by the Director of the Bureau of Alcohol, Tobacco and Firearms, U. S. Department of the Treasury, Washington, D.C., pursuant to Section 55.142, Subpart H, Title 27, Code of Federal Regulations and Title 18 United States Code, Chapter 40, Section 845(b).

5. New Applications for licensing shall:

a. Submit a completed fingerprint card with their application for the Office of State Fire Marshal to conduct a criminal background check as part of the initial licensing application process.

b. Provide the appropriate Federal licenses to handle and use explosives or explosive materials. Applicants must provide a copy of applicable Federal licenses with their application.

c. Provide proof of insurance. The coverage company must be an insurer which is either licensed by the Department of Insurance in this State or approved by the Department of Insurance as a nonadmitted surplus lines carrier for risks located in this State. In the event the liability insurance is canceled, suspended, or nonrenewed, the insurer shall give immediate notice to the State Fire Marshal's Office.

6. Each applicant for renewal shall each year:

a. Submit an application for renewal.

b. Have a SLED background check conducted by the Office of State Fire Marshal as part of the licensing renewal process.

c. Provide a copy of their current Federal licenses for handling and using explosives or explosive material with their renewal application.

d. Attend at least four (4) hours of continuing education acceptable to the Office of the State Fire Marshal. Certificates of training or other proof of training attendance must be provided when requested by the Office of State Fire Marshal.

e. Provide proof of insurance. The coverage company must be an insurer which is either licensed by the Department of Insurance in this State or approved by the Department of Insurance as a nonadmitted surplus lines carrier for risks located in this State. In the event the liability insurance is canceled, suspended, or nonrenewed, the insurer shall give immediate notice to the State Fire Marshal's Office.

C. Blasting Permits

1. Blasting Permit Application Forms shall contain the information deemed appropriate by the Office of State Fire Marshal.

2. Blasting Permit Application Forms shall be available on the State Fire Marshal's Web site.

3. No permit will be granted without submission of a complete Blasting Permit Application Form and payment of application fee.

4. No variations from the terms of the blasting permit are allowed without authorization from the State Fire Marshal or his designee.

D. Magazine Permits

1. Magazine Permit Application Forms shall contain the information deemed appropriate by the Office of State Fire Marshal.

2. Magazine Permit Application Forms shall be available on the State Fire Marshal's Web site.

3. Magazine permits expire at 12:01 AM on January 1 of each licensing cycle. Any magazine permit not renewed by December 31 shall incur a late fee of \$100.00 (each).

4. Magazine permits shall be visible on the exterior of all magazines. Defaced or destroyed permits will be reported to the SFM when discovered. The Office of State Fire Marshal may, at their discretion, charge the administrative costs of replacing the magazine permit.

5. Each magazine shall be inspected and approved by the Office of State Fire Marshal before use.

6. All magazines shall be placarded in accordance with NFPA 495.

71-8302.5. Records.

A. Licensed blasters shall keep records of each blast. Blaster's Log shall contain the following minimum data:

1. Name of company or contractor;
2. Location, date, and time of blast;
3. Name, signature, and license number of blaster in charge of blast;
4. Type of material blasted;
5. Number of holes, burden and spacing;
6. Diameter and depth of holes;
7. Types of explosives used;
8. Total amount of explosives used;
9. Maximum amount of explosives per delay period of 8 milliseconds or greater;
10. Method of firing and type of circuit;
11. Direction and distance in feet to nearest dwelling house, public building, school, church, commercial or institutional building neither owned nor leased by the person conducting the blasting;
12. Weather conditions;
13. Type and height or length of stemming;
14. Whether mats or other protections were used;
15. Type of delay electric blasting caps used and delay periods used;
16. Exact location of seismograph, if used, and the distance of seismograph from blast as indicated accurately by the person taking the seismograph reading;
17. Seismograph records, where required including:
 - a. Name of person and firm analyzing the seismograph record; and
 - b. Seismograph reading;
18. Maximum number of holes per delay period of eight milliseconds or greater.

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B. Blasters will provide a blast report on forms approved by the Office of State Fire Marshal and submit these forms within three working days of the blast when deemed necessary by the Office of State Fire Marshal.

C. Blasting records shall be retained by the licensed blaster and available for inspection by SFM during normal work hours at their place of business. These blast records shall include as a minimum for each blast:

1. Blasting Permit;
2. Seismograph reports when used;
3. Blaster's Record/log;
4. Pre-Blast Survey (if applicable).

D. Magazine log shall be available for inspection by SFM upon request during normal work hours or hours of operation of the magazine.

71-8302.6. Blasting Safety and Operations.

A. The contractor, operator, and the blaster are responsible for the conduct of blasting operations on any site.

B. These regulations do not relieve the contractor, operator, blaster or other persons of their responsibility and liability under any other laws.

C. The Office of State Fire Marshal may require the use of a seismograph on any blasting operation where damage to personal property has or may occur.

D. A Seismograph shall be used on all blasting operations within 1500 feet of a building, where the scaled distances shown in NFPA 495 are not followed, or when directed by the State Fire Marshal.

E. Operators must notify the State Fire Marshal within 24 hours of any fires or thefts involving explosives. The operators shall provide the State Fire Marshal with a copy of the report filed with the police department or the incident report from the fire department. Operators must also provide the State Fire Marshal's Office with a copy of ATF Form 5400.5.

F. The operator shall have their license in their possession when handling, possessing or using explosive materials and shall show their license when asked by any AHJ.

G. A copy of the blasting permit shall be kept at the firing station.

H. This section shall be followed for firing the blast:

1. A warning signal shall be given before every blast. Warning signals shall comply with the following:
 - a. Warning signal is a one (1) minute series of long horn or siren blasts five (5) minutes before the blast signal.
 - b. Blast signal is a series of short horn or siren blasts one (1) minute before the shot.
 - c. All clear signal is a prolonged horn or siren blast following the inspection of the blast area.
2. The signal shall be made from an air horn, siren or other device, and must be loud enough to be clearly heard in all areas that could be affected by the blast or flyrock from the blast. The signal must be distinctive and unique so that it cannot be confused with any other signaling system that might occur on the site. A vehicle horn shall not be used as a signaling system.

71-8302.7. Explosives Investigations.

All costs incurred by the State Fire Marshal for investigations involving explosives or blasting operations shall be reimbursed to the State by the individual or company involved in the investigation. Such reimbursements will only apply when the individual or company has been found in violation of the State Explosives Control Act or these Regulations.

71-8302.8. Variances.

A. This section provides licensees the opportunity to request variances of the regulations under specific conditions.

1. The State Fire Marshal may grant variances when it can be demonstrated the variance improves safety or provides an equivalent level of safety as provided in the regulations and adopted codes.

2. Such a variance may be modified or revoked by the State Fire Marshal.

3. When applicable, these variances must also be approved by the U.S. Bureau of Alcohol, Tobacco, and Firearms.

Fiscal Impact Statement:

There will be no additional cost incurred by the State or any political subdivision.

Statement of Rationale:

The guidelines for Explosives are amended to conform to national guidelines and ensure public safety.

Document No. 3214
DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL
CHAPTER 71
Statutory Authority: 1976 Code Sections 23-9-60, 39-41-260 and 40-82-70

71-8300. Fire Prevention and Life Safety

Synopsis:

The Office of State Fire Marshal is deleting 71-8300 Fire Prevention and Life Safety - Buildings (71-8300.1 through 71-8300.15) and replacing with Fire Prevention and Life Safety (71-8300.1 through 71-8300.4). The new SCRR 71-8300 will use a standardized format, simplify wording, update adopted codes and standards, and consolidate the common definitions and administrative items from the previous regulations.

Instructions:

Delete 71-8300 Fire Prevention and Life Safety - Buildings (71-8300.1 through 71-8300.15) and replace with Fire Prevention and Life Safety (71-8300.1 through 71-8300.4) as printed below.

Text:

SUBARTICLE 1
FIRE PREVENTION AND LIFE SAFETY

71-8300. Fire Prevention and Life Safety.

71-8300.1. General.

A. Title. These regulations shall be known as the State Fire Marshal's Rules and Regulations.

B. Intent. The purpose of these regulations is for safeguarding to a reasonable degree, life and property from fire, natural disasters, acts of terrorism, and other hazards associated with the construction, alteration, repair, use, and occupancy of buildings, structures, or premises. These regulations shall be the minimum standards required by the Office of State Fire Marshal for fire prevention and life safety in South Carolina for all buildings and structures.

C. Applicability.

1. All buildings, structures, or premises shall be constructed, altered, or repaired in conformance with these regulations.

2. All equipment or systems in a building, structure, or premise shall be constructed, installed, altered, or repaired in conformance with these regulations.

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3. These regulations shall not conflict with any state statute, code, or ordinance adopted pursuant to Title 6, Chapter 9 of the South Carolina Code by any municipality or political subdivision. In the event of a conflict, such statute, code, or ordinance shall apply. These regulations shall apply to state, county, municipal, and private buildings, structures, or premises unless excluded by these regulations or state statute.

4. These regulations shall not apply to:

a. Buildings constructed, or occupied exclusively as one and two-family dwellings.

b. One-story buildings less than 5,000 square feet, unless the building is classified as a Group A, E, I, R-1, R-2, R-4, or H occupancy by the adopted building code.

D. Existing Buildings.

1. Existing buildings, structures, or premises shall be permitted to continue in operation under the code the buildings, structures, or premises were constructed unless addressed by these regulations or state statute.

2. Alterations, repairs, additions, and rehabilitation to an existing building or structure, shall fully comply with the current codes for new construction when one of the following occurs:

a. The cost of construction exceeds fifty percent of the building value before the construction.

b. The building is damaged by fire, natural disaster, or otherwise, in excess of fifty (50) percent of the building value before such damage.

c. The building is moved into or within the state, excluding modular structures regulated by the Manufactured Housing Board.

3. Buildings, structures, or premises reopened after being vacant for more than one (1) year shall be considered new construction and must conform to the current codes for new construction.

4. If the occupancy classification or sub-classification of an existing building changes, the building shall conform to the current code for new construction.

5. If the occupancy classification or sub-classification of a portion of an existing building changes, that portion of the existing building shall conform with the current code for new construction or be separated per the adopted IBC.

6. Buildings or structures listed on national, state, or local historical registers undergoing repair, alteration, or change of occupancy shall comply with the IEBC Chapter for "Historic Buildings." The State Fire Marshal has the authority to accept alternative methods of compliance within the intent of these regulations.

E. Investigations.

1. If the State Fire Marshal or his designee has reason to believe that a person has violated a provision of these regulations, or if a person files a written complaint with the State Fire Marshal charging a violation of a provision of these regulations, the State Fire Marshal may initiate an investigation or may refer the complaint to the local fire code official.

2. Whenever it is necessary to make an inspection to enforce the requirements of these regulations, or whenever the fire code official has reasonable cause to believe that there exists in a building or upon any premises any conditions or violations of these regulations which make the building or premises unsafe, dangerous or hazardous, the fire code official or other designee of the State Fire Marshal may enter the building or premises at reasonable times to inspect or to perform any other duties imposed by law. If such building or premises is occupied, the fire code official shall present credentials to the occupant and request entry. If such building or premises is unoccupied, the fire code official shall first make a reasonable effort to locate the owner or other person having charge or control of the building or premises and request entry. If entry is refused, the fire code official has recourse to every remedy provided by law to secure entry.

3. For the purpose of an inspection, investigation or proceeding under these regulations, the Department may administer oaths and issue subpoenas for the attendance and testimony of witnesses and the production and examination of books, papers, and records on behalf of the State Fire Marshal or, upon request, on behalf of a party to the case. Upon failure to obey a subpoena or to answer questions propounded by the State Fire Marshal, the Department may apply to an Administrative Law Court for an order requiring the person to comply with the subpoena.

F. Enforcement.

1. No person, firm, or corporation shall erect, construct, alter, repair, remove, demolish, or use a building, structure, premises, or system or cause same to be done in violation of these regulations.

2. No person, firm, or corporation shall occupy, use, or maintain a building, structure, premises, or system in violation of these regulations.

3. All new and existing buildings, structures and premises shall be maintained in a safe condition. All devices and safeguards required in a building when erected, altered, or repaired shall be maintained per the manufacturer's requirements and the applicable codes. The owner or his designated agent is responsible for the maintenance of buildings, structures, and premises.

4. Where there is a conflict between two adopted codes, the code official shall favor the code providing the greatest protection for life safety, generally preferring active fire suppression over passive fire protection.

5. For a violation of these regulations or the adopted codes, the local fire code authority, municipal or county attorneys, or other appropriate authorities of a political subdivision, or an adjacent or neighboring property owner who would be damaged by the violation, or the State Fire Marshal, in addition to other remedies, may apply for injunctive relief, mandamus, or other appropriate proceedings. A court may grant temporary injunctive relief upon receipt of a verified complaint of an immediate danger or emergency situation.

6. If the State Fire Marshal, his designee or the fire code official has reason to believe that the lack of compliance with fire and life safety codes in any structure constitutes an immediate danger to the public which could reasonably be expected to injure seriously or cause death to members of the public, the State Fire Marshal or the local fire code official may apply to the circuit court in the county in which the dangerous condition exists for a temporary order for the purpose of enjoining the use of the dangerous structure. Upon hearing, if considered appropriate by the court, a permanent injunction may be issued to ensure that the use of that dangerous facility be prevented or controlled. Upon the elimination or rectification of the dangerous condition, the temporary or permanent injunction must be vacated.

7. If the State Fire Marshal has reason to believe that a person is violating or intends to violate provisions of these regulations, in addition to other remedies, it may order the person immediately to refrain from the conduct. The State Fire Marshal may apply to the Administrative Law Court for an injunction restraining the person from the conduct. The court may issue a temporary injunction ex parte not to exceed ten days and upon notice and full hearing may issue other orders in the matter it considers proper. No bond is required of the State Fire Marshal by the court as a condition to the issuance of an injunction or order pursuant to this section.

G. Unsafe Buildings.

1. The AHJ or the fire department official in charge of an incident is authorized to order the immediate evacuation of any building deemed unsafe when such building has hazardous conditions that present imminent danger to the public. Persons so notified shall immediately leave the structure or premises and shall not enter or re-enter until authorized to do so by the code official or fire department official in charge of the incident. The official shall cause to be posted at each entrance to such a building, a notice substantially as follows: "THIS BUILDING IS UNSAFE AND ITS USE OR OCCUPANCY HAS BEEN PROHIBITED BY THE FIRE CODE OFFICIAL FOR _____ or BY THE STATE FIRE MARSHAL."

2. The owner, operator, or occupant of a building or premises deemed unsafe by the fire code official shall abate or cause to be abated or corrected such unsafe conditions either by repair, rehabilitation, demolition, or other approved corrective action.

3. The owner, agent or person in control of any building cited as unsafe for occupancy by the State Fire Marshal may appeal to the Administrative Law Court. Emergency decisions of the State Fire Marshal or of a fire department official in charge of an incident are not stayed pending appeal.

H. Definitions: The following references apply throughout these regulations. Words not defined in these regulations shall have the meaning stated in the referenced standards adopted by these regulations.

1. "AHJ" means Authority Having Jurisdiction, which is the State Fire Marshal or any local fire official covered by South Carolina Code 23-9-30.

2. "Building Value" means the appraised market value of the structure, excluding land value, building contents, and site improvements.

3. "Department" means the Department of Labor, Licensing and Regulation, Division of Fire and Life Safety.

4. "Existing Building" means a building, structure, or premise for which preliminary or final drawings have been approved by the appropriate agency as provided in these regulations, in buildings where construction has begun, or those occupied on or before the date of adoption of these regulations.

5. "Fire Prevention" means any activity to prevent fire before fire occurs.

6. "IBC" means the International Building Code.

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7. "IEBC" means the International Existing Building Code.
8. "IFC" means the International Fire Code.
9. "IMC" means the International Mechanical Code.
10. "NEC" means the National Electrical Code or NFPA 70.
11. "NFPA" means the National Fire Protection Association.
12. "NFPA 101" means the Life Safety Code.
13. "SFM" means State Fire Marshal or his agent.

71.8300.2. Codes and Standards.

A. The requirements of the IBC, 2006 Edition (omit Chapter 1), shall constitute the minimum standards for fire prevention and life safety for construction, occupancy, and use of all buildings and structures within the scope of these regulations except as modified by these regulations. All references to NFPA Standards found in these regulations refer to the Editions specified in the IBC and IFC unless otherwise stated in these regulations or adopted by state statutes.

B. The requirements of the IEBC, 2006 Edition (omit Chapter 1), shall constitute the minimum standards for fire prevention and life safety in historic buildings and structures within the scope of these regulations except as modified by these regulations.

C. The requirements of the IFC, 2006 Edition (omit Chapter 1), shall constitute the minimum standards for fire prevention and life safety protection for construction, occupancy, and use of all buildings and structures within the scope of these regulations except as modified by these regulations.

D. The requirements of the IMC, 2006 Edition (omit Chapter 1), shall constitute the minimum standards for fire prevention and life safety protection for construction, occupancy, and use of all buildings and structures within the scope of these regulations except as modified by these regulations.

E. The requirements of NFPA 10, 2007 Edition, shall constitute the minimum standard for the installation, servicing, maintenance, recharging, repairing, and hydrostatic testing of all portable fire extinguishers.

F. The requirements of the following NFPA standards shall constitute the minimum standards for the design, installation, testing and maintenance of fixed suppression systems in South Carolina except as modified by these regulations.

1. NFPA 11, 2005 Edition
2. NFPA 12, 2008 Edition
3. NFPA 12A, 2004 Edition
4. NFPA 17, 2002 Edition
5. NFPA 17A, 2002 Edition
6. NFPA 750, 2006 Edition
7. NFPA 2001, 2008 Edition
8. NFPA 2010, 2006 Edition

G. The requirements of the following NFPA standards shall constitute the minimum standards for the design, installation, testing, and maintenance of water-based extinguishing systems in South Carolina except as modified by these regulations.

1. NFPA 13, 2007 Edition
2. NFPA 13D, 2007 Edition
3. NFPA 13R, 2007 Edition
4. NFPA 14, 2007 Edition
5. NFPA 15, 2007 Edition
6. NFPA 16, 2007 Edition
7. NFPA 18, 2006 Edition
8. NFPA 20, 2007 Edition
9. NFPA 22, 2003 Edition
10. NFPA 24, 2007 Edition
11. NFPA 25, 2008 Edition
12. NFPA 214, 2005 Edition

H. The requirements of NFPA 30, 2008 Edition, shall constitute the minimum standards for the storing, and handling of flammable and combustible liquids in South Carolina except as modified by these regulations.

I. The requirements of NFPA 30A, 2008 Edition, shall constitute the minimum standards for the storing, handling, and dispensing of flammable and combustible liquids at service stations, farms, and isolated sites in South Carolina except as modified by these regulations.

J. The requirements of NFPA 52, 2006 Edition, shall constitute the minimum standards for storing, handling, and dispensing vehicular alternative fuels in South Carolina except as modified by these regulations.

K. The requirements of NFPA 54, 2006 Edition, shall constitute the minimum standards for design, materials, components, fabrication, assembly, installation, testing, inspection, operation, and maintenance installation of fuel gas piping systems, appliances, equipment, and related accessories, installation, combustion, and ventilation air and venting in South Carolina except as modified by these regulations.

L. The requirements of NFPA 58, 2008 Edition, shall constitute the minimum standards for the design, construction, location, installation and operation of equipment for storing, handling, transporting by tank truck or tank trailer, and use of liquefied petroleum gases and the odorization of such gases in South Carolina except as modified by these regulations.

M. The requirements of NFPA 59, 2004 Edition, shall constitute the minimum standards for the design, construction, location, installation, operation, and maintenance of refrigerated and non-refrigerated utility gas plants to the point where LP-Gas or an LP-Gas and air mixture is introduced into the utility distribution system in South Carolina except as modified by these regulations.

N. The requirements of NFPA 70, 2008 Edition, shall constitute the minimum standards for fire prevention and life safety from hazards of electricity in South Carolina except as modified by these regulations.

O. The requirements of NFPA 72, 2007 Edition, shall constitute the minimum standards for the design, installation, testing, and maintenance of fire alarm systems in South Carolina except as modified by these regulations.

P. The requirements of NFPA 96, 2008 Edition, shall constitute the minimum standard for ventilation control and fire protection of commercial cooking operations in South Carolina except as modified by these regulations.

Q. The requirements of NFPA 99, 2005 Edition, shall constitute the minimum standard for flammable and non-flammable medical gasses used in health care and other facilities intended for inhalation or sedation, but not limited to, analgesia systems for dentistry, podiatry, veterinary, and similar uses in South Carolina except as modified by these regulations.

R. The requirements of NFPA 101, 2006 Edition, shall constitute the minimum standard for fire prevention and life safety in South Carolina when evaluating alternative methods of fire and life safety per SCRR 71-8300.10 except as modified by these regulations.

S. The requirements of the NFPA 102, 2006 Edition, shall constitute the minimum standard for fire prevention and life safety for all tents and membrane structures normally used in South Carolina except as modified by these regulations.

T. The requirements of NFPA 160, 2006 Edition, including Annexes B and C, shall constitute the minimum standards for all flame effects use in proximate audience pyrotechnics displays or motion picture special effects in South Carolina except as modified by these regulations.

U. The requirements of NFPA 407, 2007 Edition, shall constitute the minimum standards for the storing, handling, and dispensing of flammable and combustible liquids at private aircraft fueling facilities in South Carolina except as modified by these regulations.

V. The requirements of NFPA 409, 2004 Edition, shall constitute the minimum standards for the design construction, occupancy, and use of aircraft hangars in South Carolina except as modified by these regulations.

W. The requirements of NFPA 495, 2006 Edition, Explosive Materials Code shall constitute the minimum standard for the manufacture, transportation, use and storage for all explosives in South Carolina, except as modified herein.

X. The requirements of NFPA 1122, 2008 Edition, shall constitute the minimum standards for model rocketry associated with public firework displays or proximate audience pyrotechnic displays or motion picture special effects in South Carolina except as modified by these regulations.

Y. The requirements of NFPA 1123, 2006 Edition, including Annex A and E, shall constitute the minimum standards for all firework displays in South Carolina except as modified by these regulations.

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Z. The requirements of NFPA 1124, 2006 Edition, shall constitute the minimum standards for transportation, storage, and use of all display fireworks and pyrotechnic articles used for proximate audience pyrotechnic displays or motion picture special effects in South Carolina except as modified by these regulations.

AA. The requirements of NFPA 1126, 2006 Edition, including Annexes A, B, and D, shall constitute the minimum standards for all proximate audience displays in South Carolina except as modified by these regulations.

BB. The requirements of NFPA 1127, 2008 Edition, shall constitute the minimum standards for all high power rockets used for proximate audience pyrotechnic displays or motion picture special effects in South Carolina except as modified by these regulations.

CC. The requirements of NFPA 1142, 2007 Edition, shall constitute the minimum standards for water supplies for rural fire fighting in South Carolina except as modified by these regulations.

DD. The Office of State Fire Marshal shall post a list of the currently adopted Editions of the codes and standards listed above on the Office of State Fire Marshal's Web site when they are updated using SC Code of Laws 1-34-30.

EE. All referenced standards adopted by the Office of State Fire Marshal shall be accessible at no cost to the public through the Office of State Fire Marshal's Web page as "read only" documents.

71.8300.3. Alternate Materials and Alternate Methods of Construction.

A. The requirements of these regulations are not intended to prevent the use of any material or method of construction not specifically prescribed by the regulations, adopted codes, or standards enforced by the State Fire Marshal. The State Fire Marshal has the authority to accept alternative methods of compliance within the intent of these regulations, after finding that the materials and method of work offered is for the purpose intended, at least the equivalent of that prescribed in these regulations in quality, strength, effectiveness, fire resistance, durability, and safety. The State Fire Marshal shall require submission of sufficient evidence or proof to substantiate any claim made regarding use of alternative materials and methods.

B. Compliance with NFPA 101 may be used for consideration of alternative methods if found suitable by the State Fire Marshal.

71-8300.4. Plans, Specifications and Incident Reporting.

A. Plans and Specifications.

1. All plans and specifications must be submitted to the SFM for the following:

- a. Local detention facilities per 24-9-20.
- b. Water-based extinguishing systems per 40-10-260.
- c. Aboveground tanks storing flammable or combustible liquids per 39-41-260.
- d. LP Gas facilities per 40-82-10 et seq.

2. Submitted plans, calculations, and specifications shall:

a. Be prepared by a licensed architect and/or engineer where required by state laws or regulations.

b. Provide sufficient information to indicate how compliance with state laws, regulations, and adopted codes will be accomplished. Codes shall not be cited in whole or part as a substitute for providing specific information.

3. The Office of State Fire Marshal will publish a list of minimum information required to conduct a plan review when a list is not contained in the adopted standards. The Office of State Fire Marshal will make these lists available on the Office of State Fire Marshal's Web site.

4. The SFM may revoke any approval issued under the requirements of these regulations where the approval was based on any false statement or misrepresentation of fact in correspondences, plans, specifications, or data.

B. Incident Reporting.

1. The local fire chief or his designee shall furnish monthly to the Office of State Fire Marshal, information concerning incidents and fire fatalities occurring within their jurisdiction. These reports shall include facts relating to any fire, its cause and origin, property loss, and other pertinent information as prescribed by the Office of State Fire Marshal, in an approved format.

2. These reports are privileged against liability unless the report is made with actual malice.

Fiscal Impact Statement:

There will be no additional cost incurred by the State or any political subdivision.

Statement of Rationale:

The guidelines for Fire Prevention and Life Safety in Buildings are amended to conform with national guidelines in order ensure public safety.

Document No. 3220
DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL
CHAPTER 71

Statutory Authority: 1976 Code Sections 23-9-60 and 24-9-20

71-8306. Fire Prevention and Life Safety in Local Detention Facilities

Synopsis:

The Office of State Fire Marshal is deleting 71-8306 Tents, Grandstands, and Air-Supported Structures and replacing it with 71-8306 Fire Prevention and Life Safety in Local Detention Facilities. The new SCRR 71-8306 will use a standardized format, simplifies wording, removes obsolete language and requirements, and consolidates the requirements for new, existing, and renovated Local Detention facilities from the previous regulations 71-8308 through 71-8310.

Instructions:

Delete current Regulation 71-8306 Tents, Grandstands, and Air-Supported Structures (71-8306.1 through 71-8306.2) in its entirety and replace with new Subarticle 7 Fire Prevention and Life Safety in Local Detention Facilities (71-8306.1 through 71-8306.5)as printed below.

Text:

SUBARTICLE 7
FIRE PREVENTION AND LIFE SAFETY IN LOCAL DETENTION FACILITIES

71-8306. Fire Prevention and Life Safety in Local Detention Facilities.

71-8306.1. General.

A. The purpose of these regulations is to:

1. Safeguard, to a reasonable degree, life, and property from fire and other hazards associated with the construction, alteration, repair, use, and occupancy of local detention facilities or structures containing local detention facilities.

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2. Establish the minimum standards enforced by the State Fire Marshal for fire prevention and life safety in South Carolina for local detention facilities or structures containing local detention facilities.

B. These regulations shall apply as follows:

1. New construction of local detention facilities or structures containing local detention facilities.

2. The operation of local detention facilities or structures containing local detention facilities.

3. Additions, alteration, or repairs to existing local detention facilities or structures containing local detention facilities.

C. These regulations shall not apply to:

1. State detention facilities; or

2. Federal detention facilities.

D. Definitions.

1. "Local detention facility" means any municipal, county, or multi-jurisdictional overnight lockup, jail, prison camp, or correctional center where one or more persons are held for more than six hours, including a privately owned or operated facility holding detainees or inmates for any municipal, county, or multi-jurisdictional governmental entity.

71-8306.2. Codes and Standards.

A. All references to ICC Codes found in these regulations refer to the editions adopted in SCRR 71-8300.2 and are modified by the following regulations as shown below.

B. All references to NFPA Standards found in these regulations refer to the editions adopted in SCRR 71-8300.2 and are modified by the following regulations as shown below.

71-8306.3. Reports.

A. Local Detention Facilities must immediately report any incident of fire to the local fire department serving the facility.

B. The person in charge of a Local Detention Facility must report any incident of fire to the Jail and Prison Inspection Division of the Department of Corrections and the Office of State Fire Marshal within 24 hours of the incident.

71-8306.4. Fire Protection Systems.

A. Sprinkler Systems in local detention facilities shall comply with the following:

1. All local detention facilities classified as Group I shall be protected with a sprinkler system complying with NFPA 13.

2. In new construction, the entire structure containing the local detention facility shall be protected with a sprinkler system.

3. Renovations to existing local detention facilities shall include installation of sprinklers in the secure portions of facilities not equipped with sprinklers.

B. Standpipes. Class III Standpipes required by the IBC may be installed without hose in the secured portions of all facilities.

C. Fire Alarm Systems.

1. In new construction or construction considered as new construction per SCRR 71-8300.1, the fire alarm system must comply with the IFC and NFPA 72.

2. In existing facilities, the fire alarm must comply with the Fire Prevention Code and NFPA codes in effect at the time of construction. The Office of State Fire Marshal and the Jail and Prison Inspection Division of the Department of Corrections shall determine the extent of conformance for existing systems with current codes based on published guidelines.

D. Fixed Fire Protection Systems. Installation, inspection, testing, and maintenance shall comply with SCRR 71-8303 for all facilities.

E. Inspection, Testing, and Maintenance.

1. Inspection, testing, and maintenance of fire protection systems shall comply with the IFC and the applicable NFPA standards.
2. A properly licensed contractor shall perform all required fire protection system inspections, testing, and maintenance per the governing licensing laws and regulations.
3. The facility shall keep records of all required inspections and tests as specified in the IFC or applicable NFPA standard. When adopted codes or standards do not specify a time, facilities will keep records for at least three (3) years.

71-8306.5. Operations.

A. Emergency Planning and Preparedness. The chief administrative officer of all local detention facilities shall:

1. Coordinate annually with the local fire department providing suppression to the facility.
2. Prepare a fire safety and evacuation plan per the IFC.
3. Conduct Emergency evacuation drills per the IFC.
4. Maintain records of such drills per the IFC for a period of at least three (3) years.
5. Develop fire prevention policies.
6. Train employees annually on emergency procedures, the evacuation plan, fire prevention, and fire emergencies.
7. Conduct and document weekly fire prevention inspections and maintain records of such inspections for a period of three (3) years.

B. Fire Prevention.

1. All local detention facilities shall comply with the requirement in the IFC.
2. All facilities shall have a written policy that as a minimum addresses:
 - a. Access to smoking materials and matches by inmates;
 - b. Use of smoking materials and matches by intoxicated inmates;
 - c. Use of smoking materials and matches by inmates identified as a suicide risk.
3. Facility staff shall have immediate access at all times to necessary keys or other unlocking mechanisms to unlock exit doors from the inside and outside of the door.

Fiscal Impact Statement:

There will be no additional cost incurred by the State or any political subdivision.

Statement of Rationale:

The guidelines for Fire Prevention and Life Safety for Special Occupancies are amended to conform with national guidelines in order to ensure public safety.

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Document No. 3215
DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL
CHAPTER 71
Statutory Authority: 1976 Code Section 23-9-60

71-8301. Fire Prevention and Life Safety for Special Occupancies

Synopsis:

The Office of State Fire Marshal is deleting 71-8301 Use of Hazardous Substances (71-8301.1 through 71-8301.6) and replacing with 71-8301 Fire Prevention and Life Safety for Special Occupancies (71-8301.1 through 71-8301.3). The new SCRR 71-8301 will use a standardized format, simplify wording, remove obsolete language and requirements, and consolidate the requirements for existing daycares and all foster homes from the previous regulations.

Instructions:

Delete 71-8301 Use of Hazardous Substances (71-8301.1 through 71-8301.6) and replace with 71-8301 Fire Prevention and Life Safety for Special Occupancies (71-8301.1 through 71-8301.3).

Text:

SUBARTICLE 2
FIRE PREVENTION AND LIFE SAFETY FOR SPECIAL OCCUPANCIES

71-8301 Fire Prevention and Life Safety for Special Occupancies.

71-8301.1. General.

A. The purpose of this regulation is to clarify the application of current codes and retroactive application of the regulations to existing licensed special occupancies covered by these regulations.

B. This regulation shall apply to:

1. Existing day care facilities and
2. New or existing foster homes.

C. This regulation shall not apply to new daycare facilities. New daycare facilities shall comply with SCRR 71-8300.

71-8301.2. Codes and Standards.

A. All references to ICC Codes found in these regulations refer to the editions adopted in SCRR 71-8300.2. The building code shall define occupancy classifications referenced in these regulations.

B. All references to NFPA standards found in these regulations refer to the editions adopted in SCRR 71-8300.2 and are modified by the following regulations as shown below.

71-8301.3. Requirements for Special Occupancies.

A. All Child Day Care Facilities shall comply with the following:

1. All Child Day Care Facilities keeping children first grade and younger shall be located on the floor of exit discharge. Second grade children shall not be located more than one (1) story above or below the floor of exit discharge. This restriction does not apply to structures equipped throughout with an NFPA 13 sprinkler system.

- a. All facilities with fire alarm systems shall be designed, installed, and maintained per NFPA 72.

b. Each Child Day Care Center serving more than one hundred clients shall have a fire alarm system to provide off-premise notification to the fire department per NFPA 72.

c. All facilities licensed after 1999 shall have a listed smoke detector installed and maintained per NFPA 72 in every room occupied by clients, excluding bathrooms and closets.

d. All facilities continuously licensed before 1999 may use hard-wired single station smoke detectors with battery backup.

2. New Child Day Care Facilities and closed facilities that reopen caring for 6 or more children will be classified as Group E occupancy. These facilities must comply with the codes in effect at the time of licensure.

3. An existing Child Day Care Facility that has been continuously licensed may continue operation under the codes to which it was initially licensed. These facilities shall also meet the following standards:

a. Facilities providing care, maintenance, and supervision for thirteen (13) or more clients for less than twenty-four (24) hours but more than four (4) hours per day shall be classified as Group E occupancy.

b. Special protective covers for electrical receptacles shall be installed on all receptacles located in areas occupied by clients.

c. Emergency evacuation drills shall include complete evacuation of all persons from the building.

d. The owner shall maintain records of emergency evacuation drills for at least three (3) years.

e. Facilities shall provide a copy of their Fire Evacuation Plan to the responding fire department. The plan must note the rooms keeping children under twenty-four (24) months of age.

f. Facilities with six (6) or more children under twenty-four (24) months of age shall comply with the regulations for "Facilities with Children Under 24 Months of Age" (S.C. Reg. 71-8301(B)).

4. The State Fire Marshal has authority to approve alternate methods of compliance within the intent of the regulations for existing facilities.

B. Existing "Facilities with Children Under 24 Months of Age"

1. Facilities caring for four or more children under twenty-four (24) months of age unattended by a parent or guardian shall provide the following safeguards:

a. Rooms shall have a one (1) hour fire rated separation. No fire rated separation is required between adjacent rooms caring for children less than twenty-four (24) months of age.

b. Rooms shall have a direct exit to the outside. Exit door(s) from infant rooms shall swing in the direction of egress and the door leaf shall be at least thirty-six (36) inches wide.

c. Rooms shall be limited to twelve (12) children per direct exit. There shall be no more than twenty-four (24) children per room. Older children kept in the room shall be counted as part of the total for direct exits and room occupancy considerations.

d. Rooms shall not have any type of open flame appliances.

e. Rooms shall have smoke detectors installed and maintained per NFPA 72 inside the room and in the adjacent area of the facility near the protected room's entrance.

f. Doors in the required one-hour separation partitions shall be twenty (20) minute labeled doors equipped with door closures or a smoke actuated hold-open device.

g. Facilities shall develop a fire safety and evacuation plan complying with the requirements for Group E occupancies in the IFC.

h. Facilities shall provide a copy of their fire safety and evacuation plan to the local fire authorities. The plan must note the rooms keeping children under twenty-four (24) months of age.

i. Emergency evacuation drills shall comply with the requirements for Group E occupancies in the IFC. The owner shall maintain records per the IFC of emergency evacuation drills for at least three (3) years.

j. Portable unvented fuel-fired heating equipment shall be prohibited in all infant rooms and daycares.

C. Existing Child Group Day Care

1. Facilities providing care, maintenance, and supervision for seven (7) to twelve (12) children for less than twenty-four (24) hours but more than four (4) hours per day shall be classified as Group R-3 occupancy.

a. Group day care facilities shall be separated from other type occupancies (excluding owner residence) by a one (1) hour fire barrier constructed per the IBC.

b. Group day care facilities located in R-2 occupancies shall be located on the floor of exit discharge.

c. Each group day care facility occupied by clients shall have at least two (2) independent means of escape as defined in NFPA 101.

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d. The doorway between the level of exit discharge and any floor below shall be equipped with a self-closing 1 1/2" solid core wood door or a labeled fire rated door with a twenty (20) minute or higher rating.

e. Group day care is prohibited in manufactured housing (mobile homes).

f. A fire plan describing what actions are to be taken by the staff in the event of a fire must be developed, posted, and copies made available to staff members and the local fire department. This plan shall note the location of all crib children under twenty-four (24) months of age.

g. A fire drill shall be conducted per the IFC for educational occupancies. Records of drills shall be maintained for a period of three (3) years and report the date, time, description, and evaluation of each drill.

h. At least one (1) portable fire extinguisher with a minimum classification of 2A:10BC shall be installed in cooking areas. The fire extinguishers shall be installed and maintained per NFPA 10.

i. All heating devices must be selected, used, and installed per the IFC, the manufacturer's recommendations, and listing conditions set by an approved testing laboratory.

j. Unvented gas heaters shall have an operating oxygen depletion device, an operating safety shutoff device, and means to protect clients from burns.

k. Fireplaces shall be equipped with fire screens, partitions, or other means to protect clients from burns.

l. Facilities with six (6) or more children under twenty-four (24) months of age shall comply with S.C. Reg. 71-8301.3(B) for "Facilities with Children Under 24 Months of Age."

m. Portable unvented fuel-fired heating equipment shall be prohibited in all group day cares.

D. Existing Child Family Day Care Facilities

1. Facilities providing care, maintenance, and supervision for six (6) or less children for less than twenty-four (24) hours but more than four (4) hours per day shall be classified as Group R-3 occupancy.

a. Family day care facilities shall be separated from other type occupancies (excluding owner residence) by a one-hour fire barrier constructed per the IBC.

b. Family day care facilities located in R-2 occupancies shall be located on the floor of exit discharge.

c. Each family day care facility occupied by clients shall have at least two (2) independent means of escape as defined in NFPA 101.

d. The doorway between the level of exit discharge and any floor below shall be equipped with a self-closing 1 1/2" solid core wood door or a labeled fire rated door with a twenty (20) minute or higher rating.

e. A fire plan describing what actions are to be taken by the staff in the event of a fire must be developed, posted, and copies made available to staff members and the local fire department. This plan shall note the location of all crib children under twenty-four (24) months of age.

f. A fire drill shall be conducted per the IFC for educational occupancies. Records of drills shall be maintained for a period of three (3) years and report the date, time, description, and evaluation of each drill.

g. The interior finish in occupied spaces and exits in family day care facilities shall be a minimum of Class C.

h. At least one (1) portable fire extinguisher with a minimum classification of 2A:10BC shall be installed in cooking areas. The fire extinguishers shall be installed and maintained per NFPA 10.

i. All heating devices must be selected, used, and installed per the IFC, the manufacturer's recommendations, and listing conditions set by an approved testing laboratory.

j. Unvented gas heaters shall have an operating oxygen depletion device, an operating safety shutoff device, and means to protect clients from burns.

k. Fireplaces shall be equipped with fire screens, partitions, or other means to protect clients from burns.

l. Facilities with six (6) or more children under twenty-four (24) months of age shall comply with the regulations for "Facilities with Children Under 24 Months of Age" (S.C. Reg. 71-8301(B)).

m. Portable unvented fuel-fired heating equipment shall be prohibited in all family day cares.

E. All Foster Care Facilities

1. Foster homes providing care, maintenance, and supervision for no more than six (6) children, including the natural or adopted children of the foster parent, shall be considered a Group R-3 occupancy.

a. A listed smoke detector shall be installed and maintained per NFPA 72.

b. At least one (1) portable fire extinguisher with a minimum classification of 2A:10BC shall be installed in cooking areas. The fire extinguishers shall be installed and maintained per NFPA 10.

c. Each facility housing foster children shall have two (2) independent means of escape as defined in NFPA 101.

- d. All resident bedrooms shall have emergency egress openings per the IBC.
- e. All heating devices must be selected, used, and installed per the IFC, the manufacturer's recommendations, and listing conditions set by an approved testing laboratory.
- f. Unvented gas heaters shall have an operating oxygen depletion device, an operating safety shutoff device, and shall be located or guarded to prevent burn injuries.
- g. Fireplaces shall be equipped with fire screens, partitions, or other means to protect clients from burns.
- h. A fire plan describing what actions are to be taken by the family in the event of a fire must be developed, posted, and copies made available to the local fire department.
- i. A fire drill shall be conducted every three (3) months.
- j. Records of the drills shall be maintained on the premises for three (3) years. The records shall give the date, time, and weather conditions during the drill, number evacuated, description, and evaluation of the fire drill. Fire drills shall include complete evacuation of all persons from the building.
- k. A fire drill shall be conducted within twenty-four (24) hours of the arrival of each new foster child.
- l. Portable unvented fuel-fired heating equipment shall be prohibited in all foster homes.

Fiscal Impact Statement:

There will be no additional cost incurred by the State or any political subdivision.

Statement of Rationale:

The guidelines for Fire Prevention and Life Safety for Special Occupancies are amended to conform with national guidelines in order to ensure public safety.

Document No. 3219
DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL
 CHAPTER 71
 Statutory Authority: 1976 Code Sections 23-9-10 et seq. and 23-35-10 et seq.

71-8305. Fireworks and Pyrotechnics

Synopsis:

The Office of State Fire Marshal is updating, revising, and reformatting SCRR 71-8305 regarding Explosives. The new SCRR 71-8305 complies with Federal Bureau of Alcohol Tobacco and Firearms requirements, uses a standardized format, simplifies wording, removes obsolete language and clarifies licensing and permitting requirements for the storage, handling, and use of explosives.

The Office of State Fire Marshal deleting 71-8305 Transportation and Use of Pyrotechnics and replacing it with 71-8305 Fireworks and Pyrotechnics. The new SCRR 71-8305 will use a standardized format; simplifies wording, removes obsolete language and requirements; clarifies licensing and permitting requirements for the transportation, handling, and use of Fireworks and Pyrotechnics; and consolidates the requirements for all pyrotechnics from the previous regulations 71-8305 and 71-8312.

Instructions:

Delete the current regulations 71-8305 Transportation and Use of Pyrotechnics (71-8305.1 through 71-8305.11) in their entirety. Replace with the new regulations Subarticle 6 Fireworks and Pyrotechnics (71-8305.1 through 71-8305.8) as printed below.

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Text:

SUBARTICLE 6 FIREWORKS AND PYROTECHNICS

71-8305. Fireworks and Pyrotechnics.

71-8305.1. General.

A. The purpose of this regulation is to provide reasonable safety and protection to the public, public property, private property, performers, and display operators from the hazards associated with the handling, use, transportation, and storage of pyrotechnics and fireworks.

B. This regulation shall apply to:

1. The handling and use of fireworks intended for public fireworks display;
2. The construction, handling and use of fireworks equipment intended for public fireworks display;
3. The general conduct and operation of public firework displays;
4. The transportation and storage of fireworks for public fireworks display;
5. The transportation and use of consumer fireworks;
6. The construction, handling, and use of pyrotechnics intended for proximate audience displays; special effects for motion picture, theatrical, and television productions;
7. The construction, handling, and use of flame effects intended for proximate audience displays, or special effects for motion picture, theatrical, and television productions;
8. The construction, handling, and use of rockets intended for proximate audience displays, or special effects for motion picture, theatrical, and television productions; and
9. The general conduct and operation of proximate audience displays.

C. This regulation shall not apply to:

1. The manufacture, sale, or storage of fireworks as governed by the SC Department of Labor Licensing and Regulation, State Board of Pyrotechnic Safety;
2. The transportation, handling, and/or use of fireworks by the State Fire Marshal, his employees, or any commissioned law enforcement officers acting within their official capacities;
3. Fireworks deregulated by the U.S. Department of Transportation;
4. Weapons used in enactments, when there is no projectile;
5. Artillery field pieces used as salutes with no projectile; and
6. The outdoor use of model rockets within the scope of NFPA 1122.

D. Definitions.

1. "AHJ" means Authority Having Jurisdiction, which is the State Fire Marshal, or his agents, or any local fire official covered by 23-9-30.

2. "Consumer Fireworks" means any small device designed to produce visible effects by combustion and which must comply with the construction, chemical composition, and labeling regulations of the U.S. Consumer Product Safety Commission, as set forth in Title 16, Code of Federal Regulations, parts 1500 and 1507. Some small devices designed to produce audible effects are included, such as whistling devices, ground devices containing fifty (50) mg or less of explosive materials, and aerial devices containing 130 mg or less of explosive materials. Consumer fireworks are classified as fireworks UN0336 and UN0337 by the U.S. Department of Transportation at 49 CFR 172.101. This term does not include fused setpieces containing components which together exceed 50 mg of salute powder. Consumer Fireworks are further defined as those classified by the U.S. Department of Transportation hazard classification 1.4g. These fireworks were formerly known as "Class C Fireworks."

3. "Day box" means a portable magazine used for immediate storage of pyrotechnic materials.

4. "Display Fireworks" means large fireworks designed primarily to produce visible or audible effects by combustion, deflagration, or detonation. This term includes, but is not limited to, salutes containing more than two (2) grains (130 mg) of explosive materials, aerial shells containing more than 40 grams of pyrotechnic compositions, and other display pieces which exceed the limits of explosive materials for classification as "Consumer Fireworks." Display fireworks are classified as fireworks UN0333, UN0334, or UN0335 by the

U.S. Department of Transportation at 49 CFR 172.101. This term also includes fused setpieces containing components which together exceed fifty (50) mg of salute powder. Display fireworks are further defined as those classified by the U.S. Department of Transportation as hazard classification 1.3g. These fireworks were formerly known as "Class B Fireworks."

5. "Fireworks" means any composition or device designed to produce a visible or an audible effect by combustion, deflagration, or detonation, and which meets the definition of "consumer fireworks" or "display fireworks" as defined by this section.

6. "MSDS(s)" means Material Safety Data Sheet(s).

7. "Motion Picture" means, for the purposes of this item, any audiovisual work with a series of related images either on film, tape, or other embodiment, where the images shown in succession impart an impression of motion together with accompanying sound, if any, which is produced, adapted, or altered for exploitation as entertainment, advertising, promotional, industrial, or educational media.

8. "Proximate Audience" means any indoor use of pyrotechnics and the use of pyrotechnics before an audience located closer than the distances allowed by NFPA 1123.

9. "Public Firework Display" means a presentation of Display or Consumer Fireworks for a public gathering.

10. "Pyrotechnics" means any composition or device designed to produce visible or audible effects for entertainment purposes by combustion, deflagration, or detonation.

11. "SFM" means State Fire Marshal or his agent.

12. "Theatrical Pyrotechnics" means pyrotechnic devices for professional use in the entertainment industry similar to consumer fireworks in chemical composition and construction but not intended for consumer use.

71-8305.2. Codes and Standards.

A. All references to ICC Codes found in these regulations refer to the editions adopted in SCRR 71-8300.2. The building code shall define occupancy classifications referenced in these regulations.

B. All references to NFPA standards found in these regulations refer to the editions adopted in SCRR 71-8300.2 and are modified by the following regulations as shown below.

71-8305.3. Licensing and Permitting Fees.

A. All fees are due at time of application for licenses, tests, or permitting.

B. Permit applications are due in the Office of State Fire Marshal fifteen days before the performance date. Fees will be doubled for an application received less than fifteen days before the performance date.

C. The Office of State Fire Marshal is responsible for all administrative activities of the licensing program. The State Fire Marshal shall employ and supervise personnel necessary to effectuate the provisions of this article and shall establish fees sufficient but not excessive to cover expenses, including direct and indirect costs to the State for the operation of this licensing program. Fees may be adjusted not more than once each two years, using the method set out in South Carolina Code 40-1-50(D).

D. Fees shall be established for the following:

1. Application
2. Background Check
3. Testing
4. Licensing
5. Permitting
6. Inspection
7. Renewal

E. All fees are due at time of application for licenses, background checks, testing, permits, inspection or renewal.

F. All fees paid to the Office of State Fire Marshal are nonrefundable.

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71-8305.4. Qualifications of Operators.

A. All Operators.

1. No person shall be granted a license who has not successfully completed a written examination administered by the Office of State Fire Marshal. The exam will cover the applicable codes, state laws, and regulations and the additional requirements listed below for the specific class of license for which they are applying.

2. Any applicant who fails the written examination is allowed one re-test after a minimum seven-day waiting period. Any applicant who fails the re-test shall wait at least six months before reapplying.

3. Applicants shall submit a completed fingerprint card with their application. The Office of State Fire Marshal will conduct a criminal background check as part of the licensing application process.

4. Operators using explosives or explosive materials must have the appropriate Federal licenses. Operators shall provide a copy of applicable Federal licenses.

5. Licenses must be renewed biennially on the day of expiration shown on the license.

6. Every two years, each licensed operator shall be required to attend training offered by the Office of State Fire Marshal or attend pre-approved training providing a total of eight (8) hours of continuing education during the licensing cycle.

7. The State Fire Marshal may revoke, suspend, or deny a license because of, but not limited to:

a. Failure to comply with any order written by the SFM;

b. Conviction of a felony, a crime of violence, or any crime punishable by a term of imprisonment exceeding two years; or

c. Advocating or knowingly belonging to any organization or group which advocates violent overthrow of or violent action against the federal, state, local government, or its citizens; or

d. Having or contracting physical or mental illness or conditions that in the judgment of the State Fire Marshal would make use or possession of fireworks, pyrotechnics, or explosive materials hazardous to the licensee or the public; or

e. Violating the terms of the license or essential changes in the conditions under which the license was issued without prior approval of the Office of State Fire Marshal;

f. Violating the state laws or regulations governing Public Fireworks Displays or Proximate Audience Pyrotechnics; or

g. Giving false information or making a misrepresentation to obtain a license.

B. Public Display Operators.

1. Applications for licensing must furnish a notarized statement from a South Carolina licensed display operator concerning their participation in at least 6 fireworks displays and indicating for each display the date, the site, and the name and license number of the supervising operator.

2. The person in charge of the Public Fireworks Display shall be licensed by the Office of State Fire Marshal.

C. Pyrotechnic Operators.

1. Applications for licensing must provide written documentation from a South Carolina licensed display operator or company that the applicant has actively participated in the set-up and operation of at least six proximate audience performances using the types of pyrotechnics for the license classification the applicant is seeking. Only the State Fire Marshal may accept an alternative number of displays for this requirement based on the applicant's experience.

2. Licenses for pyrotechnic operators authorize and place the responsibility for the handling, supervision, and discharge of the fireworks or pyrotechnic device permitted by their license classification. The operator is responsible for the training of his or her assistants in the safe handling, supervision, and discharge of the fireworks or pyrotechnic devices permitted by their license classification.

a. "Pyrotechnic Operator - Unrestricted" may conduct and take charge of all activity in connection with the use of explosives or explosive materials, rockets, flame effects, Display Fireworks, binary system pyrotechnics, Consumer Fireworks, Theatrical Pyrotechnics, Novelties, and other special effects permitted by the Office of State Fire Marshal for a proximate audience display, commercial entertainment, or special effects in motion picture, theatrical, and television productions.

b. "Pyrotechnic Operator - Commercial Outdoor" may conduct and take charge of all activity in connection with the use of flame effects, Display Fireworks, binary system pyrotechnics, Consumer Fireworks, Theatrical Pyrotechnics, and Novelties permitted by the Office of State Fire Marshal for a proximate audience display and commercial entertainment.

c. "Pyrotechnic Operator - Rockets" may conduct and is restricted to all activities in connection with research, experiments, production, transportation, fuel loading, and launching of all types of experimental, solid fuel, and high power rockets. Only individuals or companies holding valid import, export, or wholesale licenses may import, export, or wholesale experimental high-powered motors.

d. "Pyrotechnic Operator - Motion Picture Special Effects" may conduct and take charge of all activity in connection with the use of explosives or explosive materials, flame effects, Display Fireworks, binary system pyrotechnics, Consumer Fireworks, Theatrical Pyrotechnics, and Novelties, and other special effects permitted by the Office of State Fire Marshal for the sole purpose of motion picture, television, theatrical or operatic productions.

e. "Pyrotechnic Operator - Commercial Indoor" may conduct and take charge of all activity in connection with the use of binary system pyrotechnics, Theatrical Pyrotechnics, and Novelties permitted by the Office of State Fire Marshal in stage or theatrical productions only.

f. "Pyrotechnic Operator - Trainee" must function under the direct supervision and control of a pyrotechnic operator for the license classification that he/she is seeking a license.

71-8305.5. Display Permits.

A. All Displays.

1. Any person who desires to hold a Public Fireworks Display or a Proximate Audience Display must obtain a permit from the Office of State Fire Marshal before the display.

2. Permits shall be valid for up to one calendar period prescribed or until any condition of the permit application changes. The State Fire Marshal shall make final determination of a change of condition in the permit.

3. All permit forms will be made available on the State Fire Marshal's Web site.

4. The State Fire Marshal may revoke, suspend, or deny a permit because of, but not limited to:

a. The display operator does not possess the correct license classification for the display; or
 b. Not complying with any order written by the State Fire Marshal; or
 c. Violating the terms of the permit or essential changes in the conditions under which the permit was issued without prior approval of the Office of State Fire Marshal; or

d. Giving false information or making a misrepresentation to obtain a permit.

5. The following additional information must be provided with the permit application:

a. A list of the number, type, and size of fireworks or effects being discharged;

b. A Diagram of display site including measurements;

c. Directions to the site; and

d. A Copy of certificate of insurance.

6. The Authority Having Jurisdiction providing fire suppression equipment and personnel for the Public Fireworks Display must sign the permit form.

7. Permits must be posted at the display site.

B. Public Fireworks Display Permits.

1. The sponsor of the display shall forward a copy of the permit to the Office of State Fire Marshal along with the items required in these regulations fifteen working days before the display. The permit becomes valid when co-signed by the State Fire Marshal.

2. The validated permit will be distributed as follows:

a. The Office of State Fire Marshal shall retain the original;

b. A copy to the sponsor;

c. A copy to the supplier, which will authorize shipment of the fireworks;

d. A copy to the Authority Having Jurisdiction providing the fire suppression equipment and personnel for the display;

e. A copy posted at the display site.

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3. All pyrotechnics shall be purchased from a pyrotechnic manufacturer or distributor licensed by the Board of Pyrotechnic Safety. A licensed Public Display Operator shall be present and supervise firing of all public fireworks displays.

4. The fireworks supplier shall carry a minimum of \$500,000 of Public Liability Insurance. The policy must list the display sponsor, the State of South Carolina, and its agents as additional insured. The coverage company must be an insurer which is either licensed by the Department of Insurance in this State or approved by the Department of Insurance as a nonadmitted surplus lines carrier for risks located in this State. In the event the liability insurance is canceled, suspended, or nonrenewed, the insurer shall give immediate notice to the Office of State Fire Marshal.

C. Proximate Audience Display Permits.

1. Public Liability Insurance in the amount of \$500,000 shall be provided by the permittee. The permittee shall furnish a certificate of insurance in this amount with their application. The permittee shall list the State of South Carolina and its agents as additional insured.

2. Public Liability Insurance in the amount of \$1,000,000 shall be provided by any permittee involved with motion picture productions. Motion picture companies employing this person(s) shall list the State of South Carolina and its agents as additional insured.

3. The coverage company must be an insurer which is either licensed by the Department of Insurance in this State or approved by the Department of Insurance as a nonadmitted surplus lines carrier for risks located in this State. In the event the liability insurance is canceled, suspended, or nonrenewed, the insurer shall give immediate notice to the Office of State Fire Marshal.

71-8305.6. General Operational Requirements of Displays.

A. All Displays.

1. The operator shall have their license in their possession when conducting a display and shall exhibit their license on request of any Authority Having Jurisdiction.

2. All displays must have a person in charge that holds the proper license issued by the Office of State Fire Marshal for the type of display being conducted.

3. The SFM or any approved authority having jurisdiction may enforce these laws and regulations.

4. Magazine log shall be available for inspection during normal work hours, 1 hour before, and 1 hour after each performance.

5. Operators must notify the Office of State Fire Marshal within 24 hours of any fires or thefts involving fireworks. The operators shall provide the Office of State Fire Marshal with a copy of the report filed with the police department or the incident report from the fire department. Operators must also provide the Office of State Fire Marshal with a copy of ATF Form 5400.5.

6. Any person who violates any provision of these laws and regulations will purchase the appropriate permit, pay the appropriate license fee, if any are required, and be subject to the following:

a. S.C. Code Ann. 23-36-170, 1976, as amended.

b. S.C. Code Ann. 23-35-150, 1976, as amended.

7. Confiscation, storage, or disposal of fireworks, pyrotechnic and explosive materials used for proximate audience or public firework displays by the SFM shall comply with S.C. Code Ann. 23-36-110, 1976, as amended.

8. Storage of special effects pyrotechnics and other material.

a. All classes of explosives shall be stored in accordance with the South Carolina Explosives Control Act or Title 27 Code of Federal Regulations, Subpart K.

b. All other fireworks or pyrotechnic materials shall be stored per the appropriate NFPA standard.

9. The AHJ may require the permittee to furnish fire support personnel other than local firefighters.

B. Public Fireworks Displays.

1. Where unusual conditions exist, the AHJ may increase the minimum clearances as necessary before granting approval of the display site. The AHJ may not reduce clearances specified in NFPA 1123 without written approval of the Office of State Fire Marshal.

2. A copy of the display permit shall be kept at the firing station.

3. Operators shall never use damaged fireworks, fireworks that are wet, or fireworks damaged by moisture. Operators shall not dry wet pyrotechnics for reuse. Operators shall handle and dispose of wet or damaged pyrotechnics per the manufacturer's instructions.

4. The operator of the display shall keep a record of all shells that fail to ignite or function. The form shall be completed and returned to the supplier within fifteen days of the display and the operator shall retain a copy for their records. The operator and supplier shall retain Malfunction Reports for three years from the date of the display. The operator and supplier must produce these reports upon request of the State Fire Marshal. The "Malfunction Report" form will be available on the State Fire Marshal's website.

5. Moorings or anchors shall secure floating vessels or platforms used for firing of a Public Fireworks Display.

6. Operators shall not reload mortars during a display.

7. If a display is postponed, the sponsor of the display shall notify the Office of State Fire Marshal and the department providing fire suppression equipment and personnel for the display of the alternate date before presenting the display.

8. It shall be the responsibility of the permittee to arrange with the AHJ for the detailing of firefighters and equipment as required.

C. Proximate Audience Display.

1. The licensed pyrotechnic operator is responsible for the storing, handling, supervision, discharge, and removal of all pyrotechnic devices and materials based on their license classification and the terms of their permit. The licensed pyrotechnic operator is responsible for supervising and training of their assistants in the safe handling and discharge of all pyrotechnic devices.

2. The permit package shall contain a copy of the permit, Certificate of Insurance, and the MSDS(s) for material used.

3. A copy of the permit package shall be kept at the control site used to initiate the display. An audible announcement shall be made not more than 10 minutes before the display to notify personnel of the use of proximate audience pyrotechnics.

4. Motion Picture productions shall display one permit package at the production office, and maintain the second permit package on the film site through the First Assistant Director. Before the start of any effect, verbal notification of Proximate Audience Pyrotechnic use shall be required before each camera roll.

5. The AHJ may inspect the proximate audience display. As a minimum, the inspection shall cover the requirements in Annex B of NFPA 1126.

6. The permittee shall furnish a fire watch during the times the special effects materials have been removed from storage and/or magazines and the conclusion of the performance. This person shall be identified by an orange shirt or vest (or other color approved by the AHJ) with three-inch white letters on the front and back stating FIRE WATCH. For motion picture productions, the method for identifying the FIRE WATCH shall be a mutually agreed means of designation between the State Fire Marshal, the permittee, and the First Assistant Director.

7. Indoor facilities used for Proximate Audience Displays must be equipped with an automatic fire alarm system and a public address system.

a. The fire alarm system shall be zoned so that the areas affected by special effects smoke can be overridden during the event.

b. An override switch shall be provided at the firing point and a second switch in the control room to shut off stage sound and make the public address system available for evacuation instructions. These switches must be labeled and visible throughout the show.

c. The fire alarm system must be returned to normal operation before the fire watch and the display operator may leave the facility.

71-8305.7. Use of Consumer Fireworks in South Carolina.

A. It shall be deemed a violation of these regulations to:

1. Explode or ignite fireworks within 600 ft. of any Assembly Occupancy, Educational Occupancy, Hazardous Occupancy, Institutional Occupancy, or any facility storing or dispensing flammable liquids, combustible liquids, LP Gas, or other hazardous materials;

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2. Explode or ignite fireworks within 75 ft. of where fireworks are stored, sold or offered for sale;
3. Ignite, discharge, and/or throw fireworks from any motor vehicle or to place, ignite, discharge, and/or throw fireworks into or at any motor vehicle; and
4. Ignite or discharge fireworks in a wanton or reckless manner to constitute a threat to the personal safety or property of another.

B. The distances in SCRR 71-8305.7 A (1) maybe reduced if the display is permitted with the Office of State Fire Marshal as a Public Fireworks Display or as a Proximate Audience Display.

C. Consumer Fireworks shall not be used for a Public Fireworks Display unless permitted by the Office of State Fire Marshal per the applicable provisions of this regulation and all permit fees are paid.

71-8305.8. Transportation of Fireworks or Pyrotechnics in South Carolina.

A. Vehicles transporting Display Fireworks (pyrotechnics classified as 1.3 explosives) in any quantity and Consumer Fireworks (pyrotechnics classified as 1.4 explosives) in quantities greater than 1000 lbs. shall be in the custody of drivers with a CDL with a HAZMAT endorsement.

B. On both sides, on the front, and on the rear, vehicles transporting Display Fireworks (pyrotechnics classified as 1.3 explosives) in any quantity and Consumer Fireworks (pyrotechnics classified as 1.4 explosives) in quantities greater than 1000 lbs. shall prominently display signs marked "EXPLOSIVES" that conform to the United States Department of Transportation and other federal regulations.

C. The fire and police departments shall be promptly notified when a vehicle transporting pyrotechnics is involved in an accident, break down, or fire. Only in the event of such an emergency shall the transfer of pyrotechnics from one vehicle to another be allowed on highways and then only when qualified supervision is provided.

D. Any vehicle used for the transportation of pyrotechnics covered by item A or B above shall have not less than one approved-type fire extinguisher with a minimum rating of 2A 10 B:C and shall be so located as to be readily available for use.

E. Operators must notify the Office of State Fire Marshal within 24 hours of any fires or thefts involving fireworks. The operator shall provide the Office of State Fire Marshal with a copy of the report filed with the police department or the incident report from the fire department. Operators must also provide the Office of State Fire Marshal with a copy of ATF Form 5400.5.

Fiscal Impact Statement:

There will be no additional cost incurred by the State or any political subdivision.

Statement of Rationale:

The guidelines Fireworks and Pyrotechnics are amended to conform to national guidelines and ensure public safety.

Document No. 3218
DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL
 CHAPTER 71

Statutory Authority: 1976 Code Section 40-82-70

71-8304. Liquefied Petroleum (LP) Gas

Synopsis:

The Office of State Fire Marshal is deleting and replacing SCRR 71-8304 regarding the Liquefied Petroleum (LP) Gas Board. The new SCRR 71-8304 will use a standardized format, simplify wording, remove obsolete language and clarify licensing and permitting requirements for LP Gas operators.

Instructions:

Delete SCRR 71-8304 (71-8304.1) regarding the Liquefied Petroleum (LP) Gas Board and replace with new 71-8304 (71-8304.1 through 71-8304.4) text as printed below.

Text:

SUBARTICLE 5
 LIQUEFIED PETROLEUM GAS

71-8304. Liquefied Petroleum (LP) Gas.

71-8304.1. General.

A. The purpose of this regulation is to provide reasonable protection of the health, welfare, and safety of the public and LP Gas operators from the hazards associated with the handling, use, transportation, and storage of Liquefied Petroleum Gas.

B. These regulations apply to:

1. LP Gas Dealers, Installers, Gas Plants, Wholesalers, Resellers, or Cylinder Exchange operators and;
2. Any person handling, dispensing, transporting, or storing LP Gas.

C. These regulations shall not apply to:

1. LP Gas pipeline transmission regulated by the SC Public Safety Commission.
2. Gas plants after the point where LP Gas or LP Gas and air mixture enters a utility distribution system.
3. Natural gas systems covered by the International Gas Code.

D. Definitions

1. "LP Gas" means Liquefied Petroleum Gas as defined in 40-82-20.

71-8304.2. Codes and Standards.

A. All references to NFPA standards found in these regulations refer to the editions adopted in SCRR 71-8300.2 and are modified by the following regulations as shown below.

71-8304.3. Licensing and Permitting Fees.

A. The Office of State Fire Marshal is responsible for all administrative activities of the licensing program. The State Fire Marshal shall employ and supervise personnel necessary to effectuate the provisions of this article and shall establish fees sufficient but not excessive to cover expenses, including direct and indirect costs to the State for the operation of this licensing program. Fees may be adjusted not more than once each two years, using the method set out in South Carolina Code 40-1-50(D).

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B. Fees shall be established for the following:

1. Application
2. Testing
3. Permitting
4. Licensing
5. Inspection
6. Renewal

C. All fees are due at time of application for licenses, testing, permits, inspection, or renewal.

D. All fees paid to the Office of State Fire Marshal are nonrefundable.

71-8304.4. Licensing Requirements.

A. Licenses

1. Each company shall possess a license issued by the Office of State Fire Marshal.

2. Licenses shall be displayed in a conspicuous location at the place of business for the LP Gas Dealer, Installer, Gas Plant, Wholesaler, Reseller, or Cylinder Exchange operator.

B. Permits

1. Each site shall have a designated person that has a permit issued by the Office of State Fire Marshal to supervise people handling, dispensing, installing, transporting, repairing, or exchanging LP Gas.

2. Any applicant who fails the written examination is allowed one (1) re-test after a minimum seven (7) day waiting period. Any applicant who fails the re-test shall wait at least thirty (30) days before reapplying.

3. Permits shall bear the name, photograph, and any other identifying information deemed necessary by the Office of State Fire Marshal.

4. Permit holders shall have their permit in their possession when supervising the handling, dispensing, installing, manufacturing, transporting, repairing, or exchanging LP Gas.

5. Permit holders shall exhibit their permits on request of any AHJ.

6. Each permit is valid for a period of two (2) years and must be renewed before it expires.

7. Permits are not transferable.

Fiscal Impact Statement:

There will be no additional cost incurred by the State or any political subdivision.

Statement of Rationale:

The guidelines for Liquefied Petroleum Gas are amended to conform to national guidelines and ensure public safety.

Document No. 3217
DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL
 CHAPTER 71

Statutory Authority: 1976 Code Sections 23-9-40 and 23-9-45

71-8303. Portable Fire Extinguishers and Fixed Fire Extinguishing Systems

Synopsis:

The Office of State Fire Marshal is deleting 71-8303 Service Stations and replacing it with 71-8303 Portable Fire Extinguishers and Fixed Fire Extinguishing Systems. The new SCRR 71-8303 will use a standardized format, simplify wording, remove obsolete language and requirements, and provides for the use of new technologies.

Instructions:

Delete current 71-8303 Service Stations (71-8303.1) in its entirety.

Replace with new 71-8303 Subarticle 4 Portable Fire Extinguishers and Fixed Fire Extinguishing Systems (71-8303.1 through 71-8303.18) as printed below.

Text:

SUBARTICLE 4
 PORTABLE FIRE EXTINGUISHERS AND FIXED FIRE EXTINGUISHING SYSTEMS

71-8303. Portable Fire Extinguishers and Fixed Fire Extinguishing Systems.

71-8303.1. General.

A. The purpose of this subarticle is to regulate the leasing, renting, reselling, servicing and testing of portable fire extinguishers and the installation, testing, and servicing of fixed fire extinguishing systems in the interest of protecting lives and property.

B. This regulation shall apply to:

1. The filling, charging, and recharging of all portable fire extinguishers other than the initial filling by the manufacturer.

2. The testing and servicing of all types of portable fire extinguishers.

3. The installation, testing, and servicing of all types of fixed fire extinguishing systems.

C. This regulation shall not apply to the following:

1. The filling or charging of a portable fire extinguisher by the manufacturer before the initial sale;

2. The installation or servicing of water-based extinguishing systems addressed by 40-10-240 et seq; and

3. Firms engaged in the retailing or wholesaling of new portable fire extinguishers.

D. Definitions

1. "Citation" means a summons to appear before the State Fire Marshal because of a violation of any part or all of this regulation and may carry a monetary fine of up to \$2,000 per violation.

2. "DOT" means U.S. Department of Transportation.

3. "Fixed Extinguishing System" means both an Engineered and Pre-Engineered fire extinguishing system.

4. "Firm" means any person, partnership, corporation, association, or governmental entity.

5. "Portable Fire Extinguisher" means a portable device containing extinguishing agent that can be expelled under pressure for the purpose of suppressing or extinguishing a fire.

6. "Servicing" includes maintenance, recharging, or hydrostatic testing of a Portable Fire Extinguisher or a Fixed Extinguishing System.

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71-8303.2. Codes and Standards.

A. All references to NFPA standards found in these regulations refer to the editions adopted in SCRR 71-8300.2 and are modified by the following regulations as shown below.

71-8303.3. Fees for Licensing, Testing, and Inspections.

A. The Office of State Fire Marshal is responsible for all administrative activities of the licensing program. The State Fire Marshal shall employ and supervise personnel necessary to effectuate the provisions of this article and shall establish fees sufficient but not excessive to cover expenses, including direct and indirect costs to the State for the operation of this licensing program. Fees may be adjusted not more than once each two years, using the method set out in South Carolina Code 40-1-50(D).

B. Fees shall be established for the following:

1. Application
2. Testing
3. Permitting
4. Licensing
5. Inspection
6. Renewal

C. All fees are due at time of application for licenses, testing, permits, inspection or renewal.

D. All fees paid to the Office of State Fire Marshal are nonrefundable.

71-8303.4. Licensing and Permitting Requirements.

A. General Licensing Requirements.

1. Each firm testing and servicing portable fire extinguishers; installing, testing, and servicing fixed fire extinguishing systems; or hydrostatic testing portable fire extinguishers or portions of fixed fire extinguishing systems must have a license issued by the Office of State Fire Marshal.

2. Each firm's license shall be displayed in a conspicuous location at their place of business.

3. Each firm shall apply in writing on a form available from the Office of State Fire Marshal, for the license classification the firm is seeking.

4. Each firm shall furnish a certificate of insurance with their application in the amount required for their license classification. The firm shall list the State of South Carolina and its agents as additional insured. The coverage company must be an insurer which is either licensed by the Department of Insurance in this State or approved by the Department of Insurance as a nonadmitted surplus lines carrier for risks located in this State. In the event the liability insurance is canceled, suspended, or not renewed, the insurer shall give immediate notice to the Office of State Fire Marshal.

5. Each firm shall possess the equipment required for the class of license sought. The State Fire Marshal shall inspect the firm's facilities to verify the firm has the minimum required equipment. The State Fire Marshal shall not license a firm until deficiencies discovered by inspection are corrected.

6. Licenses issued under this subarticle are not transferable.

7. All licenses expire when insurance coverage lapses or is cancelled and on the day of expiration shown on the license and shall be renewed biennially.

8. Expired licenses shall not be renewed. A new license shall be obtained by complying with all requirements and procedures for an original license.

B. General Permitting Requirements.

1. Each individual servicing, recharging, repairing, installing, or testing portable fire extinguishers or fixed fire extinguishing systems shall possess a valid permit issued by the Office of State Fire Marshal.

2. Each individual shall apply in writing on a form available from the Office of State Fire Marshal, for the permit classification they are seeking.

3. Applicants must provide two current 2" x 2" photographs with their application.

4. Applicants must be at least 18 years old.

5. Applicants shall pass a written examination administered by the Office of State Fire Marshal before a permit is issued. The exam will cover the applicable codes, state laws, and regulations and the additional requirements for the specific class of permit for which they are applying.

6. Any applicant who fails the written examination is allowed one (1) re-test after a minimum seven-day waiting period. Any applicant who fails the re-test shall wait at least six (6) months before reapplying.

7. Permit holder shall have their permit in their possession while working on equipment or systems covered by their permit.

8. Permit holders shall show their permits on the request of any authority having jurisdiction.

9. Permit holders shall be limited to specific type of work allowed by the class of permit they hold and the specific systems covered by their permit.

10. Permits issued under this subarticle are not transferable.

11. Permits shall expire on the day of expiration shown on the permit and shall be renewed biennially.

12. Expired permits shall not be renewed. A new permit shall be obtained by complying with all requirements and procedures for an original permit.

C. License and Permit Classifications.

1. Class "A" - may service, recharge, or repair, all types of portable fire extinguishers, including recharging carbon dioxide units; and to conduct hydrostatic tests on all types of fire extinguishers.

2. Class "B" - may service, recharge, or repair all types of portable fire extinguishers, including recharging carbon dioxide units and conducting hydrostatic tests on water, water chemical, and dry chemical types of extinguishers only.

3. Class "C" - may service, recharge, or repair all types of portable fire extinguishers, except recharging carbon dioxide units; and to conduct hydrostatic tests of water, water chemical, and dry chemical types of fire extinguishers only.

4. Class "D" - may service, recharge, repair, or install all types of fixed fire extinguishing systems.

5. Class "E" is an apprentice permit classification only. Permits in this classification may perform the services only under direct supervision of a person holding a valid permit and who works for the same firm as the apprentice. An apprentice permit is valid for one year from the day of issuance and may not be renewed.

D. Firms applying for a Class "A", "B", or "C" License must meet all of the general requirements for licensing and provide proof of public liability insurance for an amount not less than \$1,000,000.

E. Firms applying for a Class "D" License must:

1. Designate on their application for licensing each type of fixed fire-extinguishing system for which they want to be licensed;

2. Provide proof of public liability insurance for an amount not less than \$1,000,000; and

3. Provide proof of manufacturer's certification for each type of fixed fire extinguishing system shown on their application.

F. Individuals applying for a Class "A", "B", or "C" Permit must meet all of the general requirements.

G. Individuals applying for a Class "D" Permit must:

1. Designate on their application for licensing each type of fixed fire-extinguishing system for which they want to be permitted.

2. Demonstrate by a manufacturer's specific training certificate for each type of fixed fire extinguishing system for which permitting is sought.

3. Provide an affidavit to attest to the applicant's ability to obtain the proper manufacturer's installation, maintenance, and service manuals, and manufacturer's parts, and provide testament that all installations and service shall be performed in complete compliance with the manufacturer's installation, maintenance and service manuals.

H. Employees applying for a Class "E" Permit must file an application for a Class "E" Permit and provide two current 2" x 2" photographs.

71-8303.5. Renewal of Class "D" Licenses and Permits.

A. To qualify for biennial renewal of a Class D license, a firm must:

1. Apply in writing on a form available from the Office of State Fire Marshal, designating each type of fixed fire-extinguishing system for which they wish to be licensed to install, test, or service.

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2. Provide proof of public liability insurance.

3. Provide a current manufacturer's training certificate for each type fixed extinguishing system that renewal is sought.

4. Provide an affidavit to attest to the applicant's ability to obtain the proper manufacturer's installation, maintenance and service manuals and manufacturer's parts and provide testament that all installations and maintenance shall be performed in complete compliance with the manufacturer's installation, maintenance and service manuals.

B. To qualify for biennial renewal of a Class D permit, an individual must:

1. Apply in writing on a form available from the Office of State Fire Marshal, designating each type of fixed fire-extinguishing system for which they wish to be permitted to install, test, or service.

2. Provide an up to date manufacturers training certificate for each type pre engineered system that renewal is sought.

3. Provide an affidavit to attest to the applicant's ability to obtain the proper manufacturer's installation, maintenance and service manuals and manufacturer's parts and provide testament that all installations and maintenance shall be performed in complete compliance with the manufacturer's installation, maintenance and service manuals.

71-8303.6. Restrictions for Class D Fire Equipment Licenses and Permits.

A. A firm or person shall not willfully engage in the business of installing, testing or servicing Class D fire equipment or use in any advertisement or on a business card or letterhead, or make any other verbal or written communication that the person is a Class D Fire Equipment Dealer or acquiesce in such a representation, unless that person is licensed as a Class D Fire Equipment Dealer by the Office of State Fire Marshal.

B. No person shall install or service any type of Class D fire equipment not covered on their permit.

71-8303.7. Licensing Requirements: For Firms Performing Hydrostatic Testing.

A. Each firm performing hydrostatic testing of fire extinguishers manufactured according to the specifications of the United States Department of Transportation (DOT) shall be required to possess a valid license issued by the DOT. All hydrostatic testing of fire extinguishers shall be performed per the appropriate DOT standards and NFPA standards.

B. Each employee certified to conduct hydrostatic testing shall attend a DOT certification refresher course every three years and provide a copy of the current certification to the Office of State Fire Marshal upon completion.

71-8303.8. Installation and Maintenance Procedures.

A. All Portable Fire Extinguishers and Fixed Fire Extinguishing Systems covered by these regulations shall be installed, inspected, tested and serviced per the applicable NFPA standards and the manufacturer's installation, service and maintenance manuals.

B. Any portable fire extinguisher or fixed fire extinguishing system that cannot be maintained per the manufacturer's installation, service, and maintenance manuals or the applicable NFPA standards shall be removed from service and replaced.

71-8303.9. Minimum Equipment and Facility Requirements for Fire Equipment Dealer License.

The Office of State Fire Marshal
 Minimum Equipment and Facility Requirements for a Fire Equipment Dealer License

					Minimum Equipment and Facilities Required	YES	NO	N/A
1	A			D	Hydrostatic test equipment for high pressure testing and calibrated cylinder. (0-11,000 psi)			
2	A			D	Equipment for test dating high-pressure cylinders (over 900 psi). Die stamps must be a minimum of $\frac{1}{8}$ inches.			
3	A			D	Clock with sweep secondhand on or close to hydrostatic test apparatus.			
4	A	B		D	CO ₂ receiver--cascade system for proper filling of CO ₂ extinguishers.			
5	A	B		D	Supply of metallic labels for CO ₂ hose conductivity test. Labels attached to the hose must include month and year of testing, name or initials of person performing test, and name of agency performing test.			
6	A	B	C	D	Scales graduated in 1/8 ounce or 1 gram weight if refilling CO ₂ cartridges. Minimum of 20 lbs.			
7	A	B	C	D	All Scales calibrated within the last 12 months. Certification date(s) _____ Certified by _____			
8	A	B	C	D	Approved drying method for high and low pressure cylinders. Listed for its use.			
9	A	B	C	D	Proper wrenches with non-serrated jaws or valve puller (hydraulic or electric).			
10	A	B	C	D	Inspection light.			
11	A	B	C	D	Low-pressure test apparatus.			
12	A	B	C	D	Low-pressure hydrostatic test labels per NFPA 10.			
13	A	B	C	D	Scales for weighing extinguisher/system agent bottles during inspection and filling, minimum of 500 lbs. Calibrated and certified annually.			
14	A	B	C	D	Closed recovery system(s) and storage to remove and store chemicals from fire extinguishers or system cylinders during servicing.			
15	A	B	C	D	Closed recovery system(s) and storage to remove and store chemicals from halon type fire extinguishers or system cylinders during servicing.			
16	A	B	C		Current installation, maintenance and service manuals from the manufacturer of each make or brand of fire extinguisher or system the company installs, services, recharges, repairs, or maintains.			
17	A	B	C		Supply of extinguisher recharge agents for the type/brands of fire extinguishers the company requests to recharge or service.			
18	A	B	C	D	Vise 6-inch minimum (chain or bench).			
19	A	B	C	D	Facilities for proper storage of extinguishing agents.			
20	A	B	C	D	Facilities for leak testing of pressurized extinguishers.			
21	A	B	C	D	Nitrogen with regulator and indicator. Regulator not to exceed 1500 psi--minimum 500 psi.			
22	A	B	C	D	Supply of "Verification of Service" collars containing Month			

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					and Year the service was performed.			
23	A	B	C		Adapters, fittings, and tools and equipment for properly servicing and/or recharging all extinguishers being serviced and recharged.			
24	A	B	C	D	Safety cage (in shop) for hydrostatic testing of low-pressure cylinders.			
25	A	B	C	D	1/4 pound graduated scales minimum 150 pounds for weighing chemical recharging.			
26				D	Cable crimping tool (where required).			
27				D	Cocking lever (where required).			
28				D	Pipe vise, dies, reamer, etc.			
29				D	Stock and supply of fuse links, proper elbows, and nozzles for system which is being installed.			
30				D	Parts from each manufacturer's system that the permittee is permitted to work on or service, including original service manuals and all up to-date technical bulletins.			
31				D	Listed links from each manufacturer that the permittee is permitted to service or work on.			
32				D	Current service manuals from the manufacturer for each model of fixed fire extinguishing system being installed, tested, or serviced by the fire equipment license holder.			
33				D	System Reports – custom or generic.			
34				D	Non-compliance Tags for non compliant systems.			
35	A	B	C	D	Supply of tags with the appropriate company and other related information on them.			
36				D	Thermometer with a minimum of 2°F or 1°C increments.			
37				D	Agent Transfer Pump (for Halon or Clean Agents).			
38				D	Torque Wrench.			
39				D	Leak test device (for Halon or Clean Agents).			
40				D	Liquid Level detector ("Halon Scanner").			

71-8303.10. Powers and Duties of the State Fire Marshal.

A. Powers and duties of the State Fire Marshal are:

1. To evaluate the applications of firms or individuals for a license and permits to engage in the business of servicing portable fire extinguishers or installing, testing and servicing fixed fire-extinguishing systems;
2. To administer written examinations to ascertain the competency of applicants for a license to service portable fire extinguishers or install fixed fire extinguishing systems;
3. To issue licenses, permits, and apprentice permits required by this subarticle;
4. To suspend or revoke licenses and permits for cause; and
5. To administer these regulations and supervise personnel in carrying out the requirements of this regulation.

B. The State Fire Marshal, upon request, shall conduct hearings or proceedings concerning the suspension, revocation, or refusal to issue or renew licenses or permits issued under this subarticle or the application to suspend, revoke, refuse to renew, or refuse to issue the same.

C. An applicant, licensee, or permit holder whose license or permit has been refused or revoked under this subarticle, except for failure to pass a required written examination, shall not file another application for a license or permit within one year from the effective date of the refusal or revocation. After one year from that date, the applicant may re-apply, and in a public hearing, show good cause why the issuance of a license or permit does not hinder public safety and health.

D. The State Fire Marshal shall maintain a registry of all applications for licenses or permits and of all firms or persons holding licenses or permits. The State Fire Marshal shall make the roster of Fire Equipment Dealers Licenses or Fire Equipment Permits, with notation concerning the types of fixed fire extinguishing system for which licenses or permits have been granted, available on the State Fire Marshal's Web site.

E. At least ninety (90) days before the expiration of a license, the State Fire Marshal shall send written notice of the impending license or permit expiration to the license or permit holder's last known address. This subsection shall not be construed to prevent the denying or refusing to renew a license under applicable law or regulations of the State Fire Marshal.

71-8303.11. Fitness to practice; Investigation of Complaints.

A. If the State Fire Marshal has reason to believe that a person licensed under this chapter has become unfit to practice as a Fire Equipment Dealer or if a complaint is filed with the Office of State Fire Marshal alleging a violation of a provision of this chapter by a license or permit holder or if a complaint is filed with the State Fire Marshal alleging that an licensed person is fraudulently holding him or herself out as qualified to engage in business as a Fire Equipment Dealer, the State Fire Marshal shall initiate an investigation per the procedures of Chapter 40, Title 1.

71-8303.12. Administrative Sanctions.

A. If after an investigation it appears that the license or permit holder under this regulation has become unfit to practice or has violated these regulations, the State Fire Marshal shall file a Petition with the Administrative Law Judge Court stating the facts and the particular statutes and regulations at issue.

B. The Administrative Law Judge Court may, after opportunity for hearing, order that the license or permit be revoked, suspended, or otherwise disciplined on the grounds that the license or permit holder:

1. Used a false, fraudulent, or forged statement or document in obtaining a license or permit under this chapter; or
2. Committed a fraudulent, deceitful, or dishonest act or omitted a material fact in obtaining a license or permit under this chapter; or
3. Has had an authorization to practice a regulated profession or occupation in another state or jurisdiction canceled, revoked or suspended, or has otherwise been disciplined by another jurisdiction; or
4. Has intentionally used a fraudulent statement in a document connected with the license or permit or;
5. Obtained fees or assisted in obtaining fees under fraudulent circumstances; or
6. Sustained a physical or mental disability or uses alcohol or drugs to such a degree as to render further practice as a Fire Equipment Dealer dangerous to the public; or
7. Failed to perform all installation, service, and testing in complete compliance with the manufacturer's manuals.

71-8303.13. Sanctions for Unlawful Practice.

A. The Administrative Law Judge Court may, after opportunity for hearing, order injunctive relief against a person who, without possessing a valid license or permit under this chapter, practices or offers to practice or uses the title or term Fire Equipment Dealer. For each violation, the administrative law judge may impose a fine of no more than ten thousand (\$10,000) dollars.

B. A person who does not hold a license or permit as required by this Chapter, may not bring any action either at law or in equity to enforce the provisions of any contract for providing services as a Fire Equipment Dealer.

71-8303.14. Certain Acts Prohibited.

A. No person or firm shall:

1. Engage in the business of installing or servicing portable fire extinguishers without a valid and current license;

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2. Engage in the business of installing or servicing fixed fire-extinguishing systems without a valid and current license;
3. Service, test, or install fixed fire-extinguishing systems without a valid and current license;
4. Perform hydrostatic testing of DOT cylinders for portable fire extinguishers or parts of a fixed fire extinguishing systems without a valid and current hydrostatic license;
5. Obtain or attempt to obtain a license or permit by fraudulent representation;
6. Service portable fire extinguishers or test, service, or install fixed fire-extinguishing systems contrary to the provisions of these regulations;
7. Service or hydrostatic test a fire extinguisher that does not have the proper identifying labels;
8. Sell, offer for sale, or give any make, type, or model of new or used fire extinguisher, unless extinguisher has first been tested and is currently approved or listed by Underwriters' Laboratories, Inc., Factory Mutual Laboratories, Inc., or other nationally recognized testing laboratory whose testing procedures used for approval in the listing of portable fire extinguishers are acceptable to the State Fire Marshal, and unless such extinguisher carries an Underwriters' Laboratories, Inc., or manufacturer's serial number. The serial number shall be permanently stamped on the manufacturer's identification and instruction plate;
9. Permit an individual who works for the firm to engage in installation, repair, recharge, maintenance or servicing fire extinguishers or fixed fire extinguishing systems without a valid permit or license.

71-8303.15. Cease and Desist Orders; Notice to Correct Hazardous Conditions.

When the State Fire Marshal shall have reason to believe that any person is or has been violating any provisions of this regulation or any rules or regulations adopted and promulgated pursuant thereto, he or his designated agent may issue and deliver to such person an order to cease and desist such violation or to correct such hazardous condition.

71-8303.16. Suspension or Revocation of License or Permit.

A. The license of any company or individual may be suspended or revoked because of failure to comply with the terms of any order to correct violations within the specified abatement period or for failure to comply with any cease and desist orders. A license may be suspended for a period not to exceed one year from the date of license suspension. A license may be revoked for a period not to exceed two years from the date of license revocation.

B. In addition, a license may be suspended or revoked where the license or permit holder is found to have:

1. Rendered inoperative a fire extinguisher or fixed system, which is required by any rule of the State Fire Marshal, except during such time as the extinguisher, or fixed system is being inspected, serviced, or tested;
2. Falsified any records required to be maintained by this chapter or rules adopted thereto;
3. Improperly serviced, tested, or inspected a fire extinguisher or fixed fire extinguishing system;
4. Allowed another person to use his permit or license number or use a license or permit number other than the license or permit holder's valid license or permit number; or
5. Obliterated the serial number on a fire extinguisher for purposes of falsifying service records.

71-8303.17. Responsibility of Equipment Manufacturer.

All manufacturers of portable fire extinguishers and fixed fire extinguishing systems doing business in South Carolina shall provide the State Fire Marshal with all technical information as well as installation instructions that apply to their systems and equipment sold, installed, serviced or tested in South Carolina. This technical information shall include design revisions and updating information on systems sold in South Carolina.

71-8303.18. Penalties.

The State Fire Marshal authorizes any Deputy State Fire Marshal to issue a citation for each offense to any person, firm, or corporation licensed under these regulations who has violated any provision of this subarticle. The State Fire Marshal may assess fines for each charge to both the fire equipment company and the permit holder. Citations shall be assessed by the State Fire Marshal at not more than two thousand (\$2000.00) per violation.

Fiscal Impact Statement:

There will be no additional cost incurred by the State or any political subdivision.

Statement of Rationale:

The guidelines for Portable Fire Extinguishers and Fixed Fire Extinguishing Systems are amended to conform with national guidelines in order to ensure public safety.

Document No. 4053

COMMISSIONERS OF PILOTAGE

CHAPTER 136

Statutory Authority: 1976 Code Sections 40-1-70 and 54-15-140

136-080. Enforcement of Pilot Statutes and Maritime Homeland Security

Synopsis:

The Commissioners of Pilotage is adding Regulation 136-080 to ensure that every vessel subject to maritime pilotage receives a pilot on board, as charged under Section 54-15-110 and 54-15-280 of the 1976 S.C. Code, as amended, as well as Part 136-070C. No person, other than a duly licensed pilot, is permitted to conduct and pilot any vessel over the bar, into and out of any South Carolina harbor. Part 136-070C of the S.C. Code of Regulations requires that a licensed pilot shall consider any circumstance wherein a master or operator of any seagoing vessel refuses to take a pilot as a "hazardous condition" and must immediately be reported to the Coast Guard. Under Section 40-1-200 of the 1976 S.C. Code, as amended, a person acting as a pilot without licensure constitutes a Class C misdemeanor as defined in Section 16-1-100. In order to establish a process to ensure compliance with these statutes and regulations, a new Part 136-080 is added to the S.C. Code of Regulations. In addition, this regulation addresses the present role of pilots on the front line of the effort to achieve maritime homeland security.

The Drafting Notice was published in the South Carolina *State Register* on December 26, 2008.

Instructions:

Add regulation 136-080 as printed below.

Text:

136-080. Enforcement of Pilot Statutes and Maritime Homeland Security.

A. Every pilot, or operator of any pilot vessel regulated pursuant to 1976 Code 54-15-170, who detects any apparent violation of 1976 Code Sections 54-15-270 and 54-15-280, and 1976 Code Section 40-1-200, wherein an unlicensed person is acting as a pilot, said pilot shall immediately report such circumstances to the sheriff of the county having jurisdiction, and/or to such other law enforcement authority designation by the Commissioners. The reporting pilot or pilot vessel operator shall thereupon identify the vessel by name, type,

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ownership, flag, homeport, and, if known or suspected, the vessel's apparent destination within the affected port, its present location and apparent speed, and any other particulars of interest. The pilot or pilot vessel operator shall provide any sheriff, or deputy sheriff, or other duly authorized law enforcement officer of the State with full details involving any attempts to inform such a vessel of the requirements of Title 54, Chapter 15, and/or 46 CFR 15. Further, the reporting pilot and/or any other licensed pilot or pilot vessel operator may assist the appropriate law enforcement agency in lawfully causing the vessel in violation to comply with State law. Such assistance might include the use of any pilot vessel that is under the command of a State-licensed pilot.

B. Notwithstanding the requirement of Part 136-070C to immediately report such violations of pilotage statutes as "hazardous conditions" to the U.S. Coast Guard, the pilot shall also initiate a voice SECURITE' call on VHF Channels 13 and 16. When and if such a vessel is indicating it is a U.S. flagged vessel, such message shall advise all marine traffic that a vessel requiring a pilot is underway on the bar and/or harbor may be in violation of federal laws and regulations with respect to manning.

C. The Commissioners consider this enforcement role of pilots, and by the pilot vessels under their command, as being in the interest of the safety and security of the port(s) at which the pilots are licensed. Pilots and pilot vessels constitute a major surveillance asset for achieving maritime domain awareness in order to protect the port, its population, its waterways and structures, and its marine environment from the consequences of a maritime disaster, accidental or deliberate, and other like illegal activities. Pilots and pilot vessel operators shall immediately report suspicious activities and events or other actions detected upon the bar and harbor that they may consider illegal to the sheriff and/or other law enforcement official designated by the Commissioners.

D. Pilots and pilot vessels are part of Division II of the S.C. Naval Militia pursuant to 1976 S.C. Code Section 54-17-50 and S.C. Regulation 80-010(5)(b). As such they shall immediately report to the Coast Guard any and all circumstances observed that are deemed to be of a suspicious nature and that might threaten the maritime security of the port and state. Pilot vessels are considered to be law enforcement vessels of the State of South Carolina.

E. The Commissioners authorize such pilot vessels, addressed in 1976 Code 54-15-170 and S.C. Regulation 136-040, to be employed in support of maritime homeland security missions in any Maritime Security (MARSEC) condition. Unless operational control is assumed by the U.S. Coast Guard, the use of these assets shall be controlled by the respective pilots in command of such vessels, and may include, but not be limited to, transportation for law enforcement boarding terms, surveillance and detection, surveys, logistics and other maritime domain awareness purposes.

Fiscal Impact Statement:

There will be no increased costs to the State or its political subdivisions.

Statement of Rationale:

Regulation 136-080 is added to ensure that every vessel subject to maritime pilotage receives a pilot on board.