

E-1

ARIZONA BOARD OF PSYCHOLOGIST EXAMINERS (R-16-1001)

Title 4, Chapter 26, Article 1, General Provisions; Article 2, Licensure; Article 3, Regulation

Amend: R4-26-101; R4-26-108; R4-26-203.03; R4-26-205; R4-26-206;
R4-26-207; R4-26-210; R4-26-304; R4-26-310

New Section: R4-26-109; R4-26-110; R4-26-111; R4-26-203.04



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: E-1

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: Chris Kleminich, Staff Attorney

DATE: September 16, 2016

SUBJECT: ARIZONA BOARD OF PSYCHOLOGIST EXAMINERS (R-16-1001)
Title 4, Chapter 26, Article 1, General Provisions; Article 2, Licensure; Article 3, Regulation

Amend: R4-26-101; R4-26-108; R4-26-203.03; R4-26-205; R4-26-206;
R4-26-207; R4-26-208; R4-26-210; R4-26-304; R4-26-310

New Section: R4-26-109; R4-26-110; R4-26-111; R4-26-203.04

The purpose of the Arizona Board of Psychologist Examiners (Board) is to "regulate the practice of psychology for the public health, safety, and welfare." Laws 2010, Ch. 7, § 3. This rulemaking seeks to amend ten rules and create four new rules.

Proposed Action

The Board is engaging in this rulemaking to comply with statutory changes related to telepractice, temporary licensure, and license renewal, and to make clarifying changes to the rules.

A.R.S. § 32-2063(A)(12), enacted in 2014, requires the Board to make rules regarding telepractice on or before June 30, 2016. Telepractice is defined in A.R.S. § 32-2061(14) as the provision of "psychological services through interactive audio, video or electronic communication that occurs between the psychologist and the patient or client, including any electronic communication for diagnostic, treatment or consultation purposes in a secure platform, and that meets the requirements of telemedicine pursuant to section 36-3602. Telepractice includes supervision."

Provisions in A.R.S. § 32-2073, related to the issuance of temporary licenses, were also enacted in 2014.

The following is a non-exhaustive summary of the Board's proposed actions:

- Section 101: Definitions are being amended in accordance with rule modifications.
- Section 108: Consistent with the enactment of Section 203.04, related to the establishment of temporary licenses, the Board is setting a \$200 fee for temporary license applications, and a \$500 fee for the issuance of temporary licenses.
- Section 109: This new section establishes general provisions regarding telepractice.
- Section 110: This new section relates to the provision of psychological service via telepractice.
- Section 111: This new section relates to the provision of supervision via telepractice.
- Section 203.03: Four new categories are being added to the list of individuals who must apply anew for a license rather than reapplying.
- Section 203.04: This new section establishes the process for issuance of temporary licenses.
- Section 205: In accordance with changes to A.R.S. § 32-2074 that take effect on May 1, 2017, the license renewal process will be changed as of that date. Instead of expiring on April 30 of every odd-numbered year, licenses issued by the Board will now expire on the last day of a licensee's birth month during the licensee's renewal year.
- Section 206: The process of reinstatement from inactive to active status is being amended in accordance with the changes to the renewal process in Section 205.
- Section 207: Continuing education requirements are being modified. No additional continuing education hours are being required.
- Section 208: Two typographical errors are being corrected.
- Section 210: Under Section 209(A), applicants for licensure are required to obtain 3,000 hours of supervised professional experience. Subsection (C), which notes that at least 40 percent of an applicant's supervised postdoctoral experience must involve direct client or patient contact, is being expanded to note that while additional direct contact hours may be obtained to meet this requirement, the Board may not count more than 1,500 hours of total postdoctoral experience for the purpose of licensure.
- Section 304: A technical correction is being made.
- Section 310: Verbiage on practice monitoring is being added to existing provisions related to disciplinary supervision.

Exemption or Request and Approval for Exception from the Moratorium

The Board received an exception from the moratorium on June 1, 2015.

Substantive or Procedural Concerns

None.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

Yes. The Board cites to A.R.S. §§ 32-2063(A)(9) and (12) as general authority for the rules. Under A.R.S. § 32-2063(A)(9), the Board must "[a]dopt rules pursuant to [T]itle 41,

[C]hapter 6 to carry out this chapter [Title 32, Chapter 19.1, Psychologists] and to define unprofessional conduct.” Statutes providing specific authority for the rules are listed in the preamble.

2. Are the rules written in a manner that is clear, concise, and understandable to the general public?

Yes. The rules are generally clear, concise, and understandable.

3. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Yes. The Board indicates that one written comment was received from the ERISA Industry Committee (ERIC), which made general recommendations regarding the regulation of telehealth and did not specifically address the proposed rulemaking.

4. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. Only non-substantive technical and clarifying changes were made between the proposed and final rules. Staff does not believe that the final rules, when considered as a whole, are a substantial change from the proposed rules.

5. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely on in the agency’s evaluation of or justification for the rules?

No. The Board indicates that it did not review or rely on a study in its evaluation of or justification for any rule in this rulemaking.

6. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority that allows the agency to exceed the requirements of federal law?

No. The Board indicates that no federal laws are directly applicable to the subject matter of these rules, and the rules are not more stringent than federal law.

7. Do the rules require a permit or license and if so, does the agency use a general permit or is any exception applicable under A.R.S. § 41-1037?

Yes. The Board believes that the temporary licenses addressed in Section 203.04 and the biennial license renewals addressed in Section 205 are general permits consistent with A.R.S. § 41-1037, as they are issued to qualified individuals to conduct activities that are substantially similar in nature.

8. Do the rules establish a new fee or contain a fee increase?

Yes, as noted above, consistent with the enactment of Section 203.04, related to the establishment of temporary licenses, Section 108 sets a \$200 fee for temporary license applications, and a \$500 fee for the issuance of temporary licenses.

9. Conclusion

The Board requests an immediate effective date for the rules. This analyst recommends approval of the rules.



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: E-1

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: GRRC Economic Team

DATE: September 16, 2016

SUBJECT: ARIZONA BOARD OF PSYCHOLOGIST EXAMINERS (R-16-1001)
Title 4, Chapter 26, Article 1, General Provisions; Article 2, Licensure; Article 3, Regulation

Amend: R4-26-101; R4-26-108; R4-26-203.03; R4-26-205; R4-26-206;
R4-26-207; R4-26-208; R4-26-210; R4-26-304; R4-26-310

New Section: R4-26-109; R4-26-110; R4-26-111; R4-26-203.04

I have reviewed the economic, small business, and consumer impact statement (EIS) and make the following comments. These comments are made to assist the Council in its review and may be used as the Council determines.

GRRC Economist comments:

In this rulemaking, the Board is aligning its rules with statutory changes from 2014. These statutory changes permit telepractice, temporary licenses, and an alteration to the current licensing renewal schedule. Psychologist licenses will now be renewed every other year instead of every year, and these licenses will be renewed throughout the year instead of in a single month.

In August of 2016, there were 1,729 active psychologist licensees in Arizona. In FY 2016, an additional 162 individuals applied for psychologist licensure from the Board. The Board anticipates that fewer than 12 individuals will apply for a temporary license each year.

1. **Costs and Benefits for:**

a. The implementing agency:

The Board is the only agency that will be directly affected by this rulemaking. It will not require any additional employees to implement the new rules. The Board will greatly benefit

from the rolling license renewal schedule because it currently takes the Board staff roughly six months to process all license renewals. Instead of taxing the Board's resources in April of each odd numbered year, the Board will spread the same quantity of renewals over the course of 24 months.

b. Political subdivisions:

The Board indicates that this rulemaking will not directly affect political subdivisions.

c. Businesses:

Psychologists and businesses that employ psychologists will be directly impacted by the rulemaking. These rules will directly affect businesses by decreasing the amount of time required by the Board to process a license renewal. Any other impacts to businesses are derived from changes to the statutes.

d. Small businesses:

Small psychologist practices will be impacted in the same manner as all businesses listed above.

e. Consumers directly affected by the rulemaking:

These rules do not directly affect consumers. Rule clarifications regarding telepractice could indirectly benefit patients in rural areas where psychologist services are not readily available.

2. Do the probable benefits outweigh the probable costs?

Most of the economic impacts are derived from statutory changes instead of changes in the rules. The exception is the changing of the license renewal schedule. This rule change will benefit the Board and businesses, and the costs of this rule change will be minimal.

3. Analysis of methods to reduce the small business impact:

The Board indicates that it is not feasible to reduce the impact on small businesses since all psychologists could be considered small businesses. Any costs to small businesses associated with the rulemaking are minimal or nonexistent.

4. The probable effect on state revenues:

The Board indicates that the fees generated from temporary licenses will have a minimal positive impact on Arizona's general fund. Additionally, renewal fees will be deposited into the general fund throughout the year instead of once every other year. The Board notes that this change will not impact the total amount of fees; it will only alter the deposit schedule.

5. **Analysis of any less intrusive or less costly alternative methods:**

The Board notes that these rules are the least intrusive and least costly method of achieving the regulatory goal. The Board did not consider any alternatives.

6. **Whether an analysis was submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states:**

No analysis was submitted that compares the rule's impact of the competitiveness of businesses in this state to the impact on businesses in other states.

7. **A description of any data on which a rule is based with an explanation of how the data was obtained and why the data is acceptable data, and the methods used by the agency to evaluate the costs and benefits in the EIS.**

No empirical or quantitative data were submitted for use in the EIS.

8. **Conclusion:**

The submitted economic, small business and consumer impact statement is generally accurate, and contains the information required for compliance with A.R.S. §§ 41-1035, 41-1052(D)(1-3), and 41-1055. This analyst recommends that the proposed rule amendments be approved.

Board Members

Frederick S. Wechsler, Ph.D., Psy.D., ABPP
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Board of Psychologist Examiners**

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Administrative Assistant

August 16, 2016



Ms. Nicole A. Ong, Chair
The Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 402
Phoenix, AZ 85007

**Re: A.A.C. Title 4. Professions and Occupations
Chapter 26. Board of Psychologist Examiners**

Dear Ms. Ong:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

- A. Close of record date: The rulemaking record was closed on July 29, 2016, following a period for public comment and an oral proceeding. This rule package is being submitted within the 120 days provided by A.R.S. § 41-1024(B).
- B. Relation of the rulemaking to a five-year-review report: The rulemaking relates, in part, to a five-year-review report approved by Council on November 4, 2014.
- C. New fee: As specifically authorized under A.R.S. § 32-2067, the Board establishes a new application fee for the new temporary license issued under A.R.S. § 32-2073 and includes the temporary license in the fee specifically authorized for issuance of an initial license. Both of these fees are exempt from the Arizona Administrative Procedure Act under A.R.S. § 41-1005(A)(15).
- D. Fee increase: The rulemaking does not increase an existing fee.
- E. Immediate effective date: An immediate effective date is respectfully requested under A.R.S. § 41-1032(A)(3).

A.R.S. § 32-2063(A)(12) amended the Board's governing statutes by instructing the Board to make rules regarding telepractice on or before June 30, 2016. An immediate



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effective date is needed to enable the Board to have the required rules in effect as soon as possible. Failure to comply with the June 30, 2016 deadline was not due to Board delay or inaction.

The Board received an exemption from EO2015-01 on June 1, 2015. The Board immediately began working with the State Procurement Office to obtain the services of a rule writer. Because the amount appropriated for rule-writing services exceeded the signature authority of the Board's executive director, SPO handled the procurement process. The SPO process failed to produce a rule writer the Board believed would meet its needs. The Board worked with SPO to amend the process and succeeded in obtaining the services of a rule writer in November 2015. The rule writer's first invoice entry for this rulemaking was made on November 17, 2015. The procurement process caused a five-month delay in the Board's ability to comply with A.R.S. § 32-2063(A)(12). The Board has made timely progress on this rulemaking since obtaining the services of a rule writer.

- F. Certification regarding studies: I certify that the preamble accurately discloses that the Board did not review or rely on a study in its evaluation of or justification for any rule in this rulemaking.
- G. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that none of the rules in this rulemaking will require a state agency to employ a new full-time employee. No notification was provided to JLBC.
- H. List of documents enclosed:
1. Cover letter signed by the Executive Director;
 2. Notice of Final Rulemaking including the preamble, table of contents, and rule text;
 3. Economic, Small Business, and Consumer Impact Statement;
 4. Public comment.

Sincerely,



Cindy Olvey, Psy.D.
Executive Director

NOTICE OF FINAL RULEMAKING
TITLE 4. PROFESSIONS AND OCCUPATIONS
CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS

PREAMBLE

1. Articles, Parts, and Sections Affected

Rulemaking Action

R4-26-101	Amend
R4-26-108	Amend
R4-26-109	New Section
R4-26-110	New Section
R4-26-111	New Section
R4-26-203.03	Amend
R4-26-203.04	New Section
R4-26-205	Amend
R4-26-206	Amend
R4-26-207	Amend
R4-26-208	Amend
R4-26-210	Amend
R4-26-304	Amend
R4-26-310	Amend

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. §§ 32-2063(A)(9) and (12)

Implementing statute: A.R.S. §§ 32-2061(14), 32-2071(F)(6) and (G)(5), 32-2073, and 32-2074
(version 2)

3. The effective date for the rules:

The Board respectfully requests an immediate effective date under A.R.S. § 41-1032(A)(3).

a. If the agency selected a date earlier than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

A.R.S. § 41-1032(A)(3) authorizes an immediate effective date if needed to comply with a deadline in an amendment to the Board's governing statutes and the need for an immediate effective date was not created by Board delay or inaction.

A.R.S. § 32-2063(A)(12) instructed the Board to make rules regarding telepractice on or before June 30, 2016. An immediate effective date is needed to enable the Board to have the required rules in effect as soon as possible. Failure to comply with the June 30, 2016 deadline was not due to Board delay or inaction.

The Board received an exemption from EO2015-01 on June 1, 2015. The Board immediately began working with the State Procurement Office to obtain the services of a rule writer. Because the amount appropriated for rule-writing services exceeded the signature authority of the Board's executive director, SPO handled the procurement process. The SPO process failed to produce a rule writer the Board believed would meet its needs. The Board worked with SPO to amend the process and succeeded in obtaining the services of a rule writer in November 2015. The rule writer's first invoice entry for this rulemaking was made on November 17, 2015. The procurement process caused a five-month delay in the Board's ability to comply with A.R.S. § 32-2063(A)(12). The Board has made timely progress on this rulemaking since obtaining the services of a rule writer.

b. If the agency selected a date later than the 60-day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

4. Citation to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 22 A.A.R. 1109, May 13, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 1591, June 17, 2016

5. The agency's contact person who can answer questions about the rulemaking:

Name: Dr. Cindy Olvey, Executive Director

Address: Board of Psychologist Examiners

1400 W. Washington, Suite 240

Phoenix, AZ 85007

Telephone: (602) 542-8162

Fax: (602) 542-8279

E-mail: Cindy.Olvey@psychboard.az.gov

Web site: <https://psychboard.az.gov>

6. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered, to include an explanation about the rulemaking:

In 2014, the legislature made several important changes to the Board's statutes (See Laws 2014, Chapter 258). The changes include allowing psychological services and supervision to be provided by telepractice, establishing a temporary license, and amending the biennial license renewal so half of all licenses are renewed each year rather than all in one year and so licenses are renewed throughout a year rather than all during one month. Conforming changes are made to rules dealing with definitions and fees.

The Board amended R4-26-203.03 to further clarify who may reapply for licensure and who must apply anew; R4-26-206 to align provisions regarding reinstatement from inactive to active status with the change to biennial renewal; and R4-26-310 to clarify disciplinary supervision and practice monitoring.

In a rulemaking that went into effect on January 30, 2016, the Board amended many of its rules to make changes identified as needed in a five-year-review report, make the rules consistent with Board practice, and make the language clear, concise, and understandable. In this rulemaking, the Board furthers amends some of the rules to correct minor errors.

An exemption from Executive Order 2015-01 was provided for this rulemaking by Ted Vogt, Chief of Operations in the Governor's office, in an e-mail dated June 1, 2015.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Board did not review or rely on a study in its evaluation of or justification for any rule in this rulemaking.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business, and consumer impact:

Being able to provide psychological services and supervision by telepractice and able to obtain a temporary license will have economic impact for those who are in position to take advantage of the new statutory provisions. However, the economic benefit results from legislative action rather than from these rules. The rules establish minimal requirements for working by telepractice and clarify some of the statutory requirements for obtaining a temporary license.

10. A description of any changes between the proposed rulemaking, including supplemental notices, and the final rulemaking:

To clarify the terms “supervision” and “practice monitor,” as used in R4-26-310, definitions were added to R4-26-101.

In R4-26-205(H)(2), the fee listed as “no change” in the proposed rulemaking was for delinquent compliance with the continuing education requirement. This is incorrect. The correct fee is for reinstatement of an active or inactive license. Both of these fees are for the same amount (\$200) so relabeling the fee correctly is not a substantial change.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to comments:

No one attended an oral proceeding regarding the rules on July 26, 2016. A written comment was received from ERIC—the ERISA Industry Committee. ERIC is a national association that advocates for the employee benefit and compensation interests of large employers. The comment did not specifically address the proposed rulemaking. Rather, it made general recommendations regarding regulation of telehealth.

12. All agencies shall list any other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

None

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The new temporary license in R4-26-203.02 and the biennial license renewal in R4-26-205 are general permits consistent with A.R.S. § 41-1037 because they are issued to qualified individuals to conduct activities that are substantially similar in nature.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

There are numerous federal laws that apply to health care practitioners such as psychologists. These include the Affordable Care Act, Medicare and Medicaid, and HIPAA. However, none of these laws is directly applicable to the subject matter of these rules and the rules are not more stringent than federal law.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

14. Whether the rule was previously made, amended, or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

No rule in the rule package was previously made, amended, or repealed as an emergency rule.

15. The full text of the rules follows:

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS

ARTICLE 1. GENERAL PROVISIONS

Section

- R4-26-101. Definitions
- R4-26-108. Fees and Charges
- R4-26-109. ~~Repealed~~ General Provisions Regarding Telepractice
- R4-26-110. ~~Repealed~~ Providing Psychological Service by Telepractice
- R4-26-111. ~~Reserved~~ Providing Supervision through Telepractice

ARTICLE 2. LICENSURE

- R4-26-203.03. Reapplication for License; Applying Anew
- R4-26-203.04. Temporary License under A.R.S. § 32-2073(B)
- R4-26-205. Renewal of License
- R4-26-206. Reinstatement of License from Inactive to Active Status; Cancellation of License
- R4-26-207. Continuing Education
- R4-26-208. Time Frames for Processing Applications
- R4-26-210. Supervised Professional Experience

ARTICLE 3. REGULATION

- R4-26-304. Representation before the Board by Attorney Not Admitted to State Bar of Arizona
- R4-26-310. Disciplinary Supervision; Practice Monitor

ARTICLE 1. GENERAL PROVISIONS

R4-26-101. Definitions

A. The definitions in A.R.S. § 32-2061 apply to this Chapter.

B. Additionally, in this Chapter:

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change
9. No change
10. No change
11. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - i. No change
 - ii. No change
 - iii. No change
 - iv. No change
 - v. No change
 - vi. No change
 - vii. No change
12. No change
13. No change
14. No change
15. No change
16. No change
17. No change

- a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
18. No change
19. No change
20. No change
21. No change
22. “License period” means:
- a. For a licensee who holds an odd-numbered license, the two years between ~~May 1~~ the first day of the month after the licensee’s birth month of one odd-numbered year and ~~April 30~~ the last day of the licensee’s birth month of the next odd-numbered year- ; and
 - b. For a licensee who holds an even-numbered license, the two years between the first day of the month after the licensee’s birth month of one even-numbered year and the last day of the licensee’s birth month of the next even-numbered year.
23. No change
24. No change
25. “Practice monitor,” as used in R4-26-310, means a Board-approved licensed psychologist who monitors or oversees the remediation of the practice of another psychologist as part of a disciplinary process.
- ~~25;26.~~ No change
- ~~26;27.~~ No change
- ~~27;28.~~ No change
- ~~28;29.~~ No change
- ~~29;30.~~ No change
31. “Renewal year” means:
- a. Each odd-numbered year for a licensee who holds an odd-numbered license, and
 - b. Each even-numbered year for a licensee who holds an even-numbered license.
- ~~30;32.~~ No change
- ~~31;33.~~ No change
- ~~32;34.~~ No change
- ~~33;35.~~ No change

36. “Supervision,” as used in R4-26-310, means review and oversight of the professional work of a psychologist by a Board-approved licensed psychologist as part of a disciplinary process.

~~34.~~37. No change

~~35.~~38. No change

a. No change

b. No change

c. No change

~~36.~~39. No change

R4-26-108. Fees and Charges

A. As specifically authorized by A.R.S. § 32-2067(A), the Board establishes and shall collect the following fees:

1. Application for an active license to practice psychology: \$350;

2. Application for a temporary license under A.R.S. § 32-2073(B): \$200

~~2.~~3. Reapplication for an active license: \$200;

~~3.~~4. Initial Issuance of an initial active or temporary license (prorated, as applicable): \$ 500;

~~4.~~5. Duplicate license: \$25;

~~5.~~6. Biennial renewal of an active license: \$ 500;

~~6.~~7. Biennial renewal of an inactive license: \$ 85;

~~7.~~8. Reinstatement of an active or inactive license: \$200; and

~~8.~~9. Delinquent compliance with continuing education requirements: \$200.

B. No change

1. No change

2. No change

3. No change

4. No change

5. No change

6. No change

7. No change

8. No change

C. No change

R4-26-109. Repealed General Provisions Regarding Telepractice

- A. Except as otherwise provided by law, a licensee who provides psychological service or supervision by telepractice to a client or patient or supervisee located outside Arizona shall comply with not only A.R.S. Title 32, Chapter 19.1, and this Chapter but also the laws and rules of the jurisdiction in which the client or patient or supervisee is located.
- B. Before providing psychological service or supervision by telepractice, a licensee shall establish competence in use of telepractice that conforms to prevailing standards of scientific and professional knowledge.
- C. A licensee who provides psychological service or supervision by telepractice shall maintain competence in use of telepractice through continuing education, consultation, or other procedures designed to address changing technology used in telepractice.
- D. A licensee who provides psychological service or supervision by telepractice shall take all reasonable steps to ensure confidential communications stored electronically cannot be recovered or accessed by an unauthorized person when the licensee disposes of electronic equipment or data.

R4-26-110. Repealed Providing Psychological Service by Telepractice

- A. Before providing psychological service by telepractice, a licensee who is in compliance with R4-26-109 shall conduct a risk analysis as clinically indicated and document in the client or patient's record required under R4-26-106 whether use of telepractice:
 - 1. Is consistent with the client or patient's knowledge and skill regarding use of the technology involved in providing psychological service by telepractice or with ready access to assistance with use of the technology, and
 - 2. Is in the best interest of the client or patient.
- B. A licensee shall not provide psychological service by telepractice unless both conditions of the risk analysis conducted under subsection (A) are met.
- C. Before providing psychological service by telepractice, a licensee shall:
 - 1. Obtain the written informed consent of the client or patient, using language that is clear and understandable and consistent with accepted professional and legal requirements. The licensee shall ensure the written informed consent addresses the following and a copy is placed in the client or patient's record required under R4-26-106:

- a. The manner in which the licensee will verify the identity of the client or patient before each psychological service if the telepractice does not involve video;
 - b. The manner in which the licensee will ensure the client or patient's electronic communications are received only by the licensee or supervisee;
 - c. Limitations and innovative nature of using technology to provide psychological service;
 - d. Inherent confidentiality risk resulting from use of technology;
 - e. Potential risk of technology failure that disrupts provision of psychological service and how to re-establish communication if disruption occurs;
 - f. When and how the licensee will respond to routine electronic communications;
 - g. The circumstances under which the licensee and client or patient will use an alternative means of communication;
 - h. Who is authorized to access the electronic communication between the licensee and client or patient;
 - i. The manner in which the licensee stores the electronic communication between the licensee and the client or patient; and
 - j. The type of secure electronic technology the licensee will use to communicate with the client or patient;
2. Establish a written agreement with the client or patient that specifies contact information for sources of face-to-face emergency services in the client or patient's geographical area and requires the client or patient to contact a source of face-to-face emergency services when the client or patient experiences a suicidal or homicidal crisis or other emergency. If the licensee has knowledge the client or patient is experiencing a suicidal or homicidal crisis or other emergency, the licensee shall assist the client or patient to contact a source of face-to-face emergency services. The licensee shall place a copy of the written agreement required under this subsection in the client or patient's record required under R4-26-106.
 3. Obtain the name and contact information for an emergency contact;
 4. Obtain information about an alternative means of contacting the client or patient; and

5. Provide the client or patient with information about an alternative means of contacting the licensee.

D. A licensee who provides psychological service by telepractice shall repeat the risk analysis required under subsection (A) as clinically indicated.

E. If a licensee does not provide psychological service by telepractice to a client or patient, the provisions of this Section do not apply to electronic communications with the client or patient regarding:

1. Scheduling an appointment, billing, establishing benefits, or determining eligibility for services; and
2. Checking the welfare of the client or patient in accord with reasonable professional judgment.

R4-26-111. Reserved Providing Supervision through Telepractice

A. As specified under A.R.S. § 32-2071(F) and (G), a licensee who provides in-person individual supervision shall ensure that:

1. No more than 50 percent of the supervision is provided through telepractice; and
2. Supervision provided through telepractice is conducted using secure, confidential, real-time visual telecommunication technology.

B. Before providing supervision by telepractice, a licensee who is in compliance with R4-26-109 shall conduct a risk analysis as clinically indicated and document whether providing supervision by telepractice:

1. Is appropriate for the issue presented by the supervisee's client or patient involved in the supervisory process,
2. Is consistent with the supervisee's knowledge and skill regarding use of the technology involved in providing supervision by telepractice, and
3. Is in the best interest of both the supervisee and the supervisee's client or patient involved in the supervisory process.

- C. A licensee shall not provide supervision by telepractice unless all conditions of the risk analysis conducted under subsection (B) are met.
- D. Before providing supervision by telepractice, a licensee shall:
1. Enter a written agreement with the supervisee, using language that is clear and understandable and consistent with accepted professional and legal requirements. The licensee shall ensure the written agreement addresses the following and a copy is provided to the supervisee:
 - a. The manner in which the licensee will identify the supervisee before each supervisory session that does not involve video;
 - b. Limitations and innovative nature of using technology to provide supervision;
 - c. Potential risk of technology failure that disrupts provision of supervision and how to re-establish communication if disruption occurs;
 - d. When and how the licensee will respond to routine electronic communications from the supervisee;
 - e. The circumstances under which the licensee and supervisee will use an alternative means of communication; and
 - f. The type of secure electronic technology the licensee will use to communicate with the supervisee;
 2. Obtain information about an alternative means of contacting the supervisee; and
 3. Provide the supervisee with information about an alternative means of contacting the licensee.

ARTICLE 2. LICENSURE

R4-26-203.03. Reapplication for License; Applying Anew

A. No change

1. No change
2. No change

B. No change

C. No change

1. No change;
2. No change
 - a. No change
 - b. No change
 - c. No change
3. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
4. No change
5. Pay the fee required under R4-26-108(A)(2).

D. No change

1. No change
2. An individual who was permitted by the Board to withdraw an application submitted under R4-26-203 or R4-26-203.01 before the Board acted on the application, ~~and~~
3. An individual whose application submitted under R4-26-203 or R4-26-203.01 was administratively closed by the Board under R4-26-208(H) more than one year before another application is submitted,
4. An individual whose license was revoked under A.R.S. § 32-2081(N)(1),
5. An individual whose license expired under A.R.S. § 32-2074,
6. An individual whose license was cancelled under A.R.S. 32-2074, and
7. An individual who retired under A.R.S. § 32-2073(G).

R4-26-203.04. Temporary License under A.R.S. § 32-2073(B)

A. To be eligible to be issued a temporary license under A.R.S. § 32-2073(B), an individual shall:

1. Have completed the educational requirements specified in A.R.S. § 32-2071(A) through (C);
2. Have completed 1,500 hours of supervised professional experience as described in A.R.S. § 32-2071(F); and
3. Be participating in a supervised postdoctoral professional experience as described in A.R.S. § 32-2071(G).

B. An applicant seeking a temporary license under A.R.S. § 32-2073(B), shall submit an application packet to the Board that includes:

1. The application form required under R4-26-203 and provide all required information except that specified in R4-26-203(C)(3), (5), and (7); and
2. The written training plan required under A.R.S. § 32-2071(G)(7) from the entity at which the supervised postdoctoral professional experience is occurring that includes at least the following:
 - a. Goal and content of each training experience,
 - b. Expectations regarding the nature, quality, and quantity of work to be done by the supervisee during the supervised postdoctoral professional experience,
 - c. Methods of evaluating the supervisee and the supervised postdoctoral professional experience,
 - e. Total number of hours to be accrued during the supervised postdoctoral professional experience,
 - f. Total number of face-to-face contact hours the supervisee is to have with clients or patients during the supervised postdoctoral professional experience,
 - g. Total number of hours of supervision the supervisee is to receive during the supervised postdoctoral professional experience,
 - h. Qualifications of all individuals who provide supervision during the supervised postdoctoral professional experience including documentation that each is qualified under the standards at A.R.S. § 32-2071(G), and
 - i. Acknowledgement that ethics training is included in the training experience.

C. An individual issued a temporary license under A.R.S. § 32-2073(B) shall practice psychology only under supervision. It is unprofessional conduct for the holder of a temporary license issued under A.R.S. § 32-2073(B) to practice psychology without supervision.

D. A temporary license issued under A.R.S. § 32-2073(B) is valid for 36 months and is not renewable. If the Board denies an active license under R4-26-203 to the holder of a temporary license issued under A.R.S. § 32-2073(B), the temporary license terminates at the time of license denial.

E. The holder of a temporary license issued under A.R.S. § 32-2073(B) shall:

1. Comply fully with all provisions of A.R.S. Title 32, Chapter 19.1, and this Chapter;
2. Not practice psychology outside the postdoctoral experience specified in the written training plan required under subsection (B)(2) and
3. Submit to the Board any modification to the written training plan required under subsection (B)(2) within 10 days after the effective date of the modification.

R4-26-205. Renewal of License

A. A Beginning May 1, 2017, a license issued by the Board, whether active or inactive, expires on ~~April 30 of every odd-numbered year unless renewed.~~ the last day of a licensee's birth month during the licensee's renewal year.

B. The Board considers a license renewal application packet timely submitted if delivered or mailed to the Board's office and date stamped or postmarked on or before ~~April 30 of the odd-numbered year in which the license expires~~ the last day of a licensee's birth month during the licensee's renewal year.

C. No change

1. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
2. No change
3. No change
4. No change

- a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change
 - j. No change
 - k. No change
 - l. No change
 - m. No change
 - n. No change
 - o. No change
 - p. No change
 - q. No change
5. No change
- a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
6. No change
- a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
7. No change
8. No change
- D.** No change
- 1. No change
 - 2. No change

3. No change

E. No change

F. Under A.R.S. § 32-2074~~(B)~~ (C), the license of a licensee who fails to submit a renewal application, including the information about continuing education completed, on or before ~~April 30 of an odd-numbered year~~ the last day of the licensee's birth month during the licensee's renewal year expires and the licensee shall immediately stop practicing psychology.

G. A psychologist whose license expires under subsection (F) may have the license reinstated by submitting the following to the Board ~~on or before June 30 of the year in which the license expired~~ within two months after the last day of the licensee's birth month during the licensee's renewal year:

1. No change

2. No change

H. A psychologist whose license expires under subsection (F) and who fails to have the license reinstated under subsection (G) may have the license reinstated by:

1. Complying with ~~subsections (G)(1) and (2) on or before the following April 30th~~ subsection (G) within one year after the last day of the licensee's birth month during the licensee's renewal year, and

2. Paying the ~~delinquent compliance~~ fee for reinstatement of an active or inactive license as specified in R4-26-108(A)(7).

I. No change

J. No change

R4-26-206. Reinstatement of License from Inactive to Active Status; Cancellation of License

A. No change

B. A psychologist who is on inactive status for at least two years may reinstate the license to active status by presenting to the Board documentation of completion of at least 40 hours of continuing education that meets the standards in R4-26-207. A psychologist who is on inactive status for less than two years may reinstate the license to active status by presenting to the Board documentation of completion of a prorated amount of continuing education. To calculate the prorated amount of continuing education hours required, the Board shall multiply 1.67 by the number of months from the date of inactive status until the date the application for reinstatement is received by the Board. For every six months of inactive status, the Board shall require one hour of continuing education in:

1. Ethics, as specified under R4-26-207(B)(1); and

2. Domestic violence, intimate partner abuse, child abuse, or abuse of vulnerable adults, as specified under R4-26-207(B)(2).

C. No change

R4-26-207. Continuing Education

A. No change

B. A licensee shall ensure the continuing education hours obtained include at least four hours in each of the following:

1. Professional ethics; and
2. Domestic violence, intimate partner abuse, child abuse, or abuse of vulnerable adults. The topic of bullying satisfies the requirement for child abuse.

~~**B. C.** During the license period in which an individual is initially licensed, the Board shall pro-rate the number of continuing education hours, including a pro-rated number of hours addressing ethics, domestic violence, intimate partner abuse, abuse of vulnerable adults, child abuse, and bullying that the new licensee must complete during the initial license period. To calculate the number of continuing education hours that a new licensee must obtain, the Board shall divide the 40 hours of continuing education required in a license period by 24 and multiply the quotient by the number of whole months from the date of initial licensure until the end of the license period. To determine the number of ethics hours required during the first license period, the licensee shall complete one hour of ethics for every six months from the month of license issuance to the end of the license period. During the first license period, for every six months from the month of license issuance to the end of the license period, the Board shall require one hour of continuing education in:~~

1. Ethics, as specified under subsection (B)(1); and
2. Domestic violence, intimate partner abuse, child abuse, or abuse of vulnerable adults, as specified under subsection (B)(2).

~~**C.** A licensee shall ensure that the continuing education hours obtained include at least four hours in each of the following:~~

1. ~~Professional ethics; and~~
2. ~~Domestic violence, intimate partner abuse, child abuse, or abuse of vulnerable adults. The topic of bullying satisfies the requirement for child abuse.~~

D. If the standards in subsection (F) are met, the Board shall accept the following for continuing education hours. ~~In completing the continuing education requirement, a licensee shall ensure that hours are obtained from participating in at least two of the following:~~

1. Post-doctoral study sponsored by a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1) and provides a graduate-level degree program;

2. A course, seminar, workshop, or home study for which a certificate of attendance or completion is provided;
3. A continuing education program offered by a national, international, regional, or state association, society, board, or continuing education provider;
4. Teaching a graduate-level course in applied psychology at a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1). A licensee who teaches a graduate-level course in applied psychology receives the same number of continuing education hours as number of classroom hours for those who take the graduate-level course;
5. Organizing and presenting a continuing education activity. A licensee who organizes and presents a continuing education activity receives the same number of continuing education hours as those who attend the continuing education activity;
6. ~~Attending a Board meeting or serving as a member of the Board. A licensee receives up to six continuing education hours in professional ethics for attending both morning and afternoon sessions of a Board meeting and three continuing education hours for attending either the morning or afternoon session or at least four hours of a Board meeting. A licensee shall complete documentation provided by the Board at the time the licensee attends a Board meeting. During a license period, the Board shall not accept from a licensee more than 10 continuing education hours obtained by attending a Board meeting;~~
7. ~~Serving as a complaint consultant. During a license period, a licensee who serves as a Board complaint consultant to review Board complaints and ~~provide a~~ provides written ~~report~~ reports to the Board or provides expert testimony on behalf of the Board may receive continuing education hours equal to the actual number of hours served as a complaint consultant to a maximum of 20 hours. A licensee who is paid by the Board for services rendered shall not receive continuing education credit for the time or services for which payment was made;~~
7. The Board shall allow a maximum of 10 continuing education hours for each of the following during a license period:
 - a. Attending a Board meeting or serving as a member of the Board. A licensee receives up to six continuing education hours in professional ethics for attending both morning and afternoon sessions of a Board meeting and three continuing education hours for attending either the morning or afternoon session or at least four hours of a Board meeting. A licensee shall complete documentation provided by the Board at the time the licensee attends a Board meeting;
 8. b. Having an authored or co-authored psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published. A licensee who has an authored or co-authored

- psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published receives 10 continuing education hours in the year of publication;
9. c. Participating in a study group for professional growth and development as a psychologist. A licensee receives one hour of continuing education for each hour of participation to a maximum of 10 continuing education hours for participating in a study group. The Board shall allow continuing education hours for participating in a study group only if the licensee maintains the documentation required under subsection (G)(5);
 10. d. Presenting a symposium or paper at a state, regional, national, or international psychology meeting. A licensee who presents a symposium or paper receives the same number of continuing education hours as hours of the session, as published in the agenda of the meeting, at which the symposium or paper is presented to a maximum of 10 continuing education hours ~~in a license period~~;
 11. e. Presenting a poster during a poster session at a state, regional, national, or international psychology meeting. A licensee who presents a poster receives an hour of continuing education for each hour the licensee is physically present with the poster during the poster session, as published in the agenda of the meeting, to a maximum of 10 continuing education hours ~~in a license period~~; and
 12. f. Serving as an elected officer of an international, national, regional, or state psychological association or society. A licensee who serves as an elected officer may receive continuing education hours equal to the actual number of hours served to a maximum of 10 continuing education hours ~~in a license period~~.

E. No change

1. No change
2. No change
3. No change

F. Standards for continuing education. To be acceptable for continuing education credit, an activity identified in subsections (D)(1) through (4) shall:

1. Focus on the practice of psychology, as defined at A.R.S. § 32-2061~~(8)~~ (9), for at least 75 percent of the program hours; and
2. Be taught by an instructor who is:
 - a. ~~Currently licensed or certified in the instructor's profession or works at least 20 hours each week as a faculty member at a regionally accredited college or university;~~
 - b. ~~A fellow diplomate, or specialist; or~~

e. ~~Readily~~ readily identifiable as competent in the subject of the continuing education by having an advanced degree, teaching experience, work history, published professional articles, or previously presented continuing education on the same subject .

G. The Board shall accept the following documents as evidence of completion of continuing education hours:

1. A certificate of attendance or completion;
2. Statement signed by the provider verifying participation in the activity;
3. ~~Official transcript~~ Copy of transcript of course completed under subsection (D)(1);
4. Documents indicating a licensee's participation as an elected officer or appointed member as specified in subsection ~~(D)(12)~~ (D)(7)(f); or
5. An attestation signed by all participants of a study group under subsection ~~(D)(9)~~ (D)(7)(c) that includes a description of the activity, subject covered, dates, and number of hours .

H. No change

I. No change

J. No change

1. No change
2. No change
3. No change

K. No change

L. No change

R4-26-208. Time Frames for Processing Applications

A. No change

B. No change

C. No change

D. No change

E. No change

F. No change

G. No change

H. No change

I. No change

J. No change

1. No change
2. No change

H.K. If the Board denies a license or approval, the Board shall send the applicant or person requesting approval a written notice explaining:

1. No change
2. No change
3. No change
4. No change

H.L. If the last day of a time frame falls on a Saturday, Sunday, or an official state holiday, the time frame ends on the next business day.

R4-26-210. Supervised Professional Experience

A. No change

1. No change
2. No change
3. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
 - f. No change
 - g. No change
 - h. No change
 - i. No change

B. No change

1. No change
 - a. No change
 - b. No change
2. No change
3. No change
4. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change

- e. No change
- 5. No change
- 6. No change
- C. Under A.R.S. § 32-2071(G)(5), at least 40 percent of an applicant's supervised postdoctoral experience shall involve direct client or patient contact. If an applicant's supervised postdoctoral hours applied toward licensure include less than 40 percent direct ~~contract~~ contact hours, the applicant shall work additional time to achieve the required percentage of direct contact hours. While additional direct contact hours may be obtained to meet this requirement, the Board shall count no more than 1,500 hours of total postdoctoral experience for the purpose of licensure.

ARTICLE 3. REGULATION

R4-26-304. Representation before the Board by Attorney Not Admitted to State Bar of Arizona

An attorney who is not a member of the State Bar of Arizona shall not represent a party before the Board unless the attorney is admitted to practice ~~pro hac vice~~ pro hac vice before the Board under Rule 38(a) of the Rules of the Supreme Court of Arizona.

R4-26-310. Disciplinary Supervision; Practice Monitor

- A. If the Board determines, after a hearing conducted under A.R.S. Title 41, Chapter 6, Article 10, after an informal interview under A.R.S. § 32-2081(K), or through an agreement with the Board, that to protect public health and safety and ensure a licensee's ability to engage safely in the practice of psychology, it is necessary to require that the licensee practice psychology for a specified term under ~~the supervision of another licensee~~ who provides supervision or service as a practice monitor, the Board shall enter into an agreement with the licensee or issue an order regarding the disciplinary supervision or practice monitoring.
- B. Payment between a licensee and supervisor ~~and supervisee~~ or practice monitor.
 - 1. A licensed psychologist who enters into an agreement with the Board or is ordered by the Board to practice psychology under the supervision of another licensee may pay the supervising licensee for the supervisory service; ~~and~~
 - 2. A licensed psychologist who provides supervisory service to a licensed psychologist who has been ordered by the Board or entered into an agreement with the Board to practice psychology under supervision may accept payment for the supervisory service;

3. A licensed psychologist who enters into an agreement with the Board or is ordered by the Board to practice psychology under a practice monitor may pay the practice monitor for the service provided; and
 4. A licensed psychologist who provides practice monitoring to a licensed psychologist who has been ordered by the Board or entered into an agreement with the Board to practice psychology under a practice monitor may accept payment for the service provided.
- C. A licensed psychologist who supervises or serves as a practice monitor for a licensed psychologist who has entered an agreement with the Board or been ordered by the Board to practice psychology under supervision or with a practice monitor is professionally responsible only for work specified in the agreement or order.

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT¹

TITLE 4. PROFESSIONS AND OCCUPATIONS

CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS

1. Identification of the rulemaking:

In 2014, the legislature made several important changes to the Board's statutes (See Laws 2014, Chapter 258). The changes include allowing psychological services and supervision to be provided by telepractice, establishing a temporary license, and amending the biennial license renewal so half of all licenses are renewed each year rather than all in one year and so licenses are renewed throughout a year rather than all during one month.

The Board amended R4-26-203.03 to further clarify who may reapply for licensure and who must apply anew; R4-26-206 to align provisions regarding reinstatement from inactive to active status with the change to biennial renewal; and R4-26-310 to clarify disciplinary supervision and practice monitoring.

In a rulemaking that went into effect on January 30, 2016, the Board amended many of its rules to make changes identified as needed in a five-year-review report, make the rules consistent with Board practice, and make the language clear, concise, and understandable. In this rulemaking, the Board further amends some of the rules to correct minor errors.

An exemption from Executive Order 2015-01 was provided for this rulemaking by Ted Vogt, Chief of Operations in the Governor's office, in an e-mail dated June 1, 2015.

a. The conduct and its frequency of occurrence that the rule is designed to change:

A.R.S. § 32-2063(A)(12) requires the Board to make rules regarding use of telepractice on or before June 30, 2016. In spite of the Board's best efforts, this deadline was missed. Until this rulemaking is completed, the Board will continue to be out of compliance with statute.

A.R.S. § 32-2073(B) authorized the Board to begin issuing a temporary license to qualified individuals on January 1, 2015. The Board has been issuing temporary licenses but without rules that clarify the process for applicants.

¹ If adequate data are not reasonably available, the agency shall explain the limitations of the data, the methods used in an attempt to obtain the data, and characterize the probable impacts in qualitative terms.

The Board is required to begin issuing two-year licenses on May 1, 2017, with expiration dates based on birth month and license number. The Board needs to complete this rulemaking timely to avoid confusion that may result from failing to have rules that provide needed instruction to transition to the new renewal process.

- b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

It is not good government for an agency to be out of compliance with statute and fail to provide needed rule instruction for applicants and licensees.

- c. The estimated change in frequency of the targeted conduct expected from the rule change:

When the rulemaking is complete, the Board will be in compliance with statute regarding telepractice and complete information will be available to applicants and licensees regarding the two-year license and renewal process and temporary licenses.

2. A brief summary of the information included in the economic, small business, and consumer impact statement:

Being able to provide psychological services and supervision by telepractice and able to obtain a temporary license will have economic benefit for those who are in position to take advantage of the new statutory provisions. The rules establish minimal requirements for working and supervising by telepractice and clarify some of the statutory requirements for obtaining a temporary license.

The change in the license renewal process will have a major impact on productivity and efficiency of Board staff. Rather than receiving and having to process all 2,200 license renewal applications at the same time, the renewal applications will be spread throughout two years with renewals processed every month.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

Name: Dr. Cindy Olvey, Executive Director

Address: Board of Psychologist Examiners
1400 W. Washington, Suite 240
Phoenix, AZ 85007

Telephone: (602) 542-8162

Fax: (602) 542-8279

E-mail: Cindy.Olvey@psychboard.az.gov

Web site: <https://psychboard.az.gov>

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

In 2013, the legislature required insurance companies to pay for services addressing mental health disorders if the services are provided by telemedicine if the services would otherwise be covered if provided in person. This led to Laws 2014, Chapter 258, which requires the Board to make rules for providing psychological services and supervision by telepractice. Under Laws 2016, Chapter 298, the legislature authorized the state to participate in the Interjurisdictional Psychology Compact (PSYPACT), which allows qualified psychologists to practice electronically across state lines. Arizona is the first state to adopt PSYPACT. When at least seven states have adopted PSYPACT legislatively, qualified psychologists in those states will be able to practice electronically in the other compact states.

An increasing number of states allow telepractice because it increases access to care, especially in rural and remote areas and increases flexibility by making services available 24 hours each day. It can reduce the time individuals spend to obtain psychological services and may be a more affordable than in-person services.

The American Psychological Association, which accredits doctoral programs in psychology, allows an accredited program to offer up to 50 percent of supervised work experience using electronic supervision. This APA standard is reflected in this rulemaking.

There are currently 1,729 active psychologist licensees. An additional 162 individuals applied for licensure in FY2016. Use of telepractice to provide psychological services will directly benefit licensees who choose to use it because they will be able to provide services to individuals without regard to location or time. Those who choose to provide psychological services by telepractice will incur the cost of establishing and maintaining competence in use of telepractice, ensuring electronic communications are secure, and maintaining required records.

Both licensees and holders of a doctoral degree participating in supervised professional experiences will benefit from electronic supervision of those experiences. It will provide

flexibility in the location and timing of supervision. Both will incur the cost of obtaining required competence in telepractice and maintaining required records.

Although the Board expects no more than a dozen individuals to apply for a temporary license each year, those who are qualified and apply for a temporary license will benefit from being able to work as a psychologist under supervision before being fully qualified for licensure. A licensee who employs and supervises a temporary licensee will benefit from having an additional individual available to provide psychological services. A temporary licensee will incur the cost of making application and developing a written training plan.

During FY2016, the Board received 18 reapplications for licensure and 5 requests for reinstatement from inactive to active status. Four licensees worked with a practice monitor during FY2016.

The Board incurred the cost of this rulemaking and will incur the cost of implementing it. The Board will benefit importantly from moving to staggered license renewal dates and from complying fully with statutes regarding telepractice.

5. Cost-benefit analysis:

- a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:

The Board is the only state agency directly affected by the rulemaking. The Board will not need a new full-time employee to implement or enforce the rulemaking.

- b. Costs and benefits to political subdivisions directly affected by the rulemaking:

No political subdivision is directly affected by the rulemaking.

- c. Costs and benefits to businesses directly affected by the rulemaking:

Psychologists are businesses directly affected by the rulemaking. Their costs and benefits are discussed in item 4. Businesses that employ psychologists will indirectly benefit from the rulemaking.

6. Impact on private and public employment:

The Board expects the rulemaking will have no impact on private or public employment.

7. Impact on small businesses²:

- a. Identification of the small business subject to the rulemaking:

Psychologists are small businesses subject to the rulemaking.

b. Administrative and other costs required for compliance with the rulemaking:

Costs required for compliance with the rulemaking include obtaining and maintaining competence in use of telepractice, ensuring confidential communication is secured from unauthorized persons, performing a risk analysis as clinically indicated, obtaining informed consent to use of telepractice, and establishing a written agreement with the client or patient before providing psychological services by telepractice. Similar costs are incurred when supervision is provided by telepractice.

Costs related to compliance with the rule provisions regarding a temporary license include making an application, developing a training plan, and working under supervision.

c. Description of methods that may be used to reduce the impact on small businesses:

Because all psychologists are small business subject to the rulemaking, it is not possible to reduce the impact of the rulemaking on small businesses. The Board believes the costs associated with the rulemaking are minimal and arise from provisions necessary to protect public health and safety.

8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:

No private persons or consumers are directly affected by the rulemaking. However, those who need psychological services may receive important benefits indirectly.

9. Probable effects on state revenues:

As specifically authorized under A.R.S. § 32-2067, the rulemaking establishes fees for application for and issuance of a temporary license. Because the Board expects no more than a dozen applicants for a temporary license each year and because only 10 percent of the fees are contributed to the general fund, the effect on state revenue will be minimal.

Because renewal fees will now be received every month, the Board will contribute those to the general fund every month rather than only every other year. However, the total amount contributed will not change.

10. Less intrusive or less costly alternative methods considered:

The Board believes the rules contain the least intrusive and costly method possible while enabling the Board to fulfill its statutory responsibilities. No alternative was considered.

² Small business has the meaning specified in A.R.S. § 41-1001(21).

TITLE 4. PROFESSIONS AND OCCUPATIONS
CHAPTER 26. BOARD OF PSYCHOLOGIST EXAMINERS

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ARTICLE 1. GENERAL PROVISIONS

R4-26-101. Definitions

A. The definitions in A.R.S. § 32-2061 apply to this Chapter.

B. Additionally, in this Chapter:

1. “Additional examination” means an examination administered by the Board to determine the competency of an applicant and may include questions about the applicant’s knowledge and application of Arizona law, the practice of psychology, ethical conduct, and psychological assessment and treatment practices.
2. “Administrative completeness review” means the Board’s process for determining that an applicant has provided all of the information and documents required by the Board to determine whether to grant a license to the applicant.
3. “Advertising” means any media used to disseminate information regarding the qualifications of a psychologist or to solicit clients or patients for psychological services, regardless of whether the psychologist pays for the advertising. Methods of advertising include a published statement or announcement, directory listing, business card, personal resume, brochure, or any electronic communication conveying the psychologist’s professional qualifications or promoting use of the psychologist’s professional services.
4. “Applicant” means an individual requesting licensure, renewal, or approval from the Board.
5. “Application packet” means the forms and documents the Board requires an applicant to submit to the Board.
6. “Applied psychology,” as used in A.R.S. § 32-2071(A), means the practice of psychology in the area of health service delivery. The Board shall consider education and training in applied psychology as qualification for licensure only if the education and training meet the standards specified in A.R.S. § 32-2071.
7. “Case,” in the context of R4-26-106 (G), means a legal cause of action instituted before an administrative tribunal or in a judicial forum that relates to a psychologist’s practice of psychology.
8. “Case conference” means a meeting that includes the discussion of a particular client or patient or case that is related to the practice of psychology.
9. “Client or patient record” means “adequate records” as defined in A.R.S. § 32-2061(2), “medical records” as defined in A.R.S. § 12-2291 (6), and all records pertaining to assessment, evaluation, consultation, intervention, treatment, or the provision of psychological services in any form or by any medium.
10. “Complaint Screening Committee” means the committee of the Board established under A.R.S. § 32-2081 (H) to conduct an initial review of all complaints.
11. “Confidential record” means:

- a. Minutes of an executive session of the Board;
 - b. A record that is classified as confidential by a statute or rule applicable to the Board;
 - c. All materials relating to an investigation by the Board, including a complaint, response, client or patient record, witness statement, investigative report, and any other information relating to a client's or patient's diagnosis, treatment, or personal or family life; and
 - d. The following regarding an applicant or licensee:
 - i. College or university transcripts;
 - ii. Home address, home telephone number, and e-mail address;
 - iii. Examination scores;
 - iv. Date of birth
 - v. Place of birth;
 - vi. Social Security number; and
 - vii. Candidate identification number for the national examination required under A.R.S. § 32-2072(A).
12. "Credentialing agency" means the Association of State and Provincial Psychology Boards, the National Register of Health Service Providers in Psychology, or the American Board of Professional Psychology.
13. "Day" means a calendar day except in A.R.S. § 32-2075(A)(4), "day" means a total of eight hours in providing psychological services regardless of the number of calendar days over which the hours are accumulated.
14. "Diplomate or specialist" means a status bestowed on a person by the American Board of Professional Psychology after successful completion of the work and examinations required.
15. "Directly available," as used in A.R.S. § 32-2071 (F)(2), means immediately available in person or by telephone or electronic transmission.
16. "Disaster," as used in A.R.S. § 32-2075(A)(4), means a contingency or situation for which the governor declares a state of emergency under the authority provided at A.R.S. § 35-192. The Board acknowledges any state of emergency declared by the governor or determined by the Board.
17. "Dissertation" means a document prepared as part of a graduate doctoral program that includes, at a minimum, separate sections that:
- a. Review the literature on the psychology topic being investigated and state each research question and hypothesis under investigation;
 - b. Describe the method or procedure used to investigate each research question or hypothesis;
 - c. Describe and summarize the findings and results of the investigation;
 - d. Discuss the findings and compare them to the relevant literature presented in the literature review section; and

- e. List the references used in the various sections of the dissertation, a majority of which are either journals of the American Psychological Association, Psychological Abstracts, or classified as a psychology subject by the Library of Congress.
18. "Fellow" means a status bestowed on a person by a psychology association or society.
 19. "Gross negligence" means an extreme departure from the ordinary standard of care.
 20. "Internship training program" means the supervised professional experience required in A.R.S. § 32-2071 (F).
 21. "Last client or patient activity," as used in R4-26-106, means the last date a particular client or patient received direct clinical contact from the psychologist retaining the client's or patient's record.
 22. "License period" means the two years between May 1 of one odd-numbered year and April 30 of the next odd-numbered year.
 23. "National examination" means the Examination for Professional Practice in Psychology provided by the Association of State and Provincial Psychology Boards.
 24. "Party" means the Board, an applicant, a licensee, or the state.
 25. "Primarily psychological," in the context of A.R.S. § 32-2071(A)(6), means subject matter that covers the practice of psychology as defined in A.R.S. § 32-2061 (9).
 26. "Psychologist on staff," as used in A.R.S. § 32-2071(F)(2), means a psychologist who is designated by the staff psychologist specified in A.R.S. § 32-2071(F)(1) to fulfill the responsibilities of a supervising psychologist in the training program.
 27. "Psychometric testing" means measuring cognitive and emotional processes and learning through the administration of psychological tests.
 28. "Raw test data" means test scores, client or patient responses to test questions or stimuli, and notes and recordings concerning client or patient statements and behavior during a psychologist's assessment and evaluation.
 29. "Regulatory jurisdiction" means a state or territory of the U.S., the District of Columbia, or a foreign country with authority to grant or deny entry into a profession or occupation.
 30. "Retired," as used in A.R.S. § 32-2073 (G), means a psychologist has stopped practicing psychology, as defined in A.R.S. § 32-2061 (9).
 31. "Stipend" means a fee paid to a supervisee that is not based on productivity or revenue generated.
 32. "Substantive review" means the Board's process for determining whether an applicant meets the requirements of A.R.S. § 32-2071 through § 32-2076 and this Chapter.
 33. "Successfully completing," as used in A.R.S. § 32-2071(A)(4), means receiving a passing grade in a course from an institution of higher education.
 34. "Supervise" means to control, oversee, and review the activities of an employee, intern, trainee, or resident who provides psychological services.

35. "Supervisor," as referenced in A.R.S. § 32-2071(F)(2), means an individual who is:
- a. Licensed or registered as a psychologist at the independent level in the regulatory jurisdiction in which the supervision occurs,
 - b. On staff as a supervisor with the training program for which supervision is provided, and
 - c. Directly available to the supervisee in case of an emergency or ensures another supervisor is directly available to the supervisee.
36. "Year," as used in A.R.S. § 32-2075(A)(4) means a calendar year.

R4-26-102. Board Officers

- A. Under A.R.S. § 32-2063(A)(8), the Board shall annually elect a chairperson, vice chairperson, and secretary.
- B. Officers elected under subsection (A) shall take office on January 1 following election and serve until December 31.
- C. If a vacancy occurs in the office of chairperson, vice chairperson, or secretary, the Board shall elect a replacement officer at the next scheduled Board meeting.

R4-26-103. Repealed

R4-26-104. Committees

- A. As permitted under A.R.S. § 32-2064(B), the Board chairperson may appoint Board committees to assist the Board to fulfill the Board's responsibilities.
- B. The Board may appoint consulting committees to conduct investigations and make recommendations to the Board concerning official actions.

R4-26-105. Board Records

- A. A person may view public records in the Board office only during business hours, which are Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding holidays.
- B. All Board records are open to public inspection and copying except confidential records as defined in R4-26-101 or as otherwise provided by law.

R4-26-106. Client or Patient Records

- A. A psychologist shall not condition release of a client or patient record on payment for services by the client, patient, or a third party.
- B. Except as provided in subsection (C), a psychologist shall, with a client's or patient's written consent, provide access to or a copy of the client's or patient's record, including raw test data and other information as provided by law to the client or patient or the client's or patient's health care decision maker unless the

release violates copyright or other laws or violates one of the standards incorporated by reference at R4-26-301.

- C.** A psychologist may deny a request to provide access to or a copy of a client's or patient's record if the psychologist determines:
1. Access by the client or patient is reasonably likely to endanger the life or physical safety of the client or patient or another person;
 2. The record makes reference to a person other than a health professional and access by the client or patient or the client's or patient's health care decision maker is reasonably likely to cause substantial harm to that other person;
 3. Access by the client's or patient's health care decision maker is reasonably likely to cause substantial harm to the client or patient or another person;
 4. Access by the client or patient or the client's or patient's health care decision maker will reveal information obtained under a promise of confidentiality with someone other than a health professional and access is reasonably likely to reveal the source of the information; or
 5. Access by the client or patient or the client's or patient's health care decision maker may result in misuse or misrepresentation of the information and potentially harm the client or patient.
- D.** Without a client's or patient's consent, a psychologist shall release the client's or patient's raw test data only to the extent required by law or under court order compelling production.
- E.** A psychologist shall retain all client or patient records under the psychologist's control, including records of a client or patient who died, for at least six years from the date of the last client or patient activity. If a client or patient is a minor, the psychologist shall retain all client or patient records for at least three years past the client's or patient's 18th birthday or six years from the date of the last client or patient activity, whichever is longer.
- F.** Audio or video tapes created primarily for training or supervisory purposes are exempt from the requirement of subsection (E).
- G.** A psychologist who is notified by the Board or municipal, state, or federal officials of an investigation or pending case shall retain all records relating to that investigation or case until the psychologist receives written notice that the investigation is completed, the case is closed, or the matter has been fully adjudicated.
- H.** The provisions of this Section apply to all psychologists including a psychologist who is on inactive status under A.R.S. § 32-2073 (G).
- I.** A psychologist may retain client or patient records in electronic form. The psychologist shall ensure that client or patient records in electronic form are legible, stored securely, and an electronic backup copy is maintained.

R4-26-107. Change of Name, Mailing, Residential, or E-mail Address, or Telephone Number

- A. The Board shall communicate with a psychologist using the contact information provided to the Board. To ensure timely communication from the Board, a psychologist shall notify the Board, in writing, within 30 days of any change of name, mailing, residential, or e-mail address (giving both the old and new addresses), or residential, business, or mobile telephone number.
- B. A psychologist who reports a name change shall submit to the Board legal documentation that substantiates the name change.
- C. A psychologist's failure to receive a renewal notice or other mail that the Board sends to the most recent address on file with the Board office does not excuse an untimely license renewal or the omission of any other action required by the psychologist.

R4-26-108. Fees and Charges

- A. As specifically authorized by A.R.S. § 32-2067(A), the Board establishes and shall collect the following fees:
 - 1. Application for an active license to practice psychology: \$350;
 - 2. Reapplication for an active license: \$200;
 - 3. Initial license (prorated): \$ 500;
 - 4. Duplicate license: \$25;
 - 5. Biennial renewal of an active license: \$ 500;
 - 6. Biennial renewal of an inactive license: \$ 85;
 - 7. Reinstatement of an active or inactive license: \$200; and
 - 8. Delinquent compliance with continuing education requirements: \$200.
- B. As specifically authorized by A.R.S. § 32-2067(A), the Board establishes and shall collect the following charges for the services provided:
 - 1. Duplicate renewal receipt: \$5;
 - 2. Copy of statutes and rules: \$5;
 - 3. Verification of a license: \$2;
 - 4. Audio recording of a Board or Committee meeting: \$10;
 - 5. Electronic medium containing the name and address of each licensee: \$.05 per name;
 - 6. Customized electronic medium containing the name and address of each current licensee: \$.25 per name;
 - 7. Customized electronic medium containing additional, non-confidential, licensee information: \$.35 per name; and
 - 8. Copies of Board records, documents, letters, minutes, applications, files, and policy statements: \$.25 per page.

C. Except as provided by law, including A.R.S. § 41-1077, the fees listed in subsection (A) are not refundable.

ARTICLE 2. LICENSURE

R4-26-201. Application Deadline

- A. The Board shall consider a license application at the Board's next scheduled meeting if an administratively complete application packet, including reference forms mailed or e-mailed from the Board office, is received by the Board office at least 18 days before the date of the meeting.
- B. The Board shall consider a license application that is received fewer than 18 days before a scheduled meeting at a subsequent meeting.

R4-26-202. Doctorate

- A. The Board shall apply the following criteria to determine whether a doctoral program provided by an institution of higher education met the standards in A.R.S. § 32-2071(A)(2) at the time an applicant began the degree program:
 - 1. The program is identified and labeled as a psychology program if there were institutional catalogues and brochures that specified the intent of the institution of higher education to educate and train psychologists;
 - 2. The program stands as a recognized, coherent organizational entity if there was an organized sequence of courses comprising a psychology curriculum; and
 - 3. The program has clearly identified entry and exit criteria within its psychology curriculum if there were specific prerequisites for entrance into the program and delineated requirements for graduation.
- B. The Board shall verify that an applicant completed the hours in the subject areas described in A.R.S. § 32-2071(A)(4). For this purpose, the applicant shall have the institution of higher education that the applicant attended provide directly to the Board an official transcript of all courses taken and verification of the dissertation or similar project.
 - 1. The Board may require additional documentation from the applicant or from the institution to determine whether the applicant satisfied the requirements of A.R.S. § 32-2071(A)(4).
 - 2. The Board shall count five quarter hours or six trimester hours as the equivalent of three semester hours, as required under A.R.S. § 32-2071(A)(4). When an academic term is other than a semester, quarter, or trimester, 15 classroom contact hours equals one semester hour.
- C. To determine whether a comprehensive examination taken by an applicant as part of a doctoral program in psychology satisfies the requirements of A.R.S. § 32-2071(A)(4), the Board shall review documentation provided directly to the Board by the institution of higher education that granted the doctoral degree, that

demonstrates how the applicant's comprehensive examination was constructed, lists criteria for passing, and provides the information used to determine that the applicant passed.

- D.** The Board shall not accept as core program hours required under A.R.S. § 32-2071(A)(4) credit:
1. For workshops, practica, undergraduate courses, life experiences, continuing education courses, or experiential or correspondence courses;
 2. Transferred from institutions that are not accredited under A.R.S. § 32-2071(A)(1); or
 3. For seminars, readings courses, or independent study unless the applicant proves that the course was an in-depth study devoted to a particular core program content area by submitting one or more of the following:
 - a. Course description in the official catalogue of the institution of higher education,
 - b. Course syllabus, or
 - c. Signed statement from a dean or psychology department head affirming that the course was an in-depth study devoted to a particular core program content area.
- E.** The Board shall count a course or comprehensive examination only once to satisfy a requirement of A.R.S. § 32-2071(A)(4).
- F.** An honorary doctorate degree does not qualify an applicant for licensure as a psychologist.

R4-26-203. Application for Initial License

- A.** An individual who wishes to be licensed as a psychologist shall submit an application packet to the Board that includes an application form, which is available from the Board office and on its website, with an attestation that is signed and dated by the applicant, and provide the following:
1. Personal information about the applicant:
 - a. Full name;
 - b. Other names by which the applicant is or ever has been known;
 - c. Residential address and telephone number;
 - d. Business name and address;
 - e. Work telephone and fax numbers;
 - f. E-mail address;
 - g. Gender;
 - h. Date of birth;
 - i. Place of birth; and
 - j. Social Security number;
 2. An indication of the address and telephone number to be listed in the Board's public directory and used in correspondence;
 3. An indication whether the applicant is active military;

4. A statement of whether the applicant:
 - a. Holds a Certificate of Professional Qualification in Psychology, a National Register of Health Service Providers in Psychology credential, or is a diplomate or specialist of the American Board of Professional Psychology;
 - b. Is or ever has been licensed as a psychologist in another regulatory jurisdiction and if so, the name of the regulatory jurisdiction and license number;
 - c. Has applied for and been rejected or denied licensure as a psychologist in a regulatory jurisdiction and if so, the name of each regulatory jurisdiction, date of each application, and reason given for the rejection or denial;
 - d. Is or ever has been licensed or certified in a profession or occupation other than psychology and if so, the names of the professions or occupations, regulatory jurisdictions, and license numbers;
 - e. Has ever taken the national examination and if so, the name of each regulatory jurisdiction in which the examination was taken and each date of examination;
 - f. Has ever had an application for a professional license, certification, or registration other than psychology denied or rejected by a regulatory jurisdiction and if so, the name of the regulatory jurisdiction, type of license, certification, or registration denied or rejected, and date of denial or rejection;
 - g. Has ever withdrawn an application for a professional license, certification, or registration in lieu of administrative proceedings and if so, the reason for the withdrawal;
 - h. Has ever had disciplinary action initiated against the applicant's professional license, certification, or registration, or had a professional license, certification, or registration suspended or revoked by a regulatory jurisdiction and if so, the name of the regulatory jurisdiction, date of the disciplinary action, and license number;
 - i. Has ever entered into a consent agreement or stipulation arising from a complaint against any professional license, certification, or registration and if so, the name of the regulatory jurisdiction, date, and license number;
 - j. Is a member of any professional association in the field of psychology and if so, name of the association;
 - k. Has ever had membership in a professional association in the field of psychology denied or revoked and if so, the name of the professional association and date of denial or revocation;
 - l. Is currently under investigation for or has been found guilty of violating a code of professional ethics of any professional organization and if so, the name of the professional organization and date of investigation;
 - m. Is currently under investigation for or has been found to have violated a professional code of conduct by a regulatory jurisdiction and if so, the name of the regulatory jurisdiction and date of investigation;

- n. Has ever been sanctioned or placed on probation by a regulatory jurisdiction and if so, the name of the regulatory jurisdiction and date of action;
 - o. Is currently awaiting trial, has been convicted of, or pled no contest or guilty to any felony or a misdemeanor other than a minor traffic offense (a DUI is not a minor traffic offense), or ever entered into a diversion program instead of prosecution, including any convictions that have been expunged, deleted, or set aside and if so, the name of the jurisdiction, offense involved, date of offense, status of resolution, expected resolution date, and a narrative explanation;
 - p. Has been sued or prosecuted for an act or omission relating to the applicant's practice as a psychologist, the applicant's work under a certificate or license in another profession, or the applicant's work as a member of a profession in which the applicant was not certified or licensed and if so, the name of the jurisdiction, allegation involved, and date;
 - q. Has ever been involuntarily terminated or resigned instead of termination from any psychological or behavioral health position or related employment and if so, the name of the employer involved and date;
 - r. Currently uses alcohol or another drug that in any way impairs or limits the applicant's ability to practice psychology safely and competently; and
 - s. Has a medical, physical, or psychological condition that may impair or limit the applicant's ability to practice psychology safely and competently;
5. Information about the applicant's education and training:
- a. Name and address of each university or college from which the applicant graduated, dates attended, date of graduation, degree received, name of department, and major subject area of study;
 - b. Name and department of the applicant's major advisor;
 - c. Title of the applicant's dissertation or Psy.D. project for the doctoral degree;
 - d. Official title of the applicant's doctoral degree program or predoctoral specialty area;
 - e. Whether the doctoral degree program that the applicant attended was accredited by the American Psychological Association at the time of graduation;
 - f. Whether the applicant's internship training program was an American Psychological Association-accredited program or a member of the Association of Psychology and Postdoctoral Internship Centers;
 - g. Location of each internship training program in which the applicant participated and each supervisor's name and contact information; and
 - h. Documentation demonstrating that the applicant satisfied the core program requirements in A.R.S. § 32-2071(A)(4) and R4-26-202;
6. Areas of professional competence;
7. Intended area of professional practice in psychology;

8. Name, position, and address of at least two individuals to serve as references who:
 - a. Are psychologists licensed or certified to practice psychology in a United States or Canadian regulatory jurisdiction and who are not members of the Arizona Board of Psychologist Examiners;
 - b. Are familiar with the applicant's work experience in the field of psychology or in a postdoctoral program within the three years immediately before the date of application. If more than three years have elapsed since the applicant last engaged in professional activities in the field of psychology or in a postdoctoral program, the references may pertain to the most recent three-year period in which the applicant engaged in professional activities in the field of psychology or in a postdoctoral program; and
 - c. Recommend the applicant for licensure;
9. History of employment for the past 10 years in the field of psychology including, for each position held, the:
 - a. Beginning and ending dates of employment,
 - b. Number of hours worked per week,
 - c. Name and address of employer,
 - d. Name and address of supervisor, and
 - e. Type of employment; and
10. Information demonstrating that the applicant satisfied the core program requirements in A.R.S. § 32-2071(A)(4) and R4-26-202;
11. An attestation by the applicant, that the information on the application is about the applicant, is true and correct, and is not being submitted fraudulently;

B. Additionally, an applicant shall submit:

1. An original, un-retouched, passport-quality photograph of the applicant that is no larger than 1.5 X 2 inches and taken no more than 60 days before the date of application;
2. The results of a self-query from the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank;
3. As required under A.R.S. § 41-1080(A), the specified documentation of citizenship or alien status indicating the applicant's presence in the U.S. is authorized under federal law;
4. The Board's Mandatory Confidential Information form;
5. The fee required under R4-26-108; and
6. Any other information authorized by statute.

C. In addition to the requirements in subsections (A) and (B), an applicant shall arrange to have the following directly submitted to the Board:

1. An official transcript from each university or college from which the applicant attended a graduate program or received a graduate degree that contains the date the degree was conferred;

2. An official document from the degree-granting institution indicating that the applicant completed a residency that satisfies the requirements of A.R.S. § 32-2071 (K);
3. For an applicant applying supervised preinternship hours toward licensure, an attestation submitted by the doctoral program training director, faculty supervisor, or other official of the doctoral-granting institution who is knowledgeable of the applicant's preinternship experience verifying that the applicant's preinternship experience meets the requirements of A.R.S. § 32-2071(D).
4. An attestation from the applicant's supervisor, if available, or a psychologist knowledgeable of the applicant's internship training program, verifying that the applicant's internship training program meets the requirements in A.R.S. § 32-2071 (F). If the supervisor or knowledgeable psychologist is not available, the Board shall accept primary source verification received from the Association of State and Provincial Psychology Boards. In this subsection, "not available" means the supervisor or knowledgeable psychologist is deceased or all reasonable efforts to locate the supervisor or knowledgeable psychologist were unsuccessful;
5. For an applicant applying supervised postdoctoral experience toward licensure, an attestation from the applicant's postdoctoral supervisor, if available, or a psychologist knowledgeable of the applicant's postdoctoral experience verifying that the applicant's postdoctoral experience meets the requirements in A.R.S. § 32-2071 (G). If the supervisor or knowledgeable psychologist is not available, the Board shall accept primary source verification received from the Association of State and Provincial Psychology Boards. In this subsection, "not available" means the supervisor or knowledgeable psychologist is deceased or all reasonable efforts to locate the supervisor or knowledgeable psychologist were unsuccessful;
6. Verification of all other psychology licenses or certificates ever held in any regulatory jurisdiction; and
7. An official notification of the applicant's score on the national examination. An applicant who passed the national examination in accordance with the standard established at A.R.S. § 32-2072(A), shall have the examination score sent directly to the Board by the Association of State and Provincial Psychology Boards or by the regulatory jurisdiction in which the applicant originally passed the examination.

R4-26-203.01. Application for Licensure by Credential

- A.** An applicant for a psychologist license by credential under A.R.S. § 32-2071.01 (D) shall submit an application packet to the Board that includes:
1. An application form, which is available from the Board office and on its website, signed and dated by the applicant, that contains the information required by R4-26-203(A)(1) through (4), (A)(5)(a) through (f), (A)(6), (A)(7), (A)(10), and R4-26-203 (B)(2) through (6);
 2. Verification sent directly to the Board by the credentialing agency that the applicant:

- a. Holds a current Certificate of Professional Qualification in Psychology (CPQ) issued by the Association of State and Provincial Psychology Boards;
 - b. Holds a current National Register of Health Service Providers in Psychology (NRHSPP) credential and has practiced psychology independently at the doctoral level for at least five years; or
 - c. Is a diplomate or specialist of the American Board of Professional Psychology (ABPP); and
3. Verification of all other psychology licenses or certificates ever held in any jurisdiction.
- B.** An applicant for a psychologist license by credential based on a National Register of Health Service Providers in Psychology credential shall have notification that the applicant obtain a passing score on the national examination sent directly to the Board by the Association of State and Provincial Psychology Boards or by the regulatory jurisdiction in which the applicant originally passed the examination.
- C.** If the Board determines that an application for licensure by credential requires clarification, the Board may require that an applicant submit or cause the applicant's credentialing agency to submit directly to the Board any documentation including transcripts, course descriptions, catalogues, brochures, supervised experience verifications, examination scores, application for credential, or any other information that is deemed necessary by the Board.

R4-26-203.02. Application to Take National Examination before Completing Supervised Professional Experience Required for Licensure

- A.** As provided under A.R.S. § 32-2072(C), an individual who has completed the education requirements specified in A.R.S. § 32-2071(A) but has not completed the supervised professional experience requirements specified in A.R.S. § 32-2071(D) may apply to the Board for approval to take the national examination.
- B.** To apply for approval under subsection (A), an individual shall submit to the Board the application form and applicable documents required under R4-26-203(A) through (C).
- C.** When the Board approves an individual who makes application under subsections (A) and (B), the Board shall administratively close the applicant's application packet.
- D.** An individual who is granted approval under subsection (C) to take the national examination may apply for an initial license under R4-26-203 after completing the supervised professional experience requirements specified in A.R.S. § 32-2071(D) as follows:
- 1. Within 36 months after the application was administratively closed under subsection (C), request that the Board re-open the application packet; and
 - 2. Submit the portions of the application packet required under R4-26-203 that were not submitted under subsection (B).

R4-26-203.03. Reapplication for License; Applying Anew

- A.** The following may reapply for a license:
1. An individual who failed the national examination required under A.R.S. § 32-2072 and R4-26-204 no more than three times, and
 2. An individual whose application submitted under R4-26-203 or R4-26-203.01 was administratively closed by the Board under R4-26-208(H) less than one year before reapplication.
- B.** An individual identified in subsection (A) may ask the Board to base a licensing decision, in part, on applicable forms and documents previously submitted.
- C.** An individual eligible under subsection (B) to reapply for licensure shall:
1. Submit a reapplication form, which is available from the Board office, to the Board;
 2. If previously submitted references were submitted more than 12 months before the date of reapplication, provide the names, positions, and addresses of at least two individual to serve as references who:
 - a. Are psychologists licensed or certified to practice psychology in a United States or Canadian regulatory jurisdiction and are not members of the Arizona Board of Psychologist Examiners;
 - b. Are familiar with the applicant's work experience in the field of psychology or in a postdoctoral program within the three years immediately before the date of reapplication. If more than three years have elapsed since the applicant last engaged in professional activities in the field of psychology or in a postdoctoral program, the references may pertain to the most recent three-year period in which the applicant engaged in professional activities in the field of psychology or in a postdoctoral program; and
 - c. Recommend the applicant for licensure;
 3. List all professional employment since the date of the most recent application or reapplication including:
 - a. Beginning and ending dates of employment,
 - b. Number of hours worked per week,
 - c. Name and address of employer,
 - d. Position title,
 - e. Nature of work, and
 - f. Nature of supervision;
 4. Submit the results of a self-query from the National Practitioner Data Bank—Healthcare Integrity and Protection Data Bank; and

5. Pay the fee required under R4-26-108(2).

D. The following shall apply anew for a license rather than reapplying:

1. An individual whose application submitted under R4-26-203 or R4-26-203.01 was denied by the Board,
2. An individual who was permitted by the Board to withdraw an application submitted under R4-26-203 or R4-26-203.01 before the Board acted on the application, and
3. An individual whose application submitted under R4-26-203 or R4-26-203.01 was administratively closed by the Board under R4-26-208(H) more than one year before another application is submitted.

R4-26-204. Examinations

A. General rules.

1. Under A.R.S. § 32-2072(C), an applicant who fails the national examination three times in any regulatory jurisdiction shall, before taking the national examination again, review the applicant's areas of deficiency and implement a program of study or practical experience designed to remedy the deficiencies. This remedial program may consist of any combination of course work, self-study, internship experience, and supervision.
2. An applicant required under subsection (A)(1) to implement a program of study or practical experience may apply anew for licensure. The applicant shall submit a new application packet, as described in R4-26-203, and include information about any actions proposed under subsection (A)(1).
3. Examination deadline. Unless the Board grants an extension, the Board shall administratively close the file of an applicant authorized by the Board to take an examination specified in subsection (B) or (C) who fails to take the examination within one year from the date of the Board's authorization. Upon written request to the Board's Executive Director received by the Board on or before the applicant's examination deadline, the Board shall grant the applicant one extension of up to six months to take the examination. The applicant may request additional extensions for good cause, which includes but is not limited to illness or injury of the licensee or a close family member, death of a close family member, birth or adoption of a child, military service, relocation, natural disaster, financial hardship, or residence in a foreign country for at least 12 months of the license period. The Board shall ensure that an extension is for no more than six months. This Section does not apply to an applicant approved to take the national examination under R4-26-203.02.
4. The Board shall deny a license if an applicant commits any of the following acts with respect to the examination:
 - a. Violates the confidentiality of examination materials;
 - b. Removes any examination materials from the examination room;
 - c. Reproduces any portion of a licensing examination;
 - d. Aids in the reproduction or reconstruction of any portion of a licensing examination;

- e. Pays or uses another person to take a licensing examination for the applicant or to reconstruct any portion of the licensing examination;
 - f. Obtains examination material, either before, during, or after an examination, for the purpose of instructing or preparing applicants for examinations;
 - g. Sells, distributes, buys, receives, or has possession of any portion of a future, current, or previously administered licensing examination that is not authorized by the Board or its authorized agent for release to the public;
 - h. Communicates with any other examinee during the administration of a licensing examination;
 - i. Copies answers from another examinee or permits the copying of answers by another examinee;
 - j. Possesses during the administration of a licensing examination any books, equipment, notes, written or printed materials, or data of any kind, other than material distributed during the examination; or
 - k. Impersonates another examinee.
- B. National examination.** Under A.R.S. § 32-2072, the Board shall require that an applicant take and pass the national examination. An applicant authorized by the Board to take the national examination passes the examination if the applicant's score equals or exceeds the passing score specified in A.R.S. § 32-2072(A). After the Board receives the examination results, the Board shall notify the applicant in writing of the results.
- C. Additional examination.**
- 1. The Board shall require an applicant to pass the national examination before allowing the applicant to take an additional examination.
 - 2. Under A.R.S. § 32-2072(B), the Board may administer an additional examination to an applicant to determine the adequacy of the applicant's knowledge and application of Arizona law. The additional examination may also cover the practice of psychology, ethical conduct, and psychological assessment and treatment practices.
 - a. The Board shall review and approve the additional examination before administration.
 - b. The additional examination may be developed and administered by the Board, a committee of the Board, consultants to the Board, or independent contractors.
 - c. Applicants, examiners, and consultants to the Board shall execute a security acknowledgment form and agree to maintain examination security.

R4-26-205. Renewal of License

- A.** A license issued by the Board, whether active or inactive, expires on April 30 of every odd-numbered year unless renewed.
- B.** The Board considers a license renewal application packet timely submitted if delivered or mailed to the Board's office and date stamped or postmarked on or before April 30 of the odd-numbered year in which the license expires.

- C. To renew a license, a licensee shall submit to the Board a renewal application form, which is available from the Board office and on its website, signed and dated by the licensee, and provide the following:
1. Personal information about the applicant:
 - a. Full name;
 - b. Other names by which the applicant is or ever has been known;
 - c. License number;
 - d. Home address and telephone number;
 - e. Business name and address;
 - f. Work telephone and fax numbers;
 - g. E-mail address;
 - h. Gender;
 - i. Date of birth;
 - j. Place of birth; and
 - k. Social Security number;
 2. An indication of the address and telephone number to be listed in the Board's public directory and used in correspondence;
 3. An indication whether the applicant is active military;
 4. A statement of whether the applicant:
 - a. Is in compliance with or exempt from the requirements of A.R.S. § 32-3211 regarding secure storage, transfer, and access to client or patient records and if not, explain;
 - b. Is currently licensed or certified as a psychologist in a regulatory jurisdiction other than Arizona and if so, the name of the regulatory jurisdiction and license number;
 - c. Is a licensed or certified member of another profession and if so, the name of the profession, regulatory jurisdiction, and license number;
 - d. Is a member of a hospital staff or provider panel and if so, the name of the hospital or panel;
 - e. Has completed the required 40 hours of continuing education and if not, an explanation of why the required hours have not been completed;
 - f. Has, during the last license period, been denied a license or certificate to practice any profession by any regulatory jurisdiction and if so, the name of the profession and regulatory jurisdiction and the reason for denial or a copy of the notice of denial;
 - g. Has, during the last license period, relinquished responsibilities, resigned a position, or been terminated while a complaint against the applicant was being investigated or adjudicated and if so, the dates and entity conducting the investigation or adjudication;
 - h. Has, during the last license period, resigned or been terminated from a professional organization, hospital staff, the military, or provider panel or surrendered a license while a complaint against the

applicant was being investigated or adjudicated and if so, the dates and entity conducting the investigation or adjudication;

- i. Has, during the last license period, been disciplined by an agency in any regulatory jurisdiction including the Arizona Board of Psychologist Examiners, the military, or a health care institution, provider panel, or ethics panel for acts pertaining to the applicant's conduct as a psychologist or as a professional in any other field and if so, the name and address of the agency, nature and date of the disciplinary action, and statement of the charges and findings;
- j. Is currently awaiting trial, has, during the last license period, been convicted of or pled no contest or guilty to any felony or a misdemeanor, other than a minor traffic offense (a DUI is not a minor traffic offense), or ever entered into a diversion program instead of prosecution, including any conviction that was expunged, deleted, or set aside in any state or country and if so, the convicting jurisdiction, offense, date of offense, status of resolution, expected resolution, a narrative explanation, and copies of relevant documents;
- k. Is currently under investigation by any professional organization, the military, health care institution, or provider panel of which the applicant is a member or on staff, or regulatory agency concerning the ethical propriety or legality of the applicant's conduct and if so, name of the entity involved and conduct at issue;
- l. Has, during the last license period, been sued or prosecuted for an act or omission relating to the applicant's practice as a psychologist, the applicant's work under a license or certificate in another profession, or the applicant's work as a member of a profession in which the applicant was not licensed or certified and if so, the name of the jurisdiction, allegation involved, date, and copies of relevant documents;
- m. Is delinquent in payment of a judgment for child support and if so, the court that issued and date of the support order;
- n. Has, during the last license period, had an application for membership in any professional organization rejected, or has had any professional organization suspend or revoke the applicant's membership, place the applicant on probation, or otherwise censure the applicant for unethical or unprofessional conduct or other violation of eligibility or membership requirements and if so, name of the professional organization and date of the action;
- o. Currently uses alcohol or another drug that in any way impairs or limits the applicant's ability to practice psychology safely and competently;
- p. Has a medical, physical, or psychological condition that may impair or limit the applicant's ability to practice psychology safely and competently; and
- q. Is submitting the renewal application timely and if not, whether the applicant has practiced psychology in Arizona since the license expired and if so, a complete explanation;

5. The license status for which application is made;
 - a. Active,
 - b. Inactive due to mental or physical disability,
 - c. Voluntary inactive,
 - d. Medical or inactive continuation, or
 - e. Retired. If retired status is requested, the applicant shall designate whether retired status is to be achieved by allowing the license to expire or requesting voluntary inactive status;
 6. The following information about the continuing education completed during the previous license period:
 - a. Title of the continuing education;
 - b. Date completed;
 - c. Sponsoring organization, publication, or educational institution;
 - d. Number of hours in the continuing education; and
 - e. Brief description of the continuing education;
 7. A signed attestation of the veracity of the information provided; and
 8. Any other information authorized by statute.
- D.** Additionally, to renew a license, a licensee shall submit to the Board:
1. The license renewal fee required under R4-26-108;
 2. If the documentation previously submitted under R4-26-203(B)(3) was a limited form of work authorization issued by the federal government, evidence that the work authorization has not expired; and
 3. The Board's Mandatory Confidential Information form.
- E.** If a completed application, including the information about continuing education completed, is timely submitted under subsections (C) and (D), the licensee may continue to practice psychology under the active license until notified by the Board that the application for renewal has been approved or denied. If the Board denies license renewal, the licensee may continue to practice psychology until the last day for seeking review of the Board's decision or a later date fixed by a reviewing court.
- F.** Under A.R.S. § 32-2074(B), the license of a licensee who fails to submit a renewal application, including the information about continuing education completed, on or before April 30 of an odd-numbered year expires and the licensee shall immediately stop practicing psychology.
- G.** A psychologists whose license expires under subsection (F) may have the license reinstated by submitting the following to the Board on or before June 30 of the year in which the license expired:
1. The license renewal application required under subsection (C), including the information about continuing education completed, and the documents required under subsections (D)(2) and (3); and
 2. The license renewal and reinstatement fees required under R4-26-108.

- H. A psychologist whose license expires under subsection (F) and who fails to have the license reinstated under subsection (G) may have the license reinstated by:
 - 1. Complying with subsections (G)(1) through (2) on or before the following April 30th, and
 - 2. Paying the delinquent compliance fee in R4-26-108.
- I. A psychologist whose license expires under subsection (F) and who fails to have the license reinstated under subsection (G) or (H) may be licensed again only by complying with R4-26-203.
- J. If the Board audits the continuing education records of a licensee and determines that some of the hours do not conform to the standards listed in R4-26-207, the Board shall disallow the non-conforming hours. If the remaining hours are less than the number required, the Board shall deem the licensee as failing to satisfy the continuing education requirements and provide notice of the disallowance to the licensee. The licensee has 90 days from the mailing date of the Board's notification of disallowance to complete the continuing education requirements for the past reporting period and shall provide the Board with an affidavit documenting completion. If the Board does not receive an affidavit within 90 days of the mailing date of notification of disallowance or the Board deems the affidavit insufficient, the Board may take disciplinary action under A.R.S. § 32-2081.

R4-26-206. Reinstatement of License from Inactive to Active Status; Cancellation of License

- A. Except as provided in subsection (C), when considering reinstatement of a psychologist from inactive to active status, the Board shall presume that the psychologist has maintained and updated the psychologist's professional knowledge and capability to practice as a psychologist if the psychologist presents to the Board documentation of completion of a prorated amount of continuing education, calculated under subsection (B).
- B. A psychologist who is on inactive status may reinstate the license to active status by presenting to the Board documentation of completion of at least 40 hours of continuing education that meets the standards in R4-26-207.
- C. A psychologist may request that the Board cancel the psychologist's license if the psychologist is not under investigation by any regulatory jurisdiction. Fees paid to obtain a license are not refundable when the license is cancelled. If an individual whose request for license cancellation is approved by the Board subsequently decides to practice psychology, the individual shall submit a new application under R4-26-203 and meet the requirements in A.R.S. § 32-2071.

R4-26-207. Continuing Education

- A. A licensee shall complete at least 40 hours of continuing education during each license period. Unless specified otherwise, one clock hour of instruction, training, or making a presentation equals one hour of continuing education.

- B.** During the license period in which an individual is initially licensed, the Board shall pro-rate the number of continuing education hours , including a pro-rated number of hours addressing ethics, domestic violence, intimate partner abuse, abuse of vulnerable adults, child abuse, and bullying that the new licensee must complete during the initial license period. To calculate the number of continuing education hours that a new licensee must obtain, the Board shall divide the 40 hours of continuing education required in a license period by 24 and multiply the quotient by the number of whole months from the date of initial licensure until the end of the license period. To determine the number of ethics hours required during the first license period, the licensee shall complete one hour of ethics for every six months from the month of license issuance to the end of the license period.
- C.** A licensee shall ensure that the continuing education hours obtained include at least four hours in each of the following:
1. Professional ethics; and
 2. Domestic violence, intimate partner abuse, child abuse, or abuse of vulnerable adults. The topic of bullying satisfies the requirement for child abuse.
- D.** If the standards in subsection (F) are met, the Board shall accept the following for continuing education hours. In completing the continuing education requirement, a licensee shall ensure that hours are obtained from participating in at least two of the following:
1. Post-doctoral study sponsored by a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1) and provides a graduate-level degree program ;
 2. A course, seminar, workshop, or home study for which a certificate of completion is provided;
 3. A continuing education program offered by a national, international, regional, or state association, society, board, or continuing education provider;
 4. Teaching a graduate-level course in applied psychology at a university or college that is regionally accredited under A.R.S. § 32-2071(A)(1). A licensee who teaches a graduate-level course in applied psychology receives the same number of continuing education hours as number of classroom hours for those who take the graduate-level course;
 5. Organizing and presenting a continuing education activity. A licensee who organizes and presents a continuing education activity receives the same number of continuing education hours as those who attend the continuing education activity;
 6. Attending a Board meeting or serving as a member of the Board. A licensee receives up to six continuing education hours in professional ethics for attending both morning and afternoon sessions of a Board meeting and three continuing education hours for attending either the morning or afternoon session or at least four hours of a Board meeting. A licensee shall complete documentation provided by the Board at the time the licensee attends a Board meeting. During a license period, the Board shall not accept from a licensee more than 10 continuing education hours obtained by attending a Board meeting;

7. Serving as a complaint consultant. During a license period, a licensee who serves as a Board complaint consultant to review Board complaints and provide a written report to the Board may receive continuing education hours equal to the actual number of hours served as a complaint consultant to a maximum of 20 hours;
 8. Having an authored or co-authored psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published. A licensee who has an authored or co-authored psychology book, psychology book chapter, or article in a peer-reviewed psychology journal published receives 10 continuing education hours in the year of publication;
 9. Participating in a study group for professional growth and development as a psychologist. A licensee receives one hour of continuing education for each hour of participation to a maximum of 10 continuing education hours for participating in a study group. The Board shall allow continuing education hours for participating in a study group only if the licensee maintains the documentation required under subsection (G)(5);
 10. Presenting a symposium or paper at a state, regional, national, or international psychology meeting. A licensee who presents a symposium or paper receives the same number of continuing education hours as hours of the session, as published in the agenda of the meeting, at which the symposium or paper is presented to a maximum of 10 continuing education hours in a license period;
 11. Presenting a poster during a poster session at a state, regional, national, or international psychology meeting. A licensee who presents a poster receives an hour of continuing education for each hour the licensee is physically present with the poster during the poster session, as published in the agenda of the meeting, to a maximum of 10 continuing education hours in a license period; and
 12. Serving as an elected officer of an international, national, regional, or state psychological association or society. A licensee who serves as an elected officer may receive continuing education hours equal to the actual number of hours served to a maximum of 10 continuing education hours in a license period.
- E.** The Board shall not allow continuing education credit more than once in a license period for:
1. Teaching the same graduate-level course,
 2. Organizing and presenting a continuing education activity on the same topic or content area, or
 3. Presenting the same symposium or paper at a state, regional, national, or international psychology meeting.
- F.** Standards for continuing education. To be acceptable for continuing education credit, an activity identified in subsections (D)(1) through (4) shall:
1. Focus on the practice of psychology, as defined at A.R.S. § 32-2061(8), for at least 75 percent of the program hours; and
 2. Be taught by an instructor who is:

- a. Currently licensed or certified in the instructor’s profession or works at least 20 hours each week as a faculty member at a regionally accredited college or university;
 - b. A fellow diplomate, or specialist; or
 - c. Readily identifiable as competent in the subject of the continuing education by having an advanced degree, teaching experience, work history, published professional articles, or previously presented continuing education on the same subject .
- G.** The Board shall accept the following documents as evidence of completion of continuing education hours:
- 1. A certificate of attendance;
 - 2. Statement signed by the provider verifying participation in the activity;
 - 3. Official transcript;
 - 4. Documents indicating a licensee’s participation as an elected officer or appointed member as specified in subsection (D)(12); or
 - 5. An attestation signed by all participants of a study group under subsection (D)(9) that includes a description of the activity, subject covered, dates, and number of hours .
- H.** A licensee shall maintain the documents listed in subsection (G) through the license period following the license period in which the documents were obtained.
- I.** The Board may audit a licensee’s compliance with continuing education requirements. The Board may deny renewal or take other disciplinary action against a licensee who fails to obtain or document required continuing education hours. The Board may discipline a licensee who commits fraud, deceit, or misrepresentation regarding continuing education hours.
- J.** A licensee who cannot meet the continuing education requirement for good cause may seek an extension of time to complete the continuing education requirement by submitting a written request to the Board with the timely submission of the renewal application required under R4-26-205.
- 1. Good cause includes but is not limited to illness or injury of the licensee or a close family member, death of a close family member, birth or adoption of a child, military service, relocation, natural disaster, financial hardship, or residence in a foreign country for at least 12 months of the license period.
 - 2. The Board shall not grant an extension longer than one year.
 - 3. A licensee who cannot complete the continuing education requirement within the extension may apply to the Board for inactive license status under A.R.S. § 32-2073 (G).
- K.** No continuing education hours may be carried over to the next licensing period.
- L.** The Board shall not accept for continuing education hours a course, workshop, seminar, or symposium designed to increase income or office efficiency.

R4-26-208. Time Frames for Processing Applications

- A.** For the purpose of A.R.S. § 41-1073, the Board establishes the time frames listed in Table 1. An applicant or a person requesting an approval from the Board and the Board’s Executive Director may agree in writing to extend the substantive review and overall time frames by no more than 25 percent of the overall time frame.
- B.** The administrative completeness review time frame begins when the Board receives an application packet or request for approval. During the administrative completeness review time frame, the Board shall notify the applicant or person requesting approval that the application packet or request for approval is either complete or incomplete. If the application packet or request for approval is incomplete, the Board shall specify in the notice what information is missing.
- C.** If an applicant or person requesting approval receives a notice of incompleteness under subsection (B), the applicant or person requesting approval shall submit the missing information to the Board within the time to complete listed in Table 1. Both the administrative completeness review and overall time frames are suspended from the date of the Board’s notice under subsection (B) until the Board receives all of the missing information.
- D.** Upon receipt of all missing information, the Board shall send a written notice of administrative completeness to the applicant or person requesting approval. The Board shall not send a separate notice of completeness if the Board grants or denies a license or approval within the administrative completeness time frame listed in Table 1.
- E.** The substantive review time frame listed in Table 1 begins on the date of the Board’s notice of administrative completeness sent under subsection (D).
- F.** If the Board determines during the substantive review that additional information is needed, the Board shall send the applicant or person requesting approval a comprehensive written request for additional information.
- G.** An applicant or person requesting approval who receives a request under subsection (F) shall submit the additional information to the Board within the time for response listed in Table 1. Both the substantive review and overall time frames are suspended from the date of the Board’s request until the Board receives the additional information.
- H.** An applicant or person requesting approval may receive a 30-day extension of the time provided under subsection (C) or (G) by providing written notice to the Board before the time expires. If an applicant or person requesting approval fails to submit to the Board the missing or additional information within the time provided under Table 1 or the time as extended, the Board shall administratively close the applicant’s or person’s file.
- I.** At any time before the overall time frame provided in Table 1 expires, an applicant or person requesting approval may, with approval by the Board, withdraw the application or request.
- J.** Within the overall time frame listed in Table 1, the Board shall:

1. Grant a license or approval if the Board determines that the applicant or person requesting approval meets all criteria required by statute and this Chapter; or
 2. Deny a license or approval if the Board determines that the applicant or person requesting approval does not meet all criteria required by statute and this Chapter.
- H.** If the Board denies a license or approval, the Board shall send the applicant or person requesting approval a written notice explaining:
1. The reason for denial, with citations to supporting statutes or rules;
 2. The right to appeal the denial by filing an appeal under A.R.S. Title 41, Chapter 6, Article 10;
 3. The time for appealing the denial; and
 4. The right to request an informal settlement conference.
- I.** If the last day of a time frame falls on a Saturday, Sunday, or an official state holiday, the time frame ends on the next business day.

Table 1. Time Frames (in days) for Processing Applications

Type of Application or Request	Statutory or Rule Authority	Administrative Completeness Time Frame	Time to Respond to Notice of Deficiency	Substantive Review Time Frame	Time to Respond to Request for Additional Information	Overall Time Frame
Application for initial license	A.R.S. §§ 32-2071, 32-2071.01, 32-2072, and R4-26-203	30	240	90	240	120
Application for licensure by credential	A.R.S. §§ 32-2071.01, 32-2072; and A.A.C. R4-26-203.01	30	240	90	240	120
Application to Take National Examination before	A.R.S. §§ 32-2072(C) and A.A.C. R4-26-203.02	30	240	90	240	120

Completing Experience Required for Licensure						
Reapplication for Licensure	A.R.S. §§ 32-2067 and A.A.C. R4-26-203.03	30	240	90	240	120
Application for license renewal	A.R.S. § 32-2074; A.A.C. R4-26-205	60	N/A	90	N/A	150
Application for reinstatement of expired license	A.R.S. § 32-2074; A.A.C. R4-26-206	60	N/A	90	N/A	150
Request for extension of time to complete continuing education	A.R.S. § 32-2074 A.A.C. R4-26-207	60	N/A	90	N/A	150

R4-26-209. General Supervision

- A. Under A.R.S. § 32-2071(D), an applicant is required to obtain 3,000 hours of supervised professional experience.
- B. A supervising psychologist shall not supervise a member of the psychologist’s immediate family or the psychologist’s employer or business partner.
- C. Payment between a supervisor and supervisee.
 1. A supervising psychologist may pay a monetary stipend or fee to a supervisee if the amount paid by the supervisor is not based on the supervisee’s productivity or revenue generated by the supervisee;
 2. A supervising psychologist who accepts a fee for providing the supervisory service in Arizona may be subject to disciplinary action by the Board; and

3. The Board shall look to the law of the jurisdiction in which the supervision occurred to determine whether to include as part of the 3,000 hours of supervised professional experience required under A.R.S. § 32-2071(D) hours for which an applicant paid the supervisor.
- D.** A psychologist who supervises the professional experience of an unlicensed individual is professionally responsible for all work done by the individual during the supervised experience.
- E.** The Board shall include in the 3,000 hours of supervised professional experience required under A.R.S. § 32-2071(D), hours obtained through a training program only if the training program provides the supervision required under A.R.S. § 32-2071(F)(2).

R4-26-210. Supervised Professional Experience

- A.** The Board shall use the following criteria to determine whether an applicant’s supervised preinternship professional experience complies with A.R.S. § 32-2071 (E):
1. The supervised preinternship professional experience was part of the applicant’s doctoral program from an institution of higher education that meets the standards in A.R.S. § 32-2071(A);
 2. The applicant completed appropriate academic preparation before beginning the supervised preinternship professional experience. The Board shall not include any assessment or treatment conducted as part of the required academic preparation in the hours of supervised preinternship professional experience; and
 3. For each supervised preinternship professional experience training site, the applicant has a written training plan with both the training site and the institution of higher education at which the applicant is pursuing a doctoral degree that includes at least the following:
 - a. Training activities included and the amount of time allotted to each activity,
 - b. Goals and objectives of each training activity,
 - c. Methods of evaluating the supervisee and the supervised preinternship professional experiences provided,
 - d. Approval of all individuals providing supervision at sites external to the training site,
 - e. Total number of hours to be accrued during the supervised preinternship professional experience,
 - f. Total number of hours of face-to-face contact hours with clients or patients during the supervised preinternship professional experience,
 - g. Total number of hours of supervision during the supervised preinternship professional experience,
 - h. Qualifications of all individuals who provide supervision during the supervised preinternship professional experience, and
 - i. Acknowledgement that ethics training will be included in all activities.
- B.** The Board shall use the following criteria to determine whether an applicant’s internship or training program qualifies as supervised professional experience under A.R.S. § 32-2071 (F):
1. The written statement required under A.R.S. § 32-2071 (F)(9):

- a. Was established no later than the time the applicant entered the internship or training program; and
 - b. Corresponds to the internship or training program the applicant completed;
2. A supervisor was directly available to the applicant when decisions were made regarding emergency psychological services provided to a client or patient as required under A.R.S. § 32-2071 (F)(2);
 3. Course work used to satisfy the requirements of A.R.S. § 32-2071(A) or dissertation time is not credited toward the face-to-face, individual supervision time required by A.R.S. § 32-2071 (F)(6);
 4. The two hours a week of other learning activities required under A.R.S. § 32-2071 (F)(6) include one or more of the following
 - a. Case conferences involving a case in which the applicant was actively involved,
 - b. Seminars involving clinical issues,
 - c. Co-therapy with a professional staff person including discussion,
 - d. Group supervision, or
 - e. Additional individual supervision;
 5. The training program had the applicant work with other doctoral level psychology trainees and included in the written statement required under A.R.S. § 32-2071 (F)(9) a description of the program policy specifying the opportunities and resources provided to the applicant for working or interacting with other doctoral level psychology trainees in the same or other sites; and
 6. Time spent fulfilling academic degree requirements, such as course work applied to the doctoral degree, practicum, field laboratory, dissertation, or thesis credit, is not credited toward the 1,500 hours of supervised professional experience hours required by A.R.S. § 32-2071 (F). This subsection does not restrict a student from participating in activities designed to fulfill other doctoral degree requirements. However, the Board shall not credit time spent participating in activities to fulfill academic degree requirements toward the hours required under A.R.S. § 32-2071 (F).
- C. Under A.R.S. § 32-2071(G)(5), at least 40 percent of an applicant's supervised postdoctoral experience shall involve direct client or patient contact. If an applicant's supervised postdoctoral hours applied toward licensure include less than 40 percent direct contract hours, the applicant shall work additional time to achieve the required percentage of direct contact hours.

R4-26-211. Foreign Graduates

- A. Under A.R.S. § 32-2071(B), an applicant for licensure whose application is based on graduation from an institution of higher education located outside the U.S. and its territories shall demonstrate that the applicant's formal education is equivalent to a doctoral degree in psychology from a regionally accredited educational institution as described in A.R.S. § 32-2071(A).

- B.** The Board shall find that the institution of higher education from which an applicant under subsection (A) graduated is equivalent to a regionally accredited education institution only if the institution of higher education is included in one of the following:
 - 1. International Handbook of Universities, published for the International Association of Universities by Stockton Press, 345 Park Avenue South, 10th floor, New York, NY 10010-1708;
 - 2. Commonwealth Universities Yearbook, published for the Association of Commonwealth Universities by John Foster House, 36 Gordon Square, London, England, WC1H 0PF; or
 - 3. Another source the Board determines provides reliable information.
- C.** The academic transcript of an applicant under subsection (A) who graduated from an institution included under subsection (B) shall be translated into English and evaluated by a member organization of the National Association of Credential Evaluation Services (NACES). The applicant is responsible for paying all expenses incurred to obtain a translation and review of the academic transcript. An applicant can find information about obtaining a professional credential review at www.naces.org.
- D.** When the credential review required under subsection (C) is completed, the NACES member organization shall submit the review report to the Board. The Board shall review the report and determine whether the applicant's education meets the standard in subsection (A).
- E.** Upon written request, the Board may waive the credential review required under subsection (C) for an applicant who graduated from a doctoral program that is accredited by the accreditation panel of the Canadian Psychological Association.
- F.** After the Board determines that the formal education of an applicant under subsection (A) is equivalent to a doctoral degree in psychology from a regionally accredited educational institution, the applicant shall provide evidence to the Board that the applicant has met all other requirements for licensure.

ARTICLE 3. REGULATION

R4-26-301. Rules of Professional Conduct

- A.** The Board incorporates by reference standards 1.01 through 10.10 of the "Ethical Principles of Psychologists and Code of Conduct" adopted by the American Psychological Association, effective June 1, 2003. The incorporated materials do not include any later amendments or editions. A copy of the standards is available from the American Psychological Association Order Department, 750 First Street, NE, Washington, DC 20002-4242, www.apa.org/ethics/code, or the Board office.
- B.** A licensee shall practice psychology in accordance with the standards incorporated under subsection (A).

R4-26-302. Informal Interviews

- A. When a complaint is scheduled for informal interview, the Board shall send written notice of an informal interview to the licensee who is the subject of the complaint, by personal service or certified mail, return receipt requested, at least 20 days before an informal interview.
- B. The Board shall include the following in the written notice of an informal interview:
 - 1. The time, date, and place of the interview;
 - 2. An explanation of the informal nature of the proceedings;
 - 3. The licensee’s right to appear at the informal interview with legal counsel licensed in Arizona or without legal counsel;
 - 4. A statement of the allegations and issues involved;
 - 5. The licensee’s right to a formal hearing instead of the informal interview; and
 - 6. Notice that the Board may take disciplinary action at the conclusion of the informal interview;
- C. The procedure used during an informal interview may include the following:
 - 1. Swearing in and taking testimony from the licensee, complainant, and witnesses, if any;
 - 2. Optional opening and closing remarks by the licensee;
 - 3. An opportunity for the complainant to address the Board, if requested;
 - 4. Board questions to the licensee, complainant, and witnesses, if any; and
 - 5. Deliberation and discussion by the Board.

R4-26-303. Titles

A person shall not use a title that claims a potential or future degree or qualification such as “Ph.D. (Cand),” “Ph.D. (ABD),” “License Eligible,” “Candidate for Licensure,” or “Board Eligible.” The use of a title that claims a potential or future degree or qualification is a violation of A.R.S. § 32-2061 et seq.

R4-26-304. Representation before the Board by Attorney Not Admitted to State Bar of Arizona

An attorney who is not a member of the State Bar of Arizona shall not represent a party before the Board unless the attorney is admitted to practice pro hac vice before the Board under Rule 38(a) of the Rules of the Supreme Court of Arizona.

R4-26-305. Confidentiality of Investigative Materials

- A. A psychologist shall not disclose a confidential record, as defined by R4-26-101, that relates to a Board investigation to any person or entity other than the psychologist’s attorney, except:
 - 1. A redacted summary that ensures the anonymity of the client or patient;

2. Information regarding the nature of a complaint, the processes utilized by the Board, and the outcomes of a case;
3. As required by law;
4. As required by a court order compelling production; or
5. If disclosure is protected under the United States or Arizona Constitutions.

B. A psychologist who violates this Section commits an act of unprofessional conduct.

R4-26-308. Rehearing or Review of Decision

- A.** Except as provided in subsection (G), any party in a contested case or appealable agency action before the Board who is aggrieved by a Board order or decision may file with the Board, not later than 30 days after service of the decision, a written motion for rehearing or review of the decision specifying the particular grounds for rehearing or review. For purposes of this subsection, service is complete on personal service or five days after the date that a Board order or decision is mailed to the party's last known address.
- B.** A motion for rehearing or review may be amended at any time before it is ruled upon by the Board. A party may file a response within 15 days after service of the motion or amended motion by any other party. The Board may require written briefs regarding the issues raised in the motion and may provide for oral argument.
- C.** The Board may grant rehearing or review of a Board order or decision for any of the following causes materially affecting the moving party's rights:
 1. An irregularity in the administrative proceedings of the agency, its hearing officer, or the prevailing party, or any order or abuse of discretion that caused the moving party to be deprived of a fair hearing;
 2. Misconduct of the Board, its hearing officer, or the prevailing party;
 3. An accident or surprise that could not be prevented by ordinary prudence;
 4. Newly discovered material evidence that could not with reasonable diligence be discovered and produced at the original hearing;
 5. Excessive or insufficient penalties;
 6. An error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing or during the progress of the case; or
 7. The order or decision is not justified by the evidence or is contrary to law.
- D.** The Board may affirm or modify a Board order or decision or grant a rehearing or review to all or any of the parties, on all or part of the issues, for any of the reasons specified in subsection (C). An order granting a rehearing or review shall specify the grounds on which the rehearing or review is granted, and the rehearing or review shall cover only the matters specified.
- E.** Not later than 30 days after a Board order or decision is rendered, the Board may on its own initiative order a rehearing or review of its order or decision for any reason specified in subsection (C). After giving the parties

or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or review for a reason not stated in the motion.

- F.** When a motion for rehearing or review is based on affidavits, the party shall serve the affidavits with the motion. An opposing party may, within 15 days after service, serve opposing affidavits. The Board for good cause or by written agreement of all parties may extend the period for service of opposing affidavits to a total of 20 days. Reply affidavits are permitted.
- G.** If the Board finds that the immediate effectiveness of a Board order or decision is necessary to preserve public peace, health, or safety and that a rehearing or review of the Board order or decision is impracticable, unnecessary, or contrary to the public interest, the Board order or decision may be issued as a final order or decision without an opportunity for a rehearing or review. If a Board order or decision is issued as a final order or decision without an opportunity for rehearing or review, any application for judicial review of the order or decision shall be made within the time permitted for final orders or decisions.
- H.** For purposes of this Section, “contested case” is defined in A.R.S. § 41-1001 and “appealable agency action” is defined in A.R.S. § 41-1092.
- I.** A person who files a complaint with the Board against a licensee:
 - 1. Is not a party to:
 - a. A Board administrative action, decision, or proceeding; or
 - b. A court proceeding for judicial review of a Board decision under A.R.S. §§ 12-901 through 12-914;
and
 - 2. Is not entitled to seek rehearing or review of a Board action or decision under this Section.

R4-26-309. Complaints against Judicially Appointed Psychologists

- A. A.R.S. § 32-2081(B) applies when a complaint is filed against a psychologist who conducts an evaluation, treatment, or psycho-education under a court order even if the psychologist is not specifically named in the court order.
- B. If a complaint is filed against a psychologist who conducts an evaluation, treatment, or psycho-education under a court order, the Board shall return the complaint to the complainant with instructions that the court issuing the order must find there is a substantial basis to refer the complaint for consideration by the Board.

R4-26-310. Disciplinary Supervision

- A. If the Board determines, after a hearing conducted under A.R.S. Title 41, Chapter 6, Article 10, after an informal interview under A.R.S. § 32-2081(K), or through an agreement with the Board, that to protect public health and safety and ensure a licensee's ability to engage safely in the practice of psychology, it is necessary to require that the licensee practice psychology for a specified term under the supervision of another licensee, the Board shall enter into an agreement with the licensee regarding the disciplinary supervision.
- B. Payment between a supervisor and supervisee.
 - 1. A licensed psychologist who enters into an agreement with the Board or is ordered by the Board to practice psychology under the supervision of another licensee may pay the supervising licensee for the supervisory service; and
 - 2. A licensed psychologist who provides supervisory service to a licensed psychologist who has been ordered by the Board or entered into an agreement with the Board to practice psychology under supervision may accept payment for the supervisory service.
- C. A licensed psychologist who supervises a licensed psychologist who has entered an agreement with the Board or been ordered by the Board to practice psychology under supervision is professionally responsible only for work specified in the agreement or order.

32-2061. Definitions

In this chapter, unless the context otherwise requires:

1. "Active license" means a valid and existing license to practice psychology.
2. "Adequate records" means records containing, at a minimum, sufficient information to identify the client or patient, the dates of service, the fee for service, the payments for service, the type of service given and copies of any reports that may have been made.
3. "Board" means the state board of psychologist examiners.
4. "Client" means a person or an entity that receives psychological services. A corporate entity, a governmental entity or any other organization may be a client if there is a professional contract to provide services or benefits primarily to an organization rather than to an individual. If an individual has a legal guardian, the legal guardian is the client for decision-making purposes, except that the individual receiving services is the client or patient for:
 - (a) Issues that directly affect the physical or emotional safety of the individual, such as sexual or other exploitative relationships.
 - (b) Issues that the guardian agrees to specifically reserve to the individual.
5. "Exploit" means actions by a psychologist who takes undue advantage of the professional association with a client or patient, a student or a supervisee for the advantage or profit of the psychologist.
6. "Health care institution" means a facility as defined in section 36-401.
7. "Letter of concern" means an advisory letter to notify a psychologist that while there is insufficient evidence to support disciplinary action the board believes the psychologist should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the board may result in action against the psychologist's license.
8. "Patient" means a person who receives psychological services. If an individual has a legal guardian, the legal guardian is the client or patient for decision-making purposes, except that the individual receiving services is the client or patient for:
 - (a) Issues that directly affect the physical or emotional safety of the individual, such as sexual or other exploitative relationships.
 - (b) Issues that the guardian agrees to specifically reserve to the individual.
9. "Practice of psychology" means the psychological assessment, diagnosis, treatment or correction of mental, emotional, behavioral or psychological abilities, illnesses or disorders or purporting or attempting to do this consistent with section 32-2076.
10. "Psychological service" means all actions of the psychologist in the practice of psychology.
11. "Psychologically incompetent" means a person lacking in sufficient psychological knowledge or skills to a degree likely to endanger the health of clients or patients.
12. "Psychologist" means a natural person holding a license to practice psychology pursuant to this chapter.
13. "Supervisee" means any person who functions under the extended authority of the psychologist to provide, or while in training to provide, psychological services.
14. "Telepractice" means providing psychological services through interactive audio, video or electronic communication that occurs between the psychologist and the patient or client, including any electronic communication for diagnostic, treatment

or consultation purposes in a secure platform, and that meets the requirements of telemedicine pursuant to section 36-3602. Telepractice includes supervision.

15. "Unprofessional conduct" includes the following activities whether occurring in this state or elsewhere:

- (a) Obtaining a fee by fraud or misrepresentation.
- (b) Betraying professional confidences.
- (c) Making or using statements of a character tending to deceive or mislead.
- (d) Aiding or abetting a person who is not licensed pursuant to this chapter in representing that person as a psychologist.
- (e) Gross negligence in the practice of a psychologist.
- (f) Sexual intimacies or sexual intercourse with a current client or patient or a supervisee or with a former client or patient within two years after the cessation or termination of treatment. For the purposes of this subdivision, "sexual intercourse" has the same meaning prescribed in section 13-1401.
- (g) Engaging or offering to engage as a psychologist in activities not congruent with the psychologist's professional education, training and experience.
- (h) Failing or refusing to maintain and retain adequate business, financial or professional records pertaining to the psychological services provided to a client or patient.
- (i) Commission of a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case, conviction by a court of competent jurisdiction or a plea of no contest is conclusive evidence of the commission.
- (j) Making a fraudulent or untrue statement to the board or its investigators, staff or consultants.
- (k) Violating any federal or state laws or rules that relate to the practice of psychology or to obtaining a license to practice psychology.
- (l) Practicing psychology while impaired or incapacitated to the extent and in a manner that jeopardizes the welfare of the client or patient or renders the psychological services provided ineffective.
- (m) Using fraud, misrepresentation or deception to obtain or attempt to obtain a psychology license or to pass or attempt to pass a psychology licensing examination or in assisting another person to do so.
- (n) Unprofessional conduct in another jurisdiction that resulted in censure, probation or a civil penalty or in the denial, suspension, restriction or revocation of a certificate or license to practice as a psychologist.
- (o) Providing services that are unnecessary or unsafe or otherwise engaging in activities as a psychologist that are unprofessional by current standards of practice.
- (p) Falsely or fraudulently claiming to have performed a professional service, charging for a service or representing a service as the licensee's own when the licensee has not rendered the service or assumed supervisory responsibility for the service.
- (q) Representing activities or services as being performed under the licensee's supervision if the psychologist has not assumed responsibility for them and has not exercised control, oversight and review.
- (r) Failing to obtain a client's or patient's informed and written consent to release personal or otherwise confidential information to another party unless the release is otherwise authorized by law.

- (s) Failing to make client or patient records in the psychologist's possession promptly available to another psychologist licensed pursuant to this chapter on receipt of proper authorization to do so from the client or patient, a minor client's or patient's parent, the client's or patient's legal guardian or the client's or patient's authorized representative or failing to comply with title 12, chapter 13, article 7.1.
- (t) Failing to take reasonable steps to inform or protect a client's or patient's intended victim and inform the proper law enforcement officials in circumstances where the psychologist becomes aware during the course of providing or supervising psychological services that a client or patient intends or plans to inflict serious bodily harm to another person.
- (u) Failing to take reasonable steps to protect a client or patient in circumstances where the psychologist becomes aware during the course of providing or supervising psychological services that a client or patient intends or plans to inflict serious bodily harm to self.
- (v) Abandoning or neglecting a client or patient in need of immediate care without making suitable arrangements for continuation of the care.
- (w) Engaging in direct or indirect personal solicitation of clients or patients through the use of coercion, duress, undue influence, compulsion or intimidation practices.
- (x) Engaging in false, deceptive or misleading advertising.
- (y) Exploiting a client or patient, a student or a supervisee.
- (z) Failing to report information to the board regarding a possible act of unprofessional conduct committed by another psychologist licensed pursuant to this chapter unless this reporting violates the psychologist's confidential relationship with the client or patient pursuant to section 32-2085. Any psychologist who reports or provides information to the board in good faith is not subject to an action for civil damages. For the purposes of this subdivision, it is not an act of unprofessional conduct if a licensee addresses an ethical conflict in a manner that is consistent with the ethical standards contained in the document entitled "ethical principles of psychologists and code of conduct" as adopted by the American psychological association and in effect at the time the licensee makes the report.
- (aa) Violating a formal board order, consent agreement, term of probation or stipulated agreement issued under this chapter.
- (bb) Failing to furnish information in a timely manner to the board or its investigators or representatives if requested or subpoenaed by the board as prescribed by this chapter.
- (cc) Failing to make available to a client or patient or to the client's or patient's designated representative, on written request, a copy of the client's or patient's record, including raw test data, psychometric testing materials and other information as provided by law.
- (dd) Violating an ethical standard adopted by the board.

32-2062. Board; qualifications; appointments; terms; compensation; immunity

A. The state board of psychologist examiners is established consisting of nine members appointed by the governor pursuant to section 38-211.

B. Each member of the board shall be a citizen of the United States and a resident of this state at the time of appointment. Six members shall be licensed pursuant to this chapter, and three shall be public members who are not eligible for licensure.

The board shall have at all times, except for the period when a vacancy exists, at least two members who are licensed as psychologists and who are full-time faculty members from universities in this state with a doctoral program in psychology that meets the requirements of section 32-2071 and at least three members who are psychologists in professional practice. The public members shall not have a substantial financial interest in the health care industry and shall not have a household member who is eligible for licensure under this chapter.

C. Each member shall serve for a term of five years beginning and ending on the third Monday in January.

D. A vacancy on the board occurring other than by the expiration of term shall be filled by appointment by the governor for the unexpired term as provided in subsection C of this section. The governor, after a hearing, may remove any member of the board for misconduct, incompetency or neglect of duty.

E. Board members shall receive compensation in the amount of one hundred dollars for each cumulative eight hours of actual service in the business of the board and reimbursement of all expenses pursuant to title 38, chapter 4, article 2.

F. Members of the board and its employees, consultants and test examiners are personally immune from suit with respect to all acts done and actions taken in good faith and in furtherance of the purposes of this chapter.

32-2063. Powers and duties

A. The board shall:

1. Administer and enforce this chapter and board rules.
2. Regulate disciplinary actions, the granting, denial, revocation, renewal and suspension of licenses and the rehabilitation of licensees pursuant to this chapter and board rules.
3. Prescribe the forms, content and manner of application for licensure and renewal of licensure and set deadlines for the receipt of materials required by the board.
4. Keep a record of all licensees, board actions taken on all applicants and licensees and the receipt and disbursement of monies.
5. Adopt an official seal for attestation of licenses and other official papers and documents.
6. Investigate charges of violations of this chapter and board rules and orders.
7. Subject to title 41, chapter 4, article 4, employ an executive director who serves at the pleasure of the board.
8. Annually elect from among its membership a chairman, a vice-chairman and a secretary, who serve at the pleasure of the board.
9. Adopt rules pursuant to title 41, chapter 6 to carry out this chapter and to define unprofessional conduct.
10. Engage in a full exchange of information with other regulatory boards and psychological associations, national psychology organizations and the Arizona psychological association and its components.
11. By rule, adopt a code of ethics relating to the practice of psychology. The board shall base this code on the code of ethics adopted and published by the American psychological association. The board shall apply the code to all board enforcement policies and disciplinary case evaluations and development of licensing examinations.

12. Adopt rules regarding the use of telepractice on or before June 30, 2016.
- B. Subject to title 41, chapter 4, article 4, the board may employ personnel it deems necessary to carry out this chapter. The board, in investigating violations of this chapter, may employ investigators who may be psychologists. The board or its executive director may take and hear evidence, administer oaths and affirmations and compel by subpoena the attendance of witnesses and the production of books, papers, records, documents and other information relating to the investigation or hearing.
- C. Subject to section 35-149, the board may accept, expend and account for gifts, grants, devises and other contributions, money or property from any public or private source, including the federal government. The board shall deposit, pursuant to sections 35-146 and 35-147, monies received pursuant to this subsection in special funds for the purpose specified, and monies in these funds are exempt from the provisions of section 35-190 relating to lapsing of appropriations.
- D. Compensation for all personnel shall be determined pursuant to section 38-611.

32-2064. Meetings; committees; quorum

- A. The board shall hold regular quarterly meetings at a time and place determined by the chairman. The board shall hold special meetings the chairman determines necessary to carry out the functions of the board.
- B. The chairman may establish committees from the board membership necessary to carry out the functions of the board. The board may establish committees of licensed psychologists to act as consultants to the board. Members of consultant committees are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2.
- C. A majority of board members constitutes a quorum and a majority vote of a quorum present is necessary for the board to take any action.

32-2065. Board of psychologist examiners fund; account

- A. The board of psychologist examiners fund is established.
- B. Except as provided in section 32-2081 and section 32-2091.09, subsection J, pursuant to sections 35-146 and 35-147, the board shall deposit ten per cent of all monies collected pursuant to this chapter in the state general fund and deposit the remaining ninety per cent in the board of psychologist examiners fund.
- C. All monies deposited in the board of psychologist examiners fund are subject to section 35-143.01.
- D. All monies deposited in the board of psychologist examiners fund pursuant to 32-2067 and any monies received pursuant to section 32-2063, subsection C for psychologist licensing and regulation must be used only for the licensing and regulation of psychologists pursuant to this article and articles 2 and 3 of this chapter and may not be used for the licensing and regulation of behavior analysts pursuant to article 4 of this chapter.
- E. All monies deposited in the board of psychologist examiners fund pursuant to article 4 of this chapter and any monies received pursuant to section 32-2063, subsection C for behavior analyst licensing and regulation must be used only for the licensing and regulation of behavior analysts pursuant to article 4 of this chapter

and may not be used for the licensing and regulation of psychologists pursuant to this article and articles 2 and 3 of this chapter.

F. The board shall establish a separate account in the fund for monies transferred to the fund pursuant to article 4 of this chapter and any monies received pursuant to section 32-2063, subsection C for behavior analyst licensing and regulation.

32-2066. Directory; change of address; costs; civil penalty

A. The board shall compile and publish on its web site a directory containing:

1. The names and addresses of the officers and members of the board.
2. The names and addresses of all licensees.
3. The current board rules.
4. A copy of this chapter.
5. Additional information the board deems of interest and importance to licensees.

B. A licensee shall inform the board in writing of the licensee's current residence address, office address and telephone number within thirty days of each change in this information. The board may assess the costs incurred by the board in locating a licensee and may assess a civil penalty of not more than one hundred dollars against a licensee who fails to notify the board within thirty days from the date of any change of information required to be reported under this subsection.

32-2067. Fees; alternative payment methods

A. The board, by a formal vote at its annual fall meeting, may establish fees and penalties that do not exceed:

1. Four hundred dollars for an application for an active license to practice psychology.
2. Two hundred dollars for an application for a temporary license to practice psychology.
3. Two hundred fifty dollars for reapplication for an active license.
4. Five hundred dollars for issuing an initial license. The board shall prorate this fee pursuant to subsection D of this section.
5. Fifty dollars for a duplicate license.
6. Five hundred dollars for biennial renewal of an active license.
7. Eighty-five dollars for biennial renewal of an inactive license.
8. Three hundred dollars for the reinstatement of an active or inactive license.
9. Three hundred fifty dollars for any additional examination.
10. Two hundred fifty dollars for delinquent compliance with continuing education requirements.
11. Five dollars for the sale of a duplicate renewal receipt.
12. Five dollars for the sale of a copy of the board's statutes and rules.
13. Two dollars for verification of a license.
14. Ten dollars for the sale of each audiotape of board meetings.
15. Five cents per name for the sale of computerized discs that contain the name of each licensee.
16. Twenty-five cents per name for the sale of computerized discs that contain the name and address of each licensee.

17. Thirty-five cents per name for the sale of customized computerized discs that contain additional licensee information that is not required by law to remain confidential.

18. Twenty-five cents per page for copying records, documents, letters, minutes, applications, files and policy statements. This fee includes postage.

B. The board may charge additional fees for services the board deems necessary and appropriate to carry out this chapter. These fees shall not exceed the actual cost of providing the service.

C. The board shall not refund fees except as provided in section 32-2073, subsection G. On special request and for good cause the board may return the license renewal fee.

D. The board shall prorate the fee for issuing an initial license by dividing the biennial renewal fee by twenty-four and multiplying that amount by the number of months that remain until the next biennial renewal date.

E. Subject to the requirements of section 41-2544, the executive director may enter into agreements to allow licensees to pay fees by alternative methods, including credit cards, charge cards, debit cards and electronic funds transfers.

32-2071. Qualifications of applicant; education; training

(L14, Ch. 258, sec. 5. Eff. 7/1/16)

A. An applicant for licensure shall have a doctoral degree from an institution of higher education in clinical or counseling psychology, school or educational psychology or any other subject area in applied psychology acceptable to the board and shall have completed a doctoral program in psychology from an educational institution that has:

1. Been accredited by one of the following regional accrediting agencies at the time of the applicant's graduation:

- (a) The New England association of schools and colleges.
- (b) The middle states association of colleges and schools.
- (c) The north central association of colleges and schools.
- (d) The northwest association of schools and colleges.
- (e) The southern association of colleges and schools.
- (f) The western association of schools and colleges.

2. A program that is identified and labeled as a psychology program and that stands as a recognized, coherent organizational entity within the institution with clearly identified entry and exit criteria for graduate students in the program.

3. An identifiable psychology faculty in the area of health service delivery and a psychologist responsible for the program.

4. A core program that requires each student to demonstrate competence by passing suitable comprehensive examinations or by successfully completing at least three or more graduate semester hours, five or more quarter hours or six or more trimester hours or by other suitable means in the following content areas:

- (a) Scientific and professional ethics and standards in psychology.
- (b) Research, which may include design, methodology, statistics and psychometrics.

(c) The biological basis of behavior, which may include physiological psychology, comparative psychology, neuropsychology, sensation and perception and psychopharmacology.

(d) The cognitive-affective basis of behavior, which may include learning, thinking, motivation and emotion.

(e) The social basis of behavior, which may include social psychology, group processes, cultural diversity and organizational and systems theory.

(f) Individual differences, which may include personality theory, human development and abnormal psychology.

(g) Assessment, which includes instruction in interviewing and the administration, scoring and interpretation of psychological test batteries for the diagnosis of cognitive abilities and personality functioning.

(h) Treatment modalities, which include instruction in the theory and application of a diverse range of psychological interventions for the treatment of mental, emotional, psychological and behavioral disorders.

5. A psychology program that leads to a doctoral degree requiring at least the equivalent of three full-time academic years of graduate study, two years of which are at the institution from which the doctoral degree is granted.

6. A requirement that the student must successfully defend a dissertation, the content of which is primarily psychological, or an equivalent project acceptable to the board.

7. Official transcripts that have been prepared solely by the institution and not by the student and, except for manifest clerical errors or grade changes, have not been altered by the institution after the student's graduation.

8. Given the student credit only for coursework listed on its official transcripts and that is obtained only at regionally accredited educational institutions as listed in paragraph 1 of this subsection and does not give credit for continuing education experiences or courses.

B. If the institution is located outside the United States, the applicant shall demonstrate that the program meets the requirements of subsection A, paragraphs 2 through 7 and subsections C through M of this section.

C. The applicant shall complete relevant didactic courses of the program required under subsection A, paragraph 4 of this section before starting the supervised professional experiences as described pursuant to subsection F of this section.

D. Each applicant for licensure shall obtain three thousand hours of supervised professional work experiences. The applicant shall demonstrate clearly how the applicant met this requirement. The applicant shall obtain a minimum of one thousand five hundred hours through an internship as described in subsection F of this section. The applicant shall obtain the remaining one thousand five hundred hours through any combination of the following:

1. Supervised preinternship professional experiences as described in subsection E of this section.

2. Additional internship hours as described in subsection F of this section.

3. Supervised postdoctoral experiences as described in subsection G of this section.

E. If the applicant chooses to include up to one thousand five hundred hours of supervised preinternship professional experience to satisfy a portion of the three thousand hours of supervised professional experience, the following requirements must be met:

1. The applicant's supervised preinternship professional experiences shall reflect a faculty directed, organized, sequential series of supervised experiences of increasing complexity that follows appropriate academic coursework and that prepares the applicant for an internship.
2. The applicant's supervised preinternship professional experiences shall follow appropriate academic preparation. There must be a written training plan between the student and the graduate training program. The training plan for each supervised preinternship professional experience training site must designate an allotment of time for each training activity and must assure the quality, breadth and depth of training experience through the specification of goals and objectives of the supervised preinternship professional experience, the methods of evaluation of the student and supervisory experiences. If supervision is to be completed by qualified site supervisors at external sites, their approval must be included in the plan.
3. More than one part-time supervised preinternship professional experience placement of appropriate scope and complexity over the course of the graduate training may be combined to satisfy the one thousand five hundred hours of supervised preinternship professional experiences.
4. Every twenty hours of supervised preinternship professional experience must include the following:
 - (a) At least fifty per cent of the supervised preinternship professional experiences must be in psychological service-related activities. Psychological service-related activities may include treatment, assessment, interviews, report writing, case presentations, seminars on applied issues providing cotherapy, group supervision and consultations.
 - (b) At least twenty-five per cent of the supervised preinternship professional experiences must be devoted to face-to-face patient-client contact.
 - (c) At least one hour per week of regularly scheduled contemporaneous in-person individual supervision per twenty hours of supervised preinternship professional experience that addresses the direct psychological services provided by the student.
 - (d) After September 1, 2013, at least two hours of regularly scheduled contemporaneous supervision per twenty hours of supervised preinternship professional experience that addresses the direct psychological services provided by the student. At least fifty per cent of the supervision during the total supervised preinternship professional experience shall be provided through contemporaneous in-person individual supervision. Not more than fifty per cent shall be through in-person group supervision. At least seventy-five per cent of the supervision shall be by a psychologist who is licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada and who is designated by the academic program. Not more than twenty-five per cent of the supervision shall be by a licensed mental health professional who is licensed or certified by a licensing jurisdiction of the United States or Canada, a psychology intern currently under the supervision of a licensed psychologist or an individual completing a postdoctoral supervised experience currently under the supervision of a licensed psychologist.
5. The applicant must provide to the board the written training plan developed by the applicant's program and documentation of the total hours accrued by the

applicant during the supervised preinternship professional experience, including the number of face-to-face patient-client contact hours and the amount of supervision and qualifications of the supervisors for the entire supervised preinternship professional experiences. Documentation must include an acknowledgement that ethics training was included throughout the supervised preinternship professional experience.

6. Supervised professional preinternship experiences must be completed within seventy-two months.

F. The applicant shall have one thousand five hundred hours of supervised professional experience, which shall be either an internship that is approved by the American psychological association committee on accreditation, an internship that is a member of the association of psychology postdoctoral and internship centers or an organized training program that is designed to provide the trainee with a planned, programmed sequence of training experience, the focus and purpose of which are to assure breadth and quality of training, and that meets the following requirements:

1. The training program has a clearly designated staff psychologist who is responsible for the integrity and quality of the training and who is licensed or certified to practice psychology at the independent level by any licensing jurisdiction of the United States or Canada in which the program exists.

2. The training program provides at least two psychologists on staff as supervisors, at least one of whom is licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada in which the program exists and at least one of whom is directly available to the trainee in case of emergency.

3. Supervision is provided by the person who carries clinical responsibility for the cases being supervised. At least half of the training supervision shall be provided by one or more psychologists.

4. Training includes a range of assessment, consultation and treatment activities conducted directly with clients or patients.

5. A minimum of twenty-five per cent of a trainee's supervised professional experience hours is in direct client or patient contact.

6. Training includes regular in-person, individual supervision conducted on a contemporaneous basis, with a minimum of one hour of in-person, individual supervision for each twenty hours of experience and with the specific intent of dealing with psychological services rendered directly by the trainee and at least two additional hours per week in other learning activities. Beginning July 1, 2016, not more than fifty per cent of the in-person supervision may be completed using telepractice supervision as specified by the board by rule. The supervisor shall ensure that the telepractice supervision is conducted using secure, confidential real-time visual telecommunication.

7. The training program includes interaction with other psychology trainees.

8. Trainees have a title that designates their trainee status.

9. The applicant provides from the training organization a written statement that describes the goals and content of the training program and documents that clear expectations existed for the breadth, depth and quality and quantity of a trainee's work at the time of the supervised professional experience.

10. The supervised professional experience is completed within twenty-four consecutive months.

G. Not more than one thousand five hundred hours of supervised professional experience shall be postdoctoral and may start on written certification by the applicant's education program that the applicant has satisfied all requirements for the doctoral degree and on written certification that the applicant has completed an appropriate supervised professional experience as required in subsection F of this section. The applicant may complete more than one thousand five hundred hours of a supervised postdoctoral experience, but not more than one thousand five hundred hours may count towards the requirements of this subsection. The one thousand five hundred hours of supervised professional experience shall meet the following requirements:

1. Supervision is conducted by a psychologist who is licensed or certified to practice psychology at the independent level in any licensing jurisdiction of the United States or Canada in which the supervision occurs or by a psychologist who is on full-time active duty in the United States armed services and who is licensed or certified by a board of psychologist examiners in a United States jurisdiction, who has been licensed or certified for at least two years and who is competent in the areas of professional practice in which the supervisee is receiving supervised professional experience.

2. The supervisor takes full legal responsibility for the welfare of the client or patient as well as the diagnosis, intervention and outcome of the intervention and takes reasonable steps to ensure that clients or patients are informed of the supervisee's training and status and that clients or patients may meet with the supervisor at the client's or patient's request.

3. The supervisor or the appropriate custodian of records is responsible for ensuring that adequate records of client or patient contacts are maintained and that the client or patient is informed that the source of access to this information in the future is the supervisor.

4. The supervisor is fully available for consultation in the event of an emergency and provides emergency consultation coverage for the supervisee.

5. Regular in-person, individual supervision is conducted on a contemporaneous basis, with a minimum of one hour of in-person, individual supervision for each twenty hours of supervised professional experience. At least forty per cent of the supervisee's time shall be in direct contact with clients or patients. Beginning July 1, 2016, not more than fifty per cent of the in-person supervision may be completed using telepractice supervision as specified by the board by rule. The supervisor shall ensure that the telepractice supervision is conducted using secure, confidential real-time visual telecommunication technology.

6. The supervised professional experience as described in this subsection is completed within thirty-six consecutive months.

7. The applicant provides from the training organization a written training plan that describes the goals and content of the training experience and documents that clear expectations existed for the breadth, depth and quality and quantity of a trainee's work at the time of the supervised professional experience.

H. In meeting the supervised preinternship professional experience as described in subsection E of this section and the supervised professional experience as described

in subsections F and G of this section, an applicant shall not receive credit for more than forty hours of experience per week.

I. An applicant who does not satisfy the supervised professional experience requirements of subsection F of this section may qualify on demonstration of twenty years' licensed or certified practice as a psychologist in a jurisdiction of the United States or Canada.

J. An applicant who does not satisfy the supervised preinternship professional experience requirements of subsection E of this section or the supervised professional experience requirements of subsection G of this section, or a combination of subsections E and G of this section, may qualify on demonstration of ten years' licensed or certified practice as a psychologist in a jurisdiction of the United States or Canada.

K. The applicant shall complete a residency at the institution that awarded the applicant's doctoral degree. The residency shall require the following:

1. The student's active participation and involvement in learning.
2. Direct regular contact with faculty and other matriculated doctoral students.
3. Eighteen semester hours or thirty quarter hours or thirty-six trimester hours completed within a twelve month consecutive period at the institution or a minimum of three hundred hours of student-faculty contact that involves face-to-face educational meetings conducted by the institution's psychology faculty and fully documented by the institution and the student. These meetings shall include interaction between the student and faculty and the student and other students and shall relate to the program content areas specified in subsection A, paragraph 4 of this section. These meetings shall be in addition to the supervised preinternship professional experience, clerkship or externship supervision hours or dissertation hours. On request by the board, the applicant shall obtain documentation from the institution showing how the applicant's performance was assessed and documented.

L. To determine if an applicant satisfies the requirements of subsection A relating to subject areas in applied psychology, the board may require the applicant to complete a respecialization program in a program or professional school of psychology that has either an established American psychological association accredited doctoral program in clinical or counseling psychology or school or educational psychology or an established doctoral program that meets board rules. The applicant must also:

1. Meet all of the requirements of the new respecialization area. The board shall give the applicant credit for coursework that the applicant has previously successfully completed and that meets the requirements of subsection A, paragraph 4 of this section.
2. Complete one thousand five hundred hours of supervised professional experience as prescribed in subsection F of this section.
3. Present a certificate or letter from the department head, training director or dean that verifies that the applicant completed the program and that identifies the specialty area of applied psychology the applicant completed.

M. For the purposes of subsection A, paragraph 4 of this section, "other suitable means" means that an applicant demonstrates competence by being a diplomate of the American board of professional psychology or, if an applicant fails to demonstrate completion of coursework in two content areas prescribed in subsection A, paragraph 4 of this section, the applicant has fulfilled the two

deficient requirements by successfully passing a graduate course in each deficient content area as a nonmatriculated student in a doctoral level psychology program at a university that is accredited pursuant to subsection A, paragraph 1 of this section.

32-2071. Qualifications of applicant; education; training

(L14, Ch. 258, sec. 5. Eff. 7/1/16)

A. An applicant for licensure shall have a doctoral degree from an institution of higher education in clinical or counseling psychology, school or educational psychology or any other subject area in applied psychology acceptable to the board and shall have completed a doctoral program in psychology from an educational institution that has:

1. Been accredited by one of the following regional accrediting agencies at the time of the applicant's graduation:
 - (a) The New England association of schools and colleges.
 - (b) The middle states association of colleges and schools.
 - (c) The north central association of colleges and schools.
 - (d) The northwest association of schools and colleges.
 - (e) The southern association of colleges and schools.
 - (f) The western association of schools and colleges.
2. A program that is identified and labeled as a psychology program and that stands as a recognized, coherent organizational entity within the institution with clearly identified entry and exit criteria for graduate students in the program.
3. An identifiable psychology faculty in the area of health service delivery and a psychologist responsible for the program.
4. A core program that requires each student to demonstrate competence by passing suitable comprehensive examinations or by successfully completing at least three or more graduate semester hours, five or more quarter hours or six or more trimester hours or by other suitable means in the following content areas:
 - (a) Scientific and professional ethics and standards in psychology.
 - (b) Research, which may include design, methodology, statistics and psychometrics.
 - (c) The biological basis of behavior, which may include physiological psychology, comparative psychology, neuropsychology, sensation and perception and psychopharmacology.
 - (d) The cognitive-affective basis of behavior, which may include learning, thinking, motivation and emotion.
 - (e) The social basis of behavior, which may include social psychology, group processes, cultural diversity and organizational and systems theory.
 - (f) Individual differences, which may include personality theory, human development and abnormal psychology.
 - (g) Assessment, which includes instruction in interviewing and the administration, scoring and interpretation of psychological test batteries for the diagnosis of cognitive abilities and personality functioning.
 - (h) Treatment modalities, which include instruction in the theory and application of a diverse range of psychological interventions for the treatment of mental, emotional, psychological and behavioral disorders.

5. A psychology program that leads to a doctoral degree requiring at least the equivalent of three full-time academic years of graduate study, two years of which are at the institution from which the doctoral degree is granted.

6. A requirement that the student must successfully defend a dissertation, the content of which is primarily psychological, or an equivalent project acceptable to the board.

7. Official transcripts that have been prepared solely by the institution and not by the student and, except for manifest clerical errors or grade changes, have not been altered by the institution after the student's graduation.

8. Given the student credit only for coursework listed on its official transcripts and that is obtained only at regionally accredited educational institutions as listed in paragraph 1 of this subsection and does not give credit for continuing education experiences or courses.

B. If the institution is located outside the United States, the applicant shall demonstrate that the program meets the requirements of subsection A, paragraphs 2 through 7 and subsections C through M of this section.

C. The applicant shall complete relevant didactic courses of the program required under subsection A, paragraph 4 of this section before starting the supervised professional experiences as described pursuant to subsection F of this section.

D. Each applicant for licensure shall obtain three thousand hours of supervised professional work experiences. The applicant shall demonstrate clearly how the applicant met this requirement. The applicant shall obtain a minimum of one thousand five hundred hours through an internship as described in subsection F of this section. The applicant shall obtain the remaining one thousand five hundred hours through any combination of the following:

1. Supervised preinternship professional experiences as described in subsection E of this section.

2. Additional internship hours as described in subsection F of this section.

3. Supervised postdoctoral experiences as described in subsection G of this section.

E. If the applicant chooses to include up to one thousand five hundred hours of supervised preinternship professional experience to satisfy a portion of the three thousand hours of supervised professional experience, the following requirements must be met:

1. The applicant's supervised preinternship professional experiences shall reflect a faculty directed, organized, sequential series of supervised experiences of increasing complexity that follows appropriate academic coursework and that prepares the applicant for an internship.

2. The applicant's supervised preinternship professional experiences shall follow appropriate academic preparation. There must be a written training plan between the student and the graduate training program. The training plan for each supervised preinternship professional experience training site must designate an allotment of time for each training activity and must assure the quality, breadth and depth of training experience through the specification of goals and objectives of the supervised preinternship professional experience, the methods of evaluation of the student and supervisory experiences. If supervision is to be completed by qualified site supervisors at external sites, their approval must be included in the plan.

3. More than one part-time supervised preinternship professional experience placement of appropriate scope and complexity over the course of the graduate training may be combined to satisfy the one thousand five hundred hours of supervised preinternship professional experiences.

4. Every twenty hours of supervised preinternship professional experience must include the following:

(a) At least fifty per cent of the supervised preinternship professional experiences must be in psychological service-related activities. Psychological service-related activities may include treatment, assessment, interviews, report writing, case presentations, seminars on applied issues providing cotherapy, group supervision and consultations.

(b) At least twenty-five per cent of the supervised preinternship professional experiences must be devoted to face-to-face patient-client contact.

(c) At least one hour per week of regularly scheduled contemporaneous in-person individual supervision per twenty hours of supervised preinternship professional experience that addresses the direct psychological services provided by the student.

(d) After September 1, 2013, at least two hours of regularly scheduled contemporaneous supervision per twenty hours of supervised preinternship professional experience that addresses the direct psychological services provided by the student. At least fifty per cent of the supervision during the total supervised preinternship professional experience shall be provided through contemporaneous in-person individual supervision. Not more than fifty per cent shall be through in-person group supervision. At least seventy-five per cent of the supervision shall be by a psychologist who is licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada and who is designated by the academic program. Not more than twenty-five per cent of the supervision shall be by a licensed mental health professional who is licensed or certified by a licensing jurisdiction of the United States or Canada, a psychology intern currently under the supervision of a licensed psychologist or an individual completing a postdoctoral supervised experience currently under the supervision of a licensed psychologist.

5. The applicant must provide to the board the written training plan developed by the applicant's program and documentation of the total hours accrued by the applicant during the supervised preinternship professional experience, including the number of face-to-face patient-client contact hours and the amount of supervision and qualifications of the supervisors for the entire supervised preinternship professional experiences. Documentation must include an acknowledgement that ethics training was included throughout the supervised preinternship professional experience.

6. Supervised professional preinternship experiences must be completed within seventy-two months.

F. The applicant shall have one thousand five hundred hours of supervised professional experience, which shall be either an internship that is approved by the American psychological association committee on accreditation, an internship that is a member of the association of psychology postdoctoral and internship centers or an organized training program that is designed to provide the trainee with a planned, programmed sequence of training experience, the focus and purpose of

which are to assure breadth and quality of training, and that meets the following requirements:

1. The training program has a clearly designated staff psychologist who is responsible for the integrity and quality of the training and who is licensed or certified to practice psychology at the independent level by any licensing jurisdiction of the United States or Canada in which the program exists.
2. The training program provides at least two psychologists on staff as supervisors, at least one of whom is licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada in which the program exists and at least one of whom is directly available to the trainee in case of emergency.
3. Supervision is provided by the person who carries clinical responsibility for the cases being supervised. At least half of the training supervision shall be provided by one or more psychologists.
4. Training includes a range of assessment, consultation and treatment activities conducted directly with clients or patients.
5. A minimum of twenty-five per cent of a trainee's supervised professional experience hours is in direct client or patient contact.
6. Training includes regular in-person, individual supervision conducted on a contemporaneous basis, with a minimum of one hour of in-person, individual supervision for each twenty hours of experience and with the specific intent of dealing with psychological services rendered directly by the trainee and at least two additional hours per week in other learning activities. Beginning July 1, 2016, not more than fifty per cent of the in-person supervision may be completed using telepractice supervision as specified by the board by rule. The supervisor shall ensure that the telepractice supervision is conducted using secure, confidential real-time visual telecommunication.
7. The training program includes interaction with other psychology trainees.
8. Trainees have a title that designates their trainee status.
9. The applicant provides from the training organization a written statement that describes the goals and content of the training program and documents that clear expectations existed for the breadth, depth and quality and quantity of a trainee's work at the time of the supervised professional experience.
10. The supervised professional experience is completed within twenty-four consecutive months.

G. Not more than one thousand five hundred hours of supervised professional experience shall be postdoctoral and may start on written certification by the applicant's education program that the applicant has satisfied all requirements for the doctoral degree and on written certification that the applicant has completed an appropriate supervised professional experience as required in subsection F of this section. The applicant may complete more than one thousand five hundred hours of a supervised postdoctoral experience, but not more than one thousand five hundred hours may count towards the requirements of this subsection. The one thousand five hundred hours of supervised professional experience shall meet the following requirements:

1. Supervision is conducted by a psychologist who is licensed or certified to practice psychology at the independent level in any licensing jurisdiction of the United States or Canada in which the supervision occurs or by a psychologist who is on

full-time active duty in the United States armed services and who is licensed or certified by a board of psychologist examiners in a United States jurisdiction, who has been licensed or certified for at least two years and who is competent in the areas of professional practice in which the supervisee is receiving supervised professional experience.

2. The supervisor takes full legal responsibility for the welfare of the client or patient as well as the diagnosis, intervention and outcome of the intervention and takes reasonable steps to ensure that clients or patients are informed of the supervisee's training and status and that clients or patients may meet with the supervisor at the client's or patient's request.

3. The supervisor or the appropriate custodian of records is responsible for ensuring that adequate records of client or patient contacts are maintained and that the client or patient is informed that the source of access to this information in the future is the supervisor.

4. The supervisor is fully available for consultation in the event of an emergency and provides emergency consultation coverage for the supervisee.

5. Regular in-person, individual supervision is conducted on a contemporaneous basis, with a minimum of one hour of in-person, individual supervision for each twenty hours of supervised professional experience. At least forty per cent of the supervisee's time shall be in direct contact with clients or patients. Beginning July 1, 2016, not more than fifty per cent of the in-person supervision may be completed using telepractice supervision as specified by the board by rule. The supervisor shall ensure that the telepractice supervision is conducted using secure, confidential real-time visual telecommunication technology.

6. The supervised professional experience as described in this subsection is completed within thirty-six consecutive months.

7. The applicant provides from the training organization a written training plan that describes the goals and content of the training experience and documents that clear expectations existed for the breadth, depth and quality and quantity of a trainee's work at the time of the supervised professional experience.

H. In meeting the supervised preinternship professional experience as described in subsection E of this section and the supervised professional experience as described in subsections F and G of this section, an applicant shall not receive credit for more than forty hours of experience per week.

I. An applicant who does not satisfy the supervised professional experience requirements of subsection F of this section may qualify on demonstration of twenty years' licensed or certified practice as a psychologist in a jurisdiction of the United States or Canada.

J. An applicant who does not satisfy the supervised preinternship professional experience requirements of subsection E of this section or the supervised professional experience requirements of subsection G of this section, or a combination of subsections E and G of this section, may qualify on demonstration of ten years' licensed or certified practice as a psychologist in a jurisdiction of the United States or Canada.

K. The applicant shall complete a residency at the institution that awarded the applicant's doctoral degree. The residency shall require the following:

1. The student's active participation and involvement in learning.
2. Direct regular contact with faculty and other matriculated doctoral students.

3. Eighteen semester hours or thirty quarter hours or thirty-six trimester hours completed within a twelve month consecutive period at the institution or a minimum of three hundred hours of student-faculty contact that involves face-to-face educational meetings conducted by the institution's psychology faculty and fully documented by the institution and the student. These meetings shall include interaction between the student and faculty and the student and other students and shall relate to the program content areas specified in subsection A, paragraph 4 of this section. These meetings shall be in addition to the supervised preinternship professional experience, clerkship or externship supervision hours or dissertation hours. On request by the board, the applicant shall obtain documentation from the institution showing how the applicant's performance was assessed and documented.

L. To determine if an applicant satisfies the requirements of subsection A relating to subject areas in applied psychology, the board may require the applicant to complete a respecialization program in a program or professional school of psychology that has either an established American psychological association accredited doctoral program in clinical or counseling psychology or school or educational psychology or an established doctoral program that meets board rules. The applicant must also:

1. Meet all of the requirements of the new respecialization area. The board shall give the applicant credit for coursework that the applicant has previously successfully completed and that meets the requirements of subsection A, paragraph 4 of this section.
2. Complete one thousand five hundred hours of supervised professional experience as prescribed in subsection F of this section.
3. Present a certificate or letter from the department head, training director or dean that verifies that the applicant completed the program and that identifies the specialty area of applied psychology the applicant completed.

M. For the purposes of subsection A, paragraph 4 of this section, "other suitable means" means that an applicant demonstrates competence by being a diplomate of the American board of professional psychology or, if an applicant fails to demonstrate completion of coursework in two content areas prescribed in subsection A, paragraph 4 of this section, the applicant has fulfilled the two deficient requirements by successfully passing a graduate course in each deficient content area as a nonmatriculated student in a doctoral level psychology program at a university that is accredited pursuant to subsection A, paragraph 1 of this section.

[32-2071.01. Requirements for licensure; remediation; credentials](#)

A. An applicant for licensure shall demonstrate to the board's satisfaction that the applicant:

1. Has met the education and training qualifications for licensure prescribed in section 32-2071 or subsection D of this section.
2. Has passed any examination or examinations required by section 32-2072.
3. Has a professional record that indicates that the applicant has not committed any act or engaged in any conduct that constitutes grounds for disciplinary action against a licensee pursuant to this chapter.

4. Has not had a license or a certificate to practice psychology refused, revoked, suspended or restricted by a state, territory, district or country for reasons that relate to unprofessional conduct.
 5. Has not voluntarily surrendered a license in another regulatory jurisdiction in the United States or Canada while under investigation for conduct that relates to unprofessional conduct.
 6. Does not have a complaint, allegation or investigation pending before another regulatory jurisdiction in the United States or Canada that relates to unprofessional conduct.
- B. If the board finds that an applicant committed an act or engaged in conduct that would constitute grounds for disciplinary action in this state, or if the board or any jurisdiction has taken disciplinary action against an applicant, the board may issue a license if the board first determines to its satisfaction that the act or conduct has been corrected, monitored or resolved. If the act or conduct has not been resolved before issuing a license, the board must determine to its satisfaction that mitigating circumstances exist that prevent its resolution.
- C. An applicant for licensure meets the requirements of section 32-2071, subsection A, paragraphs 1, 2, 3, 4, 5, 6 and 8 if the applicant earned a doctoral degree from a program that was accredited by the American psychological association, office of program consultation and accreditation at the time of graduation.
- D. An applicant for licensure who is licensed to practice psychology at the independent level in another licensing jurisdiction of the United States or Canada meets the requirements of subsection A, paragraph 1 of this section if the applicant meets any of the following requirements:
1. Holds a certificate of professional qualification in psychology in good standing issued by the association of state and provincial psychology boards or its successor.
 2. Is currently credentialed by the national register of health service providers in psychology or its successor and submits evidence of having practiced psychology independently at the doctoral level for a minimum of five years.
 3. Is a diplomate of the American board of professional psychology.

32-2072. Examinations; exemptions

- A. An applicant for licensure must pass the examination for professional practice in psychology, which is the national examination established by the association of state and provincial psychology boards. An applicant is considered to have passed the national examination if the applicant's score equals or exceeds either:
1. Seventy per cent on the written examination.
 2. A scaled score of five hundred on the computer-based examination.
- B. The board may implement an additional examination for all applicants to cover areas of professional ethics and practice consistent with the applicant's education and experience, state law relating to the practice of psychology or other areas the board determines are suitable.
- C. An applicant may not take an examination administered for or by the board until the applicant completes the education requirements of this article. The board may approve an applicant who has obtained a doctoral degree in psychology as required under section 32-2071 to take the national examination before completing the experience requirements of this article. Except as provided in subsection D of this section, an applicant may not take an additional board examination until the

applicant passes the national examination. An applicant who fails the national examination administered for or by any jurisdiction three times is not eligible to take that examination again until the applicant meets additional requirements prescribed by the board.

D. An applicant is exempt from taking the national examination administered pursuant to this section if the applicant either:

1. Is a diplomate of the American board of professional psychology.
2. Holds a certificate of professional qualification in psychology in good standing issued by the association of state and provincial psychology boards or its successor.

32-2073. Temporary licenses; inactive status; reinstatement to active status

A. If the board requires an additional examination it may issue a temporary license to a psychologist licensed or certified under the laws of another jurisdiction, if the psychologist applies to the board for licensure and meets the educational, experience and first examination requirements of this article.

B. Beginning January 1, 2015, the board may issue a temporary license to an individual who submits an application for temporary licensure and who is working under supervision for postdoctoral experience and who meets the requirements of section 32-2071, subsections A, B, C and D, as applicable. The individual's postdoctoral experience must meet the requirements of section 32-2071, subsection G. The applicant shall submit the written training plan for the supervised professional experience required in section 32-2071, subsection G, paragraph 7 as part of the application for the temporary license.

C. A temporary license issued pursuant to subsection A of this section is effective from the date that the application is approved until the last day of the month in which the applicant receives the results of the additional examination as provided in section 32-2072.

D. A temporary license issued pursuant to subsection A of this section shall not be extended, renewed, reissued or allowed to continue in effect beyond the period authorized by this section.

E. A temporary license issued pursuant to subsection B of this section is effective for thirty-six months from the date the application is approved and is subject to an initial license fee pursuant to section 32-2067, subsection A, paragraph 4. A temporary license is not subject to renewal.

F. Denial of an application for licensure terminates a temporary license.

G. The board may place on inactive status and waive the license renewal fee requirements for a person who is temporarily or permanently unable to practice as a psychologist due to physical or mental incapacity or disability. An initial request for the waiver of renewal fees shall be accompanied by the renewal fee for an active license, which the board shall return if the waiver is granted. The board shall judge each request for the waiver of renewal fees on its own merits and may seek the verification it deems necessary to substantiate the facts of the situation. A psychologist who is retired is exempt from paying the renewal fee. A psychologist may request voluntary inactive status by submitting to the board an application on a form prescribed by the board and an affirmation that the psychologist shall not practice as a psychologist in this state for the duration of the voluntary inactive status and paying the required fee.

H. A psychologist who is on any form of inactive status shall renew the inactive status every two years by submitting a renewal form provided by the board and paying any applicable fee. A notice to renew is fully effective by mailing the renewal application to the licensee's last known address of record in the board's file. Notice is complete at the time of its deposit in the mail. A psychologist on inactive status due to physical or mental incapacity or disability or retirement shall use the term inactive to describe the person's status and shall not practice as a psychologist.

I. A psychologist on inactive status may request reinstatement of the license to active status by applying to the board. The board shall determine whether the person has been or is in violation of any provisions of this chapter and whether the person has maintained and updated the person's professional knowledge and capability to practice as a psychologist. The board may require the person to take or retake the licensure examinations and may require other knowledge or skill training experiences. If approved for active status, the person shall pay a renewal fee that equals the renewal fee for the license to be reinstated.

32-2074. Active license; issuance; renewal; expiration; continuing education; cancellation of active license

(L14, Ch. 258, sec. 7. Eff. until 5/1/17)

A. If the applicant satisfies all of the requirements for licensure pursuant to this chapter, the board shall issue an active license and shall prorate the fee for issuing that license for the period remaining until May 1 of the next odd-numbered year.

B. Except as provided in section 32-4301, a person holding an active or an inactive license shall apply to renew the license before May 1 of each odd-numbered year. The application shall include any applicable renewal fee. Except as provided in section 32-4301 or 41-1092.11, a license expires if the licensee fails to renew the license before May 1 of that year. A licensee may reinstate an expired license by paying a reinstatement fee before July 1 of that year. From July 1 of that year until May 1 of the next year, a licensee may reinstate the license by paying a reinstatement fee and providing proof of competency and qualifications to the board. This proof may include continuing education, an oral examination, a written examination or an interview with the board. A licensee whose license is not reinstated by May 1 of the next even-numbered year may reapply for licensure as prescribed by this chapter. A notice to renew is fully effective by mailing or electronically providing the notice to the licensee's last known address of record or last known e-mail address of record in the board's file. Notice is complete at the time of deposit in the mail or when the e-mail is sent.

C. A person renewing a license shall attach to the completed renewal form a report of disciplinary actions or restrictions placed against the license by another state licensing or disciplinary board or disciplinary actions or sanctions imposed by a state or national psychology ethics committee or health care institution. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action.

D. A person who renews an active license to practice psychology in this state shall satisfy a continuing education requirement designed to provide the necessary understanding of current developments, skills, procedures or treatment related to

the practice of psychology in the amount and during the period the board prescribes. The board shall prescribe documentation requirements.

E. On request of an active licensee, the board may cancel the license if the licensee is not presently under investigation by the board and the board has not begun any disciplinary proceeding against the licensee.

32-2074. Active license; issuance; renewal; expiration; continuing education; cancellation of active license

(L14, Ch. 258, sec. 8. Eff. 5/1/17)

A. Beginning May 1, 2017, if the applicant satisfies all of the requirements for licensure pursuant to this chapter, the board shall issue an active license and shall prorate the fee for issuing that license for the period remaining until the last day of the birth month of the applicant of the next odd-numbered year or even-numbered year pursuant to subsection B, paragraph 1 or 2 of this section.

B. Except as provided in section 32-4301, beginning May 1, 2017, a person holding an active or an inactive license shall apply to renew the license on or before the last day of the birth month of the licensee every other year as follows:

1. In each odd-numbered year, if the licensee holds an odd-numbered license.
2. In each even-numbered year, if the licensee holds an even-numbered license.

C. The application shall include any applicable renewal fee. Except as provided in section 32-4301 or 41-1092.11, a license expires if the licensee fails to renew the license on or before the last day of the licensee's birth month of the licensee's renewal year pursuant to subsection B of this section. A licensee may reinstate an expired license by paying a reinstatement fee within two months after the last day of the licensee's birth month in that year. Beginning two months after the last day of the licensee's birth month during the licensee's renewal year until the last day of the licensee's birth month the following year, a licensee may reinstate the license by paying a reinstatement fee and providing proof of competency and qualifications to the board. This proof may include continuing education, an oral examination, a written examination or an interview with the board. A licensee whose license is not reinstated within a year after the last day of the licensee's birth month of the licensee's renewal year may reapply for licensure as prescribed by this chapter. A notice to renew is fully effective by mailing or electronically providing the notice to the licensee's last known address of record or last known e-mail address of record in the board's file. Notice is complete at the time of deposit in the mail or when the e-mail is sent.

D. A person renewing a license shall attach to the completed renewal form a report of disciplinary actions or restrictions placed against the license by another state licensing or disciplinary board or disciplinary actions or sanctions imposed by a state or national psychology ethics committee or health care institution. The report shall include the name and address of the sanctioning agency or health care institution, the nature of the action taken and a general statement of the charges leading to the action.

E. A person who renews an active license to practice psychology in this state shall satisfy a continuing education requirement designed to provide the necessary understanding of current developments, skills, procedures or treatment related to

the practice of psychology in the amount and during the period the board prescribes. The board shall prescribe documentation requirements.

F. On request of an active licensee, the board may cancel the license if the licensee is not presently under investigation by the board and the board has not initiated any disciplinary proceeding against the licensee.

32-2075. Exemptions from licensure

A. This chapter does not limit the activities, services and use of a title by the following:

1. A school psychologist employed in a common school, high school or charter school setting and certified to use that title by the department of education if the services or activities are a part of the duties of that person's common school, high school or charter school employment.
2. An employee of a government agency in a subdoctorate position who uses the word "assistant" or "associate" after the title and is supervised by a doctorate position employee who is licensed as a psychologist, including a temporary licensee.
3. A student of psychology pursuing an official course of graduate study at an educational institution accredited as provided in section 32-2071, if after the title the word "trainee", "intern" or "extern" appears and the student uses the title only in conjunction with activities and services that are a part of the supervised program.
4. A person who resides outside of this state and who is currently licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada if the activities and services conducted in this state are within the psychologist's customary area of practice, do not exceed twenty days per year and are not otherwise in violation of this chapter and the client or patient, public or consumer is informed of the limited nature of these activities and services and that the psychologist is not licensed in this state. A person may exceed the twenty-day limitation requirement of this paragraph to assist in public service that is related to a disaster as acknowledged by the board.
5. A person in the employ of Arizona state university, northern Arizona university, the university of Arizona or another regionally accredited university in this state or other institutional services if the services are a part of the faculty duties of that person's salaried position, with the exception of faculty providing direct services or faculty providing supervision of students providing direct services, and the person has received a doctoral degree as provided in section 32-2071.
6. A supervisee who is pursuing a supervised professional experience pursuant to section 32-2071, subsection G if the services or activities are provided under the direct supervision of a licensed psychologist who is licensed or certified for at least two years and who is competent in the areas of professional practice in which the supervisee is receiving supervised professional experience, clients or patients are informed of the training nature of the services provided and the supervisee has a title that designates that person's training status.

B. This chapter does not prevent a member of other recognized professions that are licensed, certified or regulated under the laws of this state from rendering services within that person's scope of practice and code of ethics if that person does not claim to be a psychologist.

32-2076. Unauthorized practice of medicine

This chapter does not authorize a person to engage in any manner in the practice of medicine pursuant to chapter 13, 17 or 29 of this title, except that a person licensed as provided in this chapter may diagnose, treat and correct human conditions ordinarily within the scope of the practice of a psychologist.

32-2081. Grounds for disciplinary action; duty to report; immunity; proceedings; board action; notice requirements; civil penalty

A. The board, on its own motion, may investigate evidence that appears to show that a psychologist is psychologically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of psychology. A health care institution shall, and any other person may, report to the board information that appears to show that a psychologist is psychologically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of psychology.

B. The board shall not consider a complaint against a psychologist arising out of a judicially ordered evaluation, treatment or psychoeducation of a person charged with violating any provision of title 13, chapter 14 to present a charge of unprofessional conduct unless the court ordering the evaluation has found a substantial basis to refer the complaint for consideration by the board.

C. A claim of unprofessional conduct brought on or after July 3, 2015 against a psychologist arising out of court-ordered services shall be independently reviewed by three members of the board, including a public member. Each of the three board members who are reviewing the claim shall independently provide the board's executive director a recommendation indicating whether the member believes there is merit to open an investigation. If one or more of the board members who are reviewing the claim determine that there is merit to open an investigation as a complaint, an investigation shall be opened and shall follow the complaint process pursuant to this article.

D. The board may not consider a complaint for administrative action if the complaint is filed against a person who is a licensed psychologist and who is a member of the board or a staff member of the board or who is acting as an agent of or consultant to the board if the complaint relates to the person's performance of board duties.

E. The board shall notify the psychologist about whom information has been received as to the content of the information within one hundred twenty days of receiving the information. A person who reports or provides information to the board in good faith is not subject to an action for civil damages. The board, if requested, shall not disclose the name of the person providing information unless this information is essential to proceedings conducted pursuant to this section. The board shall report a health care institution that fails to report as required by this section to the institution's licensing agency.

F. A health care institution shall inform the board if the privileges of a psychologist to practice in that institution are denied, revoked, suspended or limited because of actions by the psychologist that appear to show that that person is psychologically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of psychology, along with a general statement of the reasons that led the health care institution to take this action. A health care

institution shall inform the board if a psychologist under investigation resigns the psychologist's privileges or if a psychologist resigns in lieu of disciplinary action by the health care institution. Notification shall include a general statement of the reasons for the resignation.

G. The board may require the licensee to undergo any combination of mental, physical or psychological competence examinations at the licensee's expense and shall conduct investigations necessary to determine the competence and conduct of the licensee.

H. The chairperson of the board shall appoint a complaint screening committee of not less than three members of the board, including a public member. The complaint screening committee is subject to open meeting requirements pursuant to title 38, chapter 3, article 3.1. The complaint screening committee shall review all complaints, and based on the information provided pursuant to subsection A or F of this section may take either of the following actions:

1. Dismiss the complaint if the committee determines that there is no evidence of a violation of law or community standards of practice. Complaints dismissed by the complaint screening committee shall not be disclosed in response to a telephone inquiry or placed on the board's website.

2. Refer the complaint to the full board for further review and action.

I. If the board finds, based on the information it receives under subsection A or F of this section, that the public health, safety or welfare requires emergency action, the board may order a summary suspension of a license pending proceedings for revocation or other action. If the board issues this order, it shall serve the licensee with a written notice of complaint and formal hearing pursuant to title 41, chapter 6, article 10, setting forth the charges made against the licensee and the licensee's right to a formal hearing before the board or an administrative law judge within sixty days.

J. If the board finds that the information provided pursuant to subsection A or F of this section is not of sufficient seriousness to merit direct action against the licensee, it may take any of the following actions:

1. Dismiss if the board believes there is no evidence of a violation of law or community standards of practice.

2. File a letter of concern.

3. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.

K. If the board believes the information provided pursuant to subsection A or F of this section is or may be true, it may request an informal interview with the psychologist. If the licensee refuses to be interviewed or if pursuant to an interview the board determines that cause may exist to revoke or suspend the license, it shall issue a formal complaint and hold a hearing pursuant to title 41, chapter 6, article 10. If as a result of an informal interview or a hearing the board determines that the facts do not warrant revocation or suspension of the license, it may take any of the following actions:

1. Dismiss if the board believes there is no evidence of a violation of law or community standards of practice.

2. File a letter of concern.

3. Issue a decree of censure.
 4. Fix a period and terms of probation best adapted to protect the public health and safety and to rehabilitate or educate the psychologist. Probation may include temporary suspension for a period not to exceed twelve months, restriction of the license or restitution of fees to a client or patient resulting from violations of this chapter. If a licensee fails to comply with a term of probation, the board may file a complaint and notice of hearing pursuant to title 41, chapter 6, article 10 and take further disciplinary action.
 5. Enter into an agreement with the licensee to restrict or limit the licensee's practice or activities in order to rehabilitate the psychologist, protect the public and ensure the psychologist's ability to safely engage in the practice of psychology.
 6. Issue a nondisciplinary order requiring the licensee to complete a prescribed number of hours of continuing education in an area or areas prescribed by the board to provide the licensee with the necessary understanding of current developments, skills, procedures or treatment.
- L. If the board finds that the information provided pursuant to subsection A or F of this section warrants suspension or revocation of a license, it shall hold a hearing pursuant to title 41, chapter 6, article 10. Notice of a complaint and hearing is fully effective by mailing a true copy to the licensee's last known address of record in the board's files. Notice is complete at the time of its deposit in the mail.
- M. The board may impose a civil penalty of at least three hundred dollars but not more than three thousand dollars for each violation of this chapter or a rule adopted under this chapter. The board shall deposit, pursuant to sections 35-146 and 35-147, all monies it collects from civil penalties pursuant to this subsection in the state general fund.
- N. If the board determines after a hearing that a licensee has committed an act of unprofessional conduct, is mentally or physically unable to safely engage in the practice of psychology or is psychologically incompetent, it may do any of the following in any combination and for any period of time it determines necessary:
1. Suspend or revoke the license.
 2. Censure the licensee.
 3. Place the licensee on probation.
- O. A licensee may submit a written response to the board within thirty days after receiving a letter of concern. The response is a public document and shall be placed in the licensee's file.
- P. A letter of concern is a public document and may be used in future disciplinary actions against a psychologist. A decree of censure is an official action against the psychologist's license and may include a requirement that the licensee return fees to a client or patient.
- Q. Except as provided in section 41-1092.08, subsection H or a decision made pursuant to subsection C of this section, a person may appeal a final decision made pursuant to this section to the superior court pursuant to title 12, chapter 7, article 6.
- R. If during the course of an investigation the board determines that a criminal violation may have occurred involving the delivery of psychological services, it shall inform the appropriate criminal justice agency.
- S. If the board finds that it can take rehabilitative or disciplinary action at any time during the investigative or disciplinary process, it may enter into a consent

agreement with the psychologist to limit or restrict the psychologist's practice or to rehabilitate the psychologist in order to protect the public and ensure the psychologist's ability to safely engage in the practice of psychology. The board may also require the psychologist to successfully complete a board approved rehabilitative, retraining or assessment program at the psychologist's expense.

32-2082. Right to examine and copy evidence; subpoenas; right to counsel; appeal

A. In connection with an investigation conducted pursuant to this chapter, at all reasonable times the board and its authorized agents may examine and copy documents, reports, records and other physical evidence wherever located relating to the licensee's professional competence, unprofessional conduct or mental or physical ability to safely practice psychology.

B. The board and its authorized agents may issue subpoenas to compel the attendance and testimony of witnesses and the production of documents and other physical evidence as prescribed in subsection A of this section. The board may petition the superior court to enforce a subpoena.

C. Within five days of receiving a subpoena, a person may petition the board to revoke, limit or modify the subpoena. The board shall take this action if it determines that the evidence demanded is not relevant to the investigation. The person may petition the superior court for this relief without first petitioning the board.

D. A person appearing before the board or its authorized agents may be represented by an attorney.

E. Documents associated with an investigation are not open to the public and shall remain confidential. No documents may be released without a court order compelling their production.

F. Nothing in this section or any other provision of law making communications between a psychologist and client or patient privileged applies to an investigation conducted pursuant to this chapter. The board, its employees and its agents shall keep in confidence the names of clients or patients whose records are reviewed during an investigation.

32-2083. Injunction

A. The board may petition the superior court for an order to enjoin the following:

1. A person not licensed pursuant to this chapter from practicing psychology.
2. The activities of a licensee that are an immediate threat to the public.
3. Criminal activities.

B. If the board seeks an injunction to stop the unlicensed practice of psychology, it is sufficient to charge that the respondent on a certain day in a specific county engaged in the practice of psychology without a license and without being exempt from the licensure requirements of this chapter. It is not necessary to show specific damages or injury.

C. The issuance of an injunction does not limit the board's authority to take other action against a licensee pursuant to this chapter.

32-2084. Violations; classification

- A. It is a class 2 misdemeanor for a person not licensed pursuant to this chapter to engage in the practice of psychology.
- B. It is a class 2 misdemeanor for any person to:
 - 1. Secure a license to practice psychology pursuant to this chapter by fraud or deceit.
 - 2. Impersonate a member of the board in order to issue a license to practice psychology.
- C. It is a class 2 misdemeanor for a person not licensed pursuant to this chapter to:
 - 1. Use the designation "psychology", "psychological" or "psychologist".
 - 2. Use any combination of words, initials and symbols that leads the public to believe the person is licensed to practice psychology in this state.
- D. It is a class 2 misdemeanor for a person not licensed or not exempt from licensure pursuant to this chapter to use the designation "psychotherapist" or other derivation of the root word "psycho".

32-2085. Confidential communications

- A. The confidential relations and communication between a client or patient and a psychologist licensed pursuant to this chapter, including temporary licensees, are placed on the same basis as those provided by law between an attorney and client. Unless the client or patient waives the psychologist-client privilege in writing or in court testimony, a psychologist shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the psychologist's practice. The psychologist shall divulge to the board information it requires in connection with any investigation, public hearing or other proceeding. The psychologist-client privilege does not extend to cases in which the psychologist has a duty to report information as required by law.
- B. The psychologist shall ensure that client or patient records and communications are treated by clerical and paraprofessional staff at the same level of confidentiality and privilege required of the psychologist.

32-2086. Treatment and rehabilitation program

- A. The board may establish a confidential program for the treatment and rehabilitation of psychologists who are impaired. The treatment and rehabilitation may include education, intervention, therapeutic treatment and posttreatment monitoring and support. The licensee is responsible for the costs associated with the treatment and rehabilitation, including monitoring.
- B. The board may contract with other organizations to operate the program established pursuant to subsection A of this section. A contract with a private organization shall include the following requirements:
 - 1. Periodic reports to the board regarding treatment program activity.
 - 2. Release to the board on demand of all treatment records.
 - 3. Quarterly reports to the board regarding each psychologist's diagnosis, prognosis and recommendations for continuing care, treatment and supervision.
 - 4. Immediate reporting to the board of the name of an impaired psychologist whom the treating organization believes to be a danger to the public or to the psychologist.

5. Reports to the board, as soon as possible, of the name of a psychologist who refuses to submit to treatment or whose impairment is not substantially alleviated through treatment.

C. The board may allocate an amount of not more than twenty dollars from each fee it collects from the biennial renewal of active licenses pursuant to section 32-2067 for the operation of the program established by this section.

D. A psychologist who is impaired and who does not agree to enter into a stipulated order with the board shall be placed on probation or shall be subject to other action as provided by law.

E. In order to determine that a psychologist who has been placed on a probation order or who has entered into a stipulation order pursuant to this section is not impaired by alcohol or illegal substances after that order is no longer in effect, the board or its designee may require the psychologist to submit to bodily fluid examinations and other examinations known to detect the presence of alcohol or illegal substances at any time within the five consecutive years following termination of the probationary or stipulated order.

F. A psychologist who is impaired by alcohol or illegal substances and who was under a board stipulation or probationary order that is no longer in effect must ask the board to place the psychologist's license on inactive status with cause. If the psychologist fails to do this, the board shall summarily suspend the license pursuant to section 32-2081. In order to reactivate the license the psychologist must successfully complete a board approved long-term care residential treatment program, an inpatient hospital treatment program or an intensive outpatient treatment program and shall meet the requirements of section 32-2074. After the psychologist completes treatment the board shall determine if it should reactivate the license without restrictions or refer the matter to a formal hearing for the purpose of suspending or revoking the license or to place the psychologist on probation with restrictions necessary to ensure the public's safety.

G. The board may revoke the license of a psychologist if that psychologist is impaired by alcohol or illegal substances and was previously placed on probation pursuant to subsection F of this section. If the licensee is no longer on probation, the board may accept the surrender of the license if the psychologist admits in writing to being impaired by alcohol or illegal substances.

H. An evaluator, treatment provider, teacher, supervisor or volunteer in the board's substance abuse treatment and rehabilitation program who acts in good faith within the scope of that program is not subject to civil liability, including malpractice liability, for the actions of a psychologist who is attending the program pursuant to board action.

ARIZONA STATE RETIREMENT SYSTEM (R-16-1002)

Title 2, Chapter 8, Article 1, Retirement System; Defined Benefit Plan

Amend: R2-8-126



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: E-2

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: Shama Thathi, Staff Attorney

DATE: September 16, 2016

SUBJECT: ARIZONA STATE RETIREMENT SYSTEM (R-16-1002)
Title 2, Chapter 8, Article 1, Retirement System; Defined Benefit Plan

Amend: R2-8-126

General Comments

Purpose of the Agency and Summary of What the Rulemaking Does

The Arizona State Retirement System (ASRS) provides for retirement planning and benefits for state employees and teachers. The ASRS is directed by the governor-appointed ASRS Board (Board). The Board consists of nine members and is responsible for supervising the administration of the ASRS, including the defined contribution plan, defined benefit plan, long-term disability income plan, and health benefit supplement plan. At the end of Fiscal Year 2014-15 there were approximately 558,136 ASRS members.

This rulemaking seeks to amend one rule in A.A.C. Title 2, Chapter 8, Article 1, which contains rules related to defined benefit plans.

Article Contents, Including the Subject Matter of Each Rule Affected

Article 1 contains eight rules, one of which is affected by this rulemaking. The rules address definitions; return of contributions upon termination of membership by separation from all ASRS employment by other than retirement or death; payment of survivor benefits upon the death of a member; alternate contribution rate; application of interest rates; designating a beneficiary; spousal consent to designation; remittance of contributions; actuarial assumptions and actuarial value of assets; and calculating benefits.

Year that Each Rule was Last Amended or Newly Made

The rule was last amended by final rulemaking on April 6, 2013.

Proposed Action

In addition to minor clarifying and technical changes, the ASRS proposes the following actions:

- Subsection (A): The ASRS is adding a definition for the term, “original retirement date,” to clarify that it can either be the date a member retires for the first time or the date a member retires after returning to active membership for 60 consecutive months or more.
- Subsection (F): The ASRS is adding subsection (F)(2) to address how a member’s benefits are calculated if the member dies and the beneficiary is eligible to elect the survivor benefit as monthly income.
- Subsection (G): The ASRS is clarifying that it must include any prior service credit benefit that is applicable to the life annuity of the member before the ASRS applies the calculation for an optional form of retirement benefit.
- Subsections (I) and (J): The ASRS is clarifying which annuity options are applicable only to retirees with an original retirement date on or after the effective date of those provisions.

Summary of Reasons for the Propose Action

The ASRS indicates that the amendments are necessary to improve the clarity and consistency of the rule.

Exemption or Request and Approval for Exception from the Moratorium

The ASRS received an exception from the Governor’s Office on April 7, 2016.

Substantive or Procedural Concerns

None.

1. Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?

Yes. The ASRS cites to both general and specific statutory authority. Under A.R.S. § 38-714(E)(4), the Board may “[a]dopt, amend or repeal rules for the administration of the [Social Security and Retirement] plan.”

Specific statutes include A.R.S. §§ 38-711 relating to definitions, 38-764 regarding payment of retirement benefits, 38-769 concerning maximum retirement benefits, 38-771 providing benefit options for transferred defined contribution program members, 38-771.01

relating to alternative benefits for transferred defined contribution program members, 38-774 concerning excess benefit arrangement, and 38-775 relating to required distributions.

2. Are the rules written in a manner that is clear, concise, and understandable to the general public?

Yes. The rule is clear, concise, and understandable.

3. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Yes. The ASRS indicates that it received no written comments on the rulemaking.

4. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. No substantial changes were made between the proposed rulemaking and the final rulemaking.

5. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rules?

No. The ASRS indicates that it did not review or rely upon any study for the rulemaking.

6. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority that allows the agency to exceed the requirements of federal law?

No. Under 26 U.S.C. 401(a)(9) and Treasury Regulations: §§ 1.401(a)(9)-1 (Q&A-2(d)); 1.401(a)(9)-9 (Q&A-2); 1-401(a)(9)-6 (Q&A-2), a member may participate in certain types of annuity options at certain ages, regardless whether the contingent annuitant is a former or current spouse. The ASRS indicates that with the changes in this rulemaking, the rule is not more stringent than these corresponding federal laws.

7. Do the rules require a permit or license and if so, does the agency use a general permit or is any exception applicable under A.R.S. § 41-1037?

No. The rule does not require a permit or license.

8. Do the rules establish a new fee or contain a fee increase?

No. The rule does not establish a new fee or contain a fee increase.

Conclusion

The ASRS requests the usual 60-day delayed effective date for the rule. This analyst recommends approval of the rule.



GOVERNOR'S REGULATORY REVIEW COUNCIL M E M O R A N D U M

MEETING DATE: October 4, 2016

AGENDA ITEM: E-2

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: GRRC Economic Team

DATE : September 16, 2016

SUBJECT: **ARIZONA STATE RETIREMENT SYSTEM (R-16-1002)**
Title 2, Chapter 8, Article 1, Retirement System; Defined Benefit Plan

Amend: R2-8-126

I reviewed the economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments. These comments are made to assist the Council in its review and may be used as the Council determines.

GRRC Economist Comments

In this rulemaking, the Arizona State Retirement System (ASRS) is proposing to amend a rule to clarify the language used to outline various annuity options. The amendments will clarify the rule language without substantively changing the rules' requirements. This rulemaking will help the ASRS control and mitigate possible delays associated with member or beneficiary eligibility determination.

1. **Costs and Benefits for:**

a. The implementing agency:

ASRS incurred the cost of completing this rulemaking and will incur the minimal cost of implementing it.

b. Political subdivisions:

This rulemaking does not provide any benefits or impose any costs on political subdivisions.

c. Businesses:

No businesses are directly affected by the rulemaking.

d. Small businesses:

No businesses are directly affected by the rulemaking.

e. Consumers directly affected by the rulemaking:

There are no private persons or consumers directly affected by the rulemaking.

2. Do the probable benefits outweigh the probable costs?

Based on the information provided, ASRS indicates that the benefit from the proposed amendments outweighs the costs. The rule will have minimal economic impact, if any, because it merely clarifies current annuity options without imposing any additional requirements on the public. The rulemaking primarily affects and benefits members who wish to elect one of the joint-and-survivor annuity options. This rule will clarify for which annuity options a member may be eligible upon retirement based on the age of the member and/or the member's beneficiary. Such clarification will benefit members by increasing the readability of the various annuity options. As of June 30, 2016, approximately 40,578 out of 127,292 retirees elected a Joint and Survivor retirement option.

3. Analysis of methods to reduce the small business impact:

An analysis was not submitted because ASRS estimated that there will be no economic impact to small businesses.

4. The probable effect on state revenues:

The proposed rulemaking will have no effect on state revenues.

5. Analysis of any less intrusive or less costly alternative methods:

ASRS believes this is the least costly and intrusive method because it will clarify the language used to outline various annuity options, giving ASRS members a better understanding of their eligibility for specific annuity options.

6. Whether an analysis was submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states:

No analysis was submitted that compares the rule's impact on the competitiveness of businesses in this state to the impact on businesses in other states.

7. A description of any data on which a rule is based with an explanation of how the data was obtained and why the data is acceptable data, and the methods used by the agency to evaluate the costs and benefits in the EIS.

ASRS indicates that no outside data or studies were used in the development of the proposed rule amendment.

8. Conclusion:

The submitted economic, small business and consumer impact statement is generally accurate, and contains the information required for compliance with A.R.S. §§ 41-1035, 41-1052(D)(1-3), and 41-1055. This analyst recommends that the proposed rule amendments be approved.



ARIZONA STATE RETIREMENT SYSTEM

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Paul Matson
Director

August 16, 2016

Ms. Nicole A. Ong, Chair
The Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 402
Phoenix, AZ 85007

Re: A.A.C. Title 2. Administration
Chapter 8. State Retirement System Board

Dear Ms. Ong:

The attached final rule package is submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

1. Close of record date: The rulemaking record was closed on August 16, 2016 following a period for public comment and an oral proceeding.
2. Relation of the rulemaking to a five-year-review report: This rulemaking does not relate to a Five-year Review Report.
3. New fee or fee increase: This rulemaking does not establish a new fee or increase an existing fee.
4. Immediate effective date: An immediate effective date is not requested.
5. Certification regarding studies: I certify that the Board did not rely on any studies for this rulemaking.
8. Certification that the preparer of the EIS notified the JLBC of the number of new full-time employees necessary to implement and enforce the rule: I certify that the rule in this rulemaking will not require a state agency to employ a new full-time employee. No notification was provided to JLBC.
9. List of documents enclosed:
 - a. Cover letter signed by the Board's Deputy Director;
 - b. Notice of Final Rulemaking including the preamble, table of contents for the rulemaking, and rule text; and
 - c. Economic, Small Business, and Consumer Impact Statement.

Sincerely,

Anthony Guarino
Assistant Director

NOTICE OF FINAL RULEMAKING
TITLE 2. ADMINISTRATION
CHAPTER 8. STATE RETIREMENT SYSTEM BOARD

PREAMBLE

1. Articles, Parts, and Sections Affected

R2-8-126

Rulemaking Action

Amend

2. Citations to the agency's statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 38-714(E)(4)

Implementing statutes: A.R.S. §§ 38-711, 38-764, 38-769, 38-771, 38-771.01, 38-774, and 38-775

3. The effective date for the rules:

As specified under A.R.S. § 41-1032(A), the rule will be effective 60 days after the rule package is filed with the Office of the Secretary of State.

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

Not applicable.

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable.

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Docket Opening: 21 A.A.R. 1834, September 11, 2015

Notice of Proposed Rulemaking: 21 A.A.R. 2281, October 9, 2015

Notice of Final Rulemaking: 22 A.A.R. 79, January 15, 2016

Notice of Substantive Policy Statement: 22 A.A.R. 707, April 1, 2016

Notice of Rulemaking Docket Opening: 22 A.A.R. 1064, May 6, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 1727, July 8, 2016

5. The agency's contact person who can answer questions about the rulemaking:

Name: Jessica A.R. Thomas, Rules Writer

Address: Arizona State Retirement System

3300 N. Central Ave., Ste. 1400

Phoenix, AZ 85012-0250

Telephone: (602) 240-2039

E-Mail: JessicaT@azasrs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed, or renumbered, to include an explanation about the rulemaking:

R2-8-126 provides notice to members regarding what type of annuity the member may elect at retirement based on age and/or dollar amount. However, the ASRS will amend subsections (F), (H), (I) and (J) of this rule to better clarify which annuity options are applicable only to retirees with an original retirement date on or after the effective date of those provisions. These amendments are necessary to improve the clarity and consistency of the rule as discussed in the Economic Impact Statement.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

No study was reviewed.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

9. A summary of the economic, small business, and consumer impact:

The ASRS promulgates rules that allow the agency to provide for the proper administration of the state retirement trust fund. ASRS rules affect ASRS members and ASRS employers regarding how they contribute to, and receive benefits from, the ASRS. The ASRS effectively administers how public-sector employers and employees participate in the ASRS. As such, the ASRS does not issue permits or licenses, or charge fees, and its rules have little to no economic impact on private-sector businesses, with the exception of some employer partner charter schools, which have voluntarily contracted to join the ASRS. Thus, there is little to no economic, small business, or consumer impact, other than the minimal cost to the ASRS to prepare the rule package. The rule will have minimal economic impact, if any, because it merely clarifies current annuity options without imposing any additional requirements on the public. Clarifying the applicability of R2-8-126(I) and (J), as well as amending subsections (F) and (H) while adopting a new subsection (K) will increase understandability of the annuity options available to a member at retirement and will ensure ASRS members and their spouses have notice regarding those options; thus, reducing the regulatory burden and the economic impact.

10. A description of any changes between the proposed rulemaking, including supplemental notices, and the final rulemaking:

There were no changes between the proposed rulemaking and the final rulemaking.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The ASRS received no written comments regarding the rulemaking. No one attended the oral proceeding on August 16, 2016.

12. All agencies shall list any other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

None.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

The rules do not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

26 U.S.C. 401(a)(9), and corresponding Treasury Regulations: §§ 1.401(a)(9)-1 (Q&A-2(d)); 1.401(a)(9)-9 (Q&A-2); 1-401(a)(9)-6 (Q&A-2) specifically apply to this rulemaking. These federal regulations indicate that a member may participate in certain types of annuity options at certain ages, regardless whether the contingent annuitant is a current or former spouse. With the changes completed in this rulemaking, R2-8-126 will not be more stringent than these federal laws.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

No materials are incorporated by reference.

14. Whether the rule was previously made, amended, or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 2. ADMINISTRATION
CHAPTER 8. STATE RETIREMENT SYSTEM BOARD
ARTICLE 1. RETIREMENT SYSTEM; DEFINED BENEFIT PLAN

Section

R2-8-126. Calculating Optional Forms of Benefits

ARTICLE 1. RETIREMENT SYSTEM; DEFINED BENEFIT PLAN

R2-8-126. Calculating Optional Forms of Benefits

- A. For the purposes of this Section, the following definitions apply, unless stated otherwise:
1. ~~“prior-Prior~~ “Prior service credit” means a “service credit” listed in R2-8-501(24), credited service that is earned pursuant to A.R.S. § 38-739, or a service credit that is transferred or redeemed pursuant to A.R.S. §§ 38-730, 38-771, or 38-921 et seq.
 2. “Original retirement date” means:
 - a. The date a member retires from the ASRS for the first time; or
 - b. The date a member retires from the ASRS after returning to active membership for 60 consecutive months or more pursuant to A.R.S. § 38-766(C).
- B. An individual who is 104 years of age or older at the time of retirement is not eligible to ~~select~~ elect an option of life annuity with a term certain.
- C. An individual who is 93 years of age or older at the time of retirement is not eligible to ~~select~~ elect the options of life annuity with ten years certain or life annuity with 15 years certain.
- D. An individual who is 85 years of age or older at the time of retirement is not eligible to ~~select~~ elect the option of life annuity with 15 years certain.
- E. As authorized under A.R.S. § 38-764(F), if the life annuity of any ~~Plan~~ member is less than a monthly amount determined by the Board, the ASRS shall not pay the annuity. Instead, the ASRS shall make a lump sum payment in the amount determined by using appropriate actuarial assumptions.
- F. The ASRS shall calculate a member’s or beneficiary’s benefits, based on the attained age of the member or beneficiary, determined in years and full months, as of:
1. ~~the effective-~~ The date of the benefit payment-member’s retirement; or
 2. The date of the member’s death, if the beneficiary is eligible to elect the survivor benefit as monthly income for life pursuant to A.R.S. § 38-762(C).
- G. ~~The~~ Before the ASRS applies the calculation for an optional form of retirement benefit provided in A.R.S. § 38-760, the ASRS shall add include any prior service credit benefit that is payable to a member applicable to the life annuity of the member before the ASRS applies any optional payment plan calculation provided for in A.R.S. § 38-760.
- H. A member who is ten ~~or more~~ years and one day, or more, older than the member’s non-spousal contingent annuitant is not eligible to participate in a 100% joint-and-survivor option. A member who is 24 ~~or more~~ years and one day, or more, older than the member’s non-spousal contingent annuitant is not eligible to participate in a 66 2/3% joint-and-survivor option.

- I. ~~Notwithstanding~~ For members whose original retirement date is on or after March 6, 2016, ~~notwithstanding~~ subsection (H), a member who is ten ~~or more~~ years and one day, or more, older than the member's ex-spouse contingent annuitant is eligible to participate in a 100% joint-and-survivor option, if:
1. The member ~~selected~~ elected the ex-spouse as the contingent annuitant prior to divorce from the ex-spouse; and
 2. The member submits a DRO to the ASRS which requires the ex-spouse to be the contingent annuitant on the member's account.
- J. ~~Notwithstanding~~ For members whose original retirement date is on or after March 6, 2016, ~~notwithstanding~~ subsection (H), a member who is 24 ~~or more~~ years and one day, or more, older than the member's ex-spouse contingent annuitant is eligible to participate in a 66 2/3% joint-and-survivor option, if:
1. The member ~~selected~~ elected the ex-spouse as the contingent annuitant prior to divorce from the ex-spouse; and
 2. The member submits a DRO to the ASRS which requires the ex-spouse to be the contingent annuitant on the member's account.
- K. Notwithstanding subsection (F), for purposes of determining whether a member is eligible to participate in a joint-and-survivor option, the ASRS shall calculate the difference in a member's age and the contingent annuitant's age based on the birthdates of the member and the contingent annuitant.

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT¹

TITLE 2. ADMINISTRATION

CHAPTER 8. STATE RETIREMENT SYSTEM BOARD

1. Identification of the rulemaking:

R2-8-126 provides notice to members regarding what type of annuity the member may elect at retirement based on age and/or dollar amount. However, the ASRS will amend subsections (I) and (J) of this rule to better clarify those annuity options are applicable only to retirees with an original retirement date on or after the effective date of those provisions. The ASRS will also amend subsections (F) and (H) while adopting a new subsection (K) to better clarify how the ASRS determines the age(s) for members and beneficiaries depending on whether the age calculation is for purposes of receiving benefits or determining benefit eligibility.

Clarifying that subsections (I) and (J) only apply to members with retirement dates on or after the effective date of those provisions, will make the rule clearer and increase understandability of the retirement options available to members. Amending subsections (F) and (H) while establishing subsection (K), will ensure that members understand how the ASRS will determine benefit eligibility based on age, thereby reducing the regulatory burden imposed on the public. The amendments outlined above will clarify the rule language without substantively changing the rules' requirements. This rulemaking will help the ASRS control and mitigate possible delays associated with determining whether a member or beneficiary is eligible for a particular benefit option, resulting in the more efficient operation and administration of the ASRS.

a. The conduct and its frequency of occurrence that the rule is designed to change:

A.R.S. § 38-775 describes what distributions the ASRS is required to make under federal law. The statute incorporates 26 U.S.C. 401(a)(9), and corresponding Treasury Regulations: §§ 1.401(a)(9)-1 (Q&A-2(d)); 1.401(a)(9)-9 (Q&A-2); 1-401(a)(9)-6 (Q&A-2). These federal regulations indicate that a member may participate in certain types of annuity options at certain ages, regardless whether the contingent annuitant is a current or former spouse. However, certain provisions in the rule need to be amended as discussed above, in order to ensure that members are

¹ If adequate data are not reasonably available, the agency shall explain the limitations of the data, the methods used in an attempt to obtain the data, and characterize the probable impacts in qualitative terms. (A.R.S. § 41-1055(C)).

aware of the eligibility restrictions on certain annuity options. With the changes completed in this rulemaking, R2-8-126 will be clearer and more consistent with federal law. Ultimately, this will reduce any administrative delay in determining whether a member is eligible for certain annuity options.

b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

If a member does not understand for which annuity options they are eligible, their election of a particular annuity for which they are not eligible will cause administrative delay. Moreover, misunderstanding may lead to incorrect benefit amounts being paid by the ASRS to incorrect beneficiaries and/or members. This potential inaccuracy may decrease the funded status of the ASRS, which could result in increased rates for retirement and health benefit supplement contributions. More importantly, such inaccuracies must be corrected when they are discovered which can lead to further administrative delay and expenses in order to ensure the correct person is receiving the correct benefit amount based on the annuity option the member elected at retirement. The conduct is likely to continue without this rulemaking because, as discussed in subsection (a) above, many members have difficulty in understanding for which annuity options they are eligible.

c. The estimated change in frequency of the targeted conduct expected from the rule change:

This rulemaking will clarify for which annuity options a member is eligible, thereby increasing understandability of the annuity options and reducing incorrect benefits paid by the ASRS as a result of the member's misunderstanding. As discussed above and below, these amendments will increase the clarity and consistency of the rule, which should result in reducing the member's confusion, as well as any potential delay caused by the confusion.

2. A brief summary of the information included in the economic, small business, and consumer impact statement:

The ASRS promulgates rules that allow the agency to provide for the proper administration of the state retirement trust fund. ASRS rules affect ASRS members and ASRS employers regarding how they contribute to, and receive benefits from, the ASRS. The ASRS

effectively administrates how public-sector employers and employees participate in the ASRS. As such, the ASRS does not issue permits or licenses, or charge fees, and its rules have little to no economic impact on private-sector businesses, with the exception of some employer partner charter schools, which have voluntarily contracted to join the ASRS. Thus, there is little to no economic, small business, or consumer impact, other than the minimal cost to the ASRS to prepare the rule package. The rule will have minimal economic impact, if any, because it merely clarifies current annuity options without imposing any additional requirements on the public. Clarifying the applicability of R2-8-126(I) and (J) and amending subsections (F) and (H) while establishing a new subsection (K), will increase understandability of the annuity options available to a member at retirement and will ensure ASRS members and their beneficiaries have notice regarding those options; thus, reducing the regulatory burden and the economic impact.

3. The person to contact to submit or request additional data on the information included in the economic, small business, and consumer impact statement:

Name: Jessica A.R. Thomas, Rules Writer
Address: Arizona State Retirement System
3300 N. Central Ave., Suite 1400
Phoenix, AZ 85012-0250
Telephone: (602) 240-2039
E-mail: JessicaT@azasrs.gov

4. Persons who will be directly affected by, bear the costs of, or directly benefit from the rulemaking:

In general, all members of the ASRS and their beneficiaries will be directly affected by, bear the costs of, and directly benefit from this rulemaking. The ASRS incurred the cost of the rulemaking. The ASRS currently has a total membership of approximately 558,136.

Specifically, members who wish to elect one of the joint-and-survivor annuity options will be affected and benefited by this rulemaking. This rule will clarify for which annuity options a member may be eligible upon retirement based on the age of the member and/or the member's beneficiary. Such clarification will benefit members by increasing the readability of the various annuity options.

5. Cost-benefit analysis:

- a. Costs and benefits to state agencies directly affected by the rulemaking including the number of new full-time employees at the implementing agency required to implement and enforce the proposed rule:

All ASRS members are directly affected by this rulemaking because it will clarify for which annuity options a member may be eligible upon retirement based on the age of the member and/or the member's beneficiary. However, the ASRS has determined that no new full-time employees will be required to implement and enforce the rule.

- b. Costs and benefits to political subdivisions directly affected by the rulemaking:

This rulemaking does not provide any benefits or impose any costs on political subdivisions.

- c. Costs and benefits to businesses directly affected by the rulemaking:

No businesses are directly affected by the rulemaking.

- 6. Impact on private and public employment:

The rulemaking will have no impact on private or public employment, except to the extent that members may adjust when they retire based on a better understanding of their eligibility for specific annuity options.

- 7. Impact on small businesses²:

- a. Identification of the small business subject to the rulemaking:

No businesses, regardless of size, are subject to the rulemaking.

- b. Administrative and other costs required for compliance with the rulemaking:

Not applicable.

- c. Description of methods that may be used to reduce the impact on small businesses:

Not applicable.

- 8. Cost and benefit to private persons and consumers who are directly affected by the rulemaking:

² Small business has the meaning specified in A.R.S. § 41-1001(20).

All ASRS members are directly affected by the rulemaking. The effect has been previously described above.

9. Probable effects on state revenues:

There will be no effect on state revenues.

10. Less intrusive or less costly alternative methods considered:

The ASRS believes this is the least costly and least intrusive method because it will clarify the statutory requirements for remitting an ACR without imposing any additional requirements on the public.

TITLE 2. ADMINISTRATION

CHAPTER 8. STATE RETIREMENT SYSTEM BOARD

Authority: A.R.S. § 38-701 et seq.

**ARTICLE 1. RETIREMENT SYSTEM; DEFINED
BENEFIT PLAN**

Section

- R2-8-101. Repealed
- R2-8-102. Repealed
- R2-8-103. Repealed
- R2-8-104. Definitions
- R2-8-105. Repealed
- R2-8-106. Reserved
- R2-8-107. Reserved
- R2-8-108. Reserved
- R2-8-109. Reserved
- R2-8-110. Reserved
- R2-8-111. Reserved
- R2-8-112. Reserved
- R2-8-113. Emergency Expired
- R2-8-114. Emergency Expired
- R2-8-115. Return of Contributions Upon Termination of Membership by Separation from All ASRS Employment by Other Than Retirement or Death; Payment of Survivor Benefits Upon the Death of a Member
- R2-8-116. Alternate Contribution Rate
- R2-8-117. Repealed
- R2-8-118. Application of Interest Rates
- R2-8-119. Expired
- R2-8-120. Designating a Beneficiary; Spousal Consent to Designation
- R2-8-121. Repealed
- R2-8-122. Remittance of contributions
- R2-8-123. Actuarial Assumptions and Actuarial Value of Assets
 - Table 1. Expired
 - Table 2. Expired
 - Table 3. Repealed
 - Table 3A. Expired
 - Table 3B. Expired
 - Table 4. Expired
 - Table 4A. Repealed
 - Table 4B. Repealed
 - Table 4C. Repealed
 - Table 5. Expired
 - Table 6. Expired
 - Table 7. Expired
- R2-8-124. Repealed
- R2-8-125. Repealed
- R2-8-126. Calculating Benefits
 - Table 1. Repealed
 - Table 2. Repealed
 - Table 3. Repealed
 - Table 4. Repealed
 - Table 5. Repealed
 - Table 6. Repealed
 - Table 7. Repealed
 - Table 8. Repealed
 - Table 9. Repealed
 - Table 10. Repealed
 - Table 11. Repealed
 - Exhibit A. Repealed
 - Exhibit B. Repealed
 - Table 1. Repealed
 - Table 2. Repealed

Table 3. Repealed
Exhibit C. Repealed
Exhibit D. Repealed
Table 1. Repealed
Table 2. Repealed
Table 3. Repealed
Table 4. Repealed
Table 5. Repealed
Table 6. Repealed
Exhibit E. Repealed
Table 1. Repealed
Table 2. Repealed
Table 3. Repealed
Table 4. Repealed
Table 5. Repealed
Table 6. Repealed
Exhibit F. Repealed
Table 1. Repealed
Table 2. Repealed
Table 3. Repealed
Table 4. Repealed
Table 5. Repealed
Table 6. Repealed
Exhibit G. Repealed
Exhibit H. Repealed
Exhibit I. Repealed
Exhibit J. Repealed
Exhibit K. Repealed
Exhibit L. Repealed
Table 1. Repealed
Table 2. Repealed
Table 3. Repealed
Table 4. Repealed
Table 5. Repealed
Table 6. Repealed
Table 7. Repealed
Exhibit M. Repealed
Table 1. Repealed
Table 2. Repealed
Table 3. Repealed
Table 4. Repealed
Table 5. Repealed
Table 6. Repealed

**ARTICLE 2. STATE RETIREMENT DEFINED
CONTRIBUTION PROGRAM**

Article 2, consisting of R2-8-201 through R2-8-207, made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2).

Section
R2-8-201. Expired
R2-8-202. Expired
R2-8-203. Expired
R2-8-204. Expired
R2-8-205. Expired
R2-8-206. Expired
R2-8-207. Expired

ARTICLE 3. RESERVED

ARTICLE 4. PRACTICE AND PROCEDURE BEFORE THE BOARD

Article 4, consisting of R2-8-401 through R2-8-405, made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

Section

- R2-8-401. Definitions
- R2-8-402. General Procedures
- R2-8-403. Request for a Hearing of an Appealable Agency Action
- R2-8-404. Board Decisions on Hearings before the Office of Administrative Hearings
- R2-8-405. Rehearing; Review of a Final Decision

ARTICLE 5. PURCHASING SERVICE CREDIT

Article 5, consisting of R2-8-501 through R2-8-521, made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

- R2-8-501. Definitions
- R2-8-502. Request to Purchase Service Credit and Notification of Cost
- R2-8-503. Requirements Applicable to All Service Credit Purchases
- R2-8-504. Service Credit Calculation for Purchasing Service Credit
- R2-8-505. Restrictions on Purchasing Overlapping Service Credit; Transfers
- R2-8-506. Cost Calculation for Purchasing Service Credit
- R2-8-507. Required Documentation and Calculations for Forfeited Service Credit
- R2-8-508. Required Documentation and Calculations for Leave of Absence Service Credit
- R2-8-509. Required Documentation and Calculations for Military Service Credit
- R2-8-510. Required Documentation and Calculations for Presidential Call-up Service Credit
- R2-8-511. Required Documentation and Calculations for Other Public Service Credit
- R2-8-512. Purchasing Service Credit by Check, Cashier's Check, or Money Order
- R2-8-513. Purchasing Service Credit by Irrevocable Payroll Deduction Authorization
- R2-8-513.01. Irrevocable Payroll Deduction Authorization and Transfer of Employment to a Different ASRS Employer
- R2-8-513.02. Termination Date
- R2-8-514. Purchasing Service Credit by Direct Rollover
- R2-8-515. Purchasing Service Credit by Trustee-to-Trustee Transfer
- R2-8-516. Purchasing Service Credit by Indirect IRA Rollover
- R2-8-517. Purchasing Service Credit by Distributed Rollover Contribution
- R2-8-518. Repealed
- R2-8-519. Purchasing Service Credit by Termination Pay Distribution
- R2-8-520. Termination of Employment and Request Return of Retirement Contributions or Death of Member While Purchasing Service Credit by an Irrevocable Payroll Deduction Authorization
- R2-8-521. Adjustment of Errors

ARTICLE 6. PUBLIC PARTICIPATION IN RULEMAKING

Article 6, consisting of R2-8-601 through R2-8-607, made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

Section

- R2-8-601. Definitions
- R2-8-602. Reviewing Agency Rulemaking Record and Directory of Substantive Policy Statements
- R2-8-603. Petition for Rulemaking
- R2-8-604. Review of a Rule, Agency Practice, or Substantive Policy Statement
- R2-8-605. Objection to Rule Based Upon Economic, Small Business, and Consumer Impact
- R2-8-606. Oral Proceedings
- R2-8-607. Petition for Delayed Effective Date

ARTICLE 7. CONTRIBUTIONS NOT WITHHELD

Article 7, consisting of R2-8-701 through R2-8-709, made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

Section

- R2-8-701. Definitions
- R2-8-702. General Information
- R2-8-703. ASRS Employer's Discovery of Error
- R2-8-704. Member's Discovery of Error
- R2-8-705. ASRS' Discovery of Error
- R2-8-706. Determination of Contributions Not Withheld
- R2-8-707. Submission of Payment
- R2-8-708. Dispute of an ASRS Determination Regarding Contributions Not Withheld
- R2-8-709. Nonpayment of Contributions

**ARTICLE 1. RETIREMENT SYSTEM; DEFINED
BENEFIT PLAN**

R2-8-101. Repealed

Historical Note

Former Rule, Social Security Regulation 1; Former Section R2-8-01 renumbered as Section R2-8-101 without change effective May 21, 1982 (Supp. 82-3). Amended subsections (A) and (C) effective April 12, 1984 (Supp. 84-2). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-102. Repealed

Historical Note

Former Rule, Social Security Regulation 2; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-02 renumbered as Section R2-8-102 without change effective May 21, 1982 (Supp. 82-3). Amended as an emergency by adding subsection (E) effective January 1, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Permanent rule, subsections (A), (B), and (D), amended effective April 12, 1984 (Supp. 84-2). Correction, subsection (B), as amended effective April 12, 1984 (Supp. 84-3). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-103. Repealed

Historical Note

Former Rule, Social Security Regulation 3; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-03 renumbered as Section R2-8-103 without change effective May 21, 1982 (Supp. 82-3). Amended as an emergency by adding subsection (E) effective January 1, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Permanent rule, subsections (A) thru (C), amended effective April 12, 1984 (Supp. 84-2). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-104. Definitions

- A. The definitions in A.R.S. § 38-711 apply to this Chapter.
- B. Unless otherwise specified, in this Chapter:
 1. "Actuarial assumption" means an estimate of an uncertain future event that affects pension liabilities, or assets, or both.
 2. "Authorized employer representative" means an individual specified by the ASRS employer to provide the ASRS with information about a member who previously worked for the ASRS employer.
 3. "Contribution" means:
 - a. Amounts required by A.R.S. Title 38, Chapter 5, Article 2 to be paid to the ASRS by a member or an employer on behalf of a member other than amounts attributed to the long-term disability program;
 - b. Any voluntary amounts paid to the ASRS by a member to be placed in the member's account; and
 - c. Amounts credited by transfer under A.R.S. § 38-924.
 4. "Day" means a calendar day, and excludes the:
 - a. Day of the act or event from which a designated period of time begins to run; and
 - b. Last day of the period if a Saturday, Sunday, or official state holiday.
 5. "Designated beneficiary" means the same as in A.R.S. § 38-762(G).
 6. "Director" means the Director appointed by the Board as provided in A.R.S. § 38-715.
 7. "Individual retirement account" or "IRA" means the types of eligible retirement plans specified in A.R.S. § 38-770(D)(3)(a) and (b).
 8. "Investment return rate" means a percentage of total return on an asset.
 9. "Party" means the same as in A.R.S. § 41-1001(14).
 10. "Person" means the same as in A.R.S. § 41-1001(15).
 11. "Plan" means the same as "defined benefit plan" in A.R.S. § 38-712(B), and as administered by the ASRS.
 12. "Retirement account" means the same as in A.R.S. § 38-771(J)(2).
 13. "Rollover" means a contribution to the ASRS by an eligible member of an eligible rollover distribution from one or more of the retirement plans listed in A.R.S. § 38-747(H)(2) and (H)(3).
 14. "System" means the same as "defined contribution plan" in A.R.S. § 38-769(O)(7), and as administered by the ASRS.
 15. "Terminate employment" means to end the employment relationship between a member and an ASRS employer with the intent that the member does not return to employment with an ASRS employer.
 16. "United States" means the same as in A.R.S. § 1-215(39).

Historical Note

Former Rule, Social Security Regulation 4; Former Section R2-8-04 renumbered as Section R2-8-104 without change effective May 21, 1982 (Supp. 82-3). Amended subsections (G), (J), and (K) effective April 12, 1984 (Supp. 84-2). Typographical error corrected in subsection (5)(c) "required" corrected to "required" (Supp. 97-1). Amended by final rulemaking at 21 A.A.R. 2515, effective December 5, 2015 (Supp. XX)

R2-8-105. Repealed

Historical Note

Former Rule, Social Security Regulation 5; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-05 renumbered as Section R2-8-105 without change effective May 21, 1982 (Supp. 82-3). Amended as an emergency by adding subsection (E) effective January 1, 1984, pursuant to A.R.S. § 41-1003, valid for only 90 days (Supp. 83-6). Emergency expired. Permanent rule amended effective April 12, 1984 (Supp. 84-2). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-106. Reserved

R2-8-107. Reserved

R2-8-108. Reserved

R2-8-109. Reserved

R2-8-110. Reserved

R2-8-111. Reserved

R2-8-112. Reserved

R2-8-113. Emergency Expired

Historical Note

New Section made by emergency rulemaking at 11 A.A.R. 579, effective January 4, 2005 (05-1). Emergency rule expired (Supp. 05-2).

R2-8-114. Emergency Expired

Historical Note

New Section made by emergency rulemaking at 11 A.A.R. 579, effective January 4, 2005 (05-1). Emergency rule expired (Supp. 05-2).

R2-8-115. Return of Contributions Upon Termination of Membership by Separation from All ASRS Employment by Other Than Retirement or Death; Payment of Survivor Benefits Upon the Death of a Member

A. The following definitions apply to this Section unless otherwise specified:

1. "Acceptable documentation" means any ASRS form request containing all the accurate, required information, dates, and signatures necessary to process the form request.
2. "Eligible retirement plan" means the same as in A.R.S. § 38-770(D)(3).
3. "Employer number" means a unique identifier the ASRS assigns to a member employer.
4. "Employer plan" means the types of eligible retirement plans specified in A.R.S. § 38-770(D)(3)(c), (d), (e), and (f).
5. "Process date" means the calendar day the ASRS generates contribution withdrawal documents to be sent to a member.
6. "Warrant" means a voucher authorizing payment of funds due to a member.

B. A member who terminates from all ASRS employment by other than retirement or death and desires a return of the member's contributions, including amounts received for the purchase of service, any employer contributions authorized under A.R.S. § 38-740, and interest on the contributions, shall request from the ASRS, in writing or verbally, the documents necessary to apply for the withdrawal of the member's contributions.

C. Upon request, to withdraw by the member, the ASRS shall provide:

1. An Application for Withdrawal of Contributions and Termination of Membership form to the member, and
2. An Ending Payroll Verification - Withdrawal of Contribution and Termination of Membership form to the employer.

D. The member shall complete and return to the ASRS the Application for Withdrawal of Contributions and Termination of Membership form that includes the following information:

1. The member's full name;
2. The member's Social Security number;
3. The member's current mailing address;
4. The member's daytime telephone number, if applicable;
5. The member's birth date;
6. The date of termination;
7. Dated signature of the member certifying that the member:
 - a. Is no longer employed by any ASRS employer;
 - b. Is neither under contract nor has any verbal or written agreement for future employment with an ASRS employer;
 - c. Is not currently in a leave of absence status with an ASRS employer;
 - d. Understands that each of the member's former ASRS employer will complete a payroll verification form if payroll transactions occurred with the ASRS employer within the six months before the process date;
 - e. Has read and understands the Special Tax Notice Regarding Plan Payments the member received with the application;
 - f. Understands that the member is forfeiting all future retirement rights and privileges of membership with the ASRS;
 - g. Understands that long-term disability benefits will be canceled if the member elects to withdraw contributions while receiving or electing to receive long-term disability benefits;
 - h. Understands that if the member elects to roll over all or any portion of the member's distribution to another employer plan, it is the member's responsibility to verify that the receiving employer plan will accept the rollover and, if

- applicable, agree to separately account for the pre-tax and post-tax amounts rolled over and the related subsequent earnings on the amounts;
- i. Understands that if the member elects to roll over all or any portion of the member's distribution to an individual retirement account, it is the member's responsibility to separately account for pre-tax and post-tax amounts; and
 - j. Understands that if the member elects a rollover to another employer plan or individual retirement account, any portion of the distribution not designated for rollover will be paid directly to the member and any taxable amounts will be subject to 20% federal income tax withholding and 5% state tax withholding;
8. Specify that:
- a. The entire amount of the distribution be paid directly to the member,
 - b. The entire amount of the distribution be transferred to an eligible retirement plan, or
 - c. An identified amount of the distribution be transferred to an eligible retirement plan and the remaining amount be paid directly to the member; and
9. If the member selects all or a portion of the withdrawal be paid to an eligible retirement plan, specify:
- a. The type of eligible retirement plan;
 - b. The eligible retirement plan account number, if applicable; and
 - c. The name and mailing address of the eligible retirement plan.
- E. If the member requesting the withdrawal has been inactive for five years or more, and if the member's account balance is \$1,000 or more, the member requesting the withdrawal shall provide a copy of a driver license or a form of other government issued identification to the ASRS.
- F. If a payroll transaction for the member occurred with any ASRS employer within six months before the process date each ASRS employer shall complete an Ending Payroll Verification - Withdrawal of Contributions and Termination of Membership form electronically that includes the following information:
1. The member's full name;
 2. The member's Social Security number;
 3. The member's termination date;
 4. The member's final pay period ending date;
 5. The final amount of contributions, including any adjustments or corrections, but not including any long-term disability contributions;
 6. The ASRS employer's name and telephone number;
 7. The employer number;
 8. The name and title of the authorized employer representative;
 9. Certification by the authorized employer representative that:
 - a. The member terminated employment and is neither under contract nor bound by any verbal or written agreement for employment with the employer;
 - b. There is no agreement to re-employ the member; and
 - c. The authorized employer representative has the legal power to bind the employer in transactions with the ASRS; and
 10. The signature of the authorized employer representative and date of signature.
- G. If the member requests a return of contributions and a warrant is distributed during the fiscal year that the member began membership in the ASRS, no interest is paid to the account of the member.
- H. If the member requests a return of contributions after the first fiscal year of membership, the ASRS shall credit interest at the rate specified in Column 3 of the table in R2-8-118(A) to the account of the member as of June 30 of each year, on the basis of the balance in the account of the member as of the previous June 30. The ASRS shall credit interest for a partial fiscal year of membership in the ASRS on the previous June 30 balance based on the number of days of membership up to and including the day the ASRS issues the warrant divided by the total number days in the fiscal year. Contributions made after the previous June 30 are returned without interest.
- I. Upon submitting to the ASRS the completed and accurate Application for Withdrawal of Contributions and Termination of Membership form and, if applicable, after the ASRS has received any Ending Payroll Verification - Withdrawal of Contributions and Termination of Membership forms, a member is entitled to payment of the amount due to the member as specified in subsection (G) or (H) unless a present or former spouse submits to the ASRS a domestic relations order that specifies entitlement to all or part of the return of contributions under A.R.S. § 38-773 before the ASRS returns the contributions as specified by the member.
- J. Upon the death of a member, the ASRS shall distribute the survivor benefits according to the most recent, acceptable documentation that is on file with the ASRS that was received prior to the date of the member's death, unless otherwise provided by law.
- K. If there is no designation of beneficiary or if the designated beneficiary predeceases the member, the survivor benefit is paid as specified in A.R.S. § 38-762(E). The designated beneficiary or other person specified in A.R.S. § 38-762(E) shall:
1. Provide a certified copy of a death certificate or a certified copy of a court order that establishes the member's death;
 2. Provide a certified copy of the court order of appointment as administrator, if applicable; and
 3. Except if the deceased member was retired and elected the joint and survivor option, complete and have notarized an application for survivor benefits, provided by the ASRS, that includes:
 - a. The deceased member's full name,

- b. The deceased member's Social Security number,
- c. The following, as it pertains to the designated beneficiary or other person specified in A.R.S. § 38-762(E):
 - i. Full name;
 - ii. Mailing address;
 - iii. Contact telephone number;
 - iv. Date of birth, if applicable; and
 - v. Social Security number or Tax ID number, if applicable.

Historical Note

Former Rule, Social Security Regulation 1; Amended effective Dec. 20, 1979 (Supp. 79-6). Former Section R2-8-15 renumbered as Section R2-8-115 without change effective May 21, 1982 (Supp. 82-3). Amended by final rulemaking at 11 A.A.R. 1416, effective April 5, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 644, effective February 7, 2006 (Supp. 06-1). Amended by final rulemaking at 22 A.A.R. 79, effective March 6, 2016 (Supp. XX).

R2-8-116. Alternate Contribution Rate

- A. For purposes of this section, the following definitions apply:
 - 1. "ACR" means an alternate contribution rate pursuant to A.R.S. § 38-766.02, the resulting amount of which is not deducted from the employee's compensation.
 - 2. "Class of positions" means all employment positions of the employer that perform the same, or substantially similar, function or duties, for the employer as determined by the ASRS in subsection (B).
 - 3. "Compensation" has the same meaning as A.R.S. § 38-711(7) and does not include ACR amounts.
 - 4. "Leased from a third party" means:
 - a. The employee is not employed by an employer; and
 - b. A co-employment relationship, as defined in A.R.S. § 23-561(4), does not exist.
- B. An employer that employs a retired member shall pay an ACR to the ASRS, unless the employer provides proof that:
 - 1. The retired member is leased from a third party; and
 - 2. All employees in the entire class of positions, to which the retired member's position belongs, have been leased from a third party; and
 - 3. No employee who has not been leased is performing the same, or substantially similar, function or duties, as the retired member.
- C. In order to determine whether an employer satisfies the criteria in subsection (B), the employer shall submit information and documentation, pursuant to A.R.S. § 38-766.02(E), within 14 days of written request by the ASRS.
- D. The employer shall directly remit payment of an ACR to the ASRS from the employer's funds, through the employer's secure ASRS account within 14 days of the first pay period end date after the hire of the retired member.
- E. If the employer does not remit the ACR by the date it is due pursuant to subsection (D), the ASRS shall charge interest on the ACR amount from the date it was due to the date the ACR payment is remitted to the ASRS at the assumed actuarial interest rate listed in R2-8-118(B).
- F. A payment of an ACR on behalf of a retired member pursuant to A.R.S. § 38-766.02, shall not entitle a retired member to a refund of an ACR payment or any additional ASRS benefit as described in A.R.S. § 38-766.01(E).

Historical Note

Former Rule, Retirement System Regulation 2; Former Section R2-8-16 renumbered as Section R2-8-116 without change effective May 21, 1982 (Supp. 82-3). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3). New Section made by final rulemaking at 22 A.A.R. 1341, effective July 4, 2016 (Supp. 16-X).

R2-8-117. Repealed

Historical Note

Former Rule, Retirement System Regulation 3; Former Section R2-8-17 renumbered as Section R2-8-117 without change effective May 21, 1982 (Supp. 82-3). Section repealed by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-118. Application of Interest Rates

A. Application of interest from inception of the ASRS through the present is as follows:

Effective Date of Interest Rate Change	Assumed Interest and Return Rate	Actuarial Investment Return Rate	Interest Rate Used to Determine Return of Contributions Upon Termination of Membership by Separation from Service by Other Than Retirement or Death	Interest Rate Used to Determine Survivor Benefits
7-1-1953	2.50%		2.50%	2.50%
7-1-1959	3.00%		3.00%	3.00%
7-1-1966	3.75%		3.75%	3.75%

7-1-1969	4.25%	4.25%		4.25%
7-1-1971	4.75%	4.75%		4.75%
7-1-1975	5.50%	5.50%		5.50%
7-1-1976	6.00%	5.50%		6.00%
7-1-1981	7.00%	5.50%		7.00%
7-1-1982	7.00%	7.00%		7.00%
7-1-1984	8.00%	8.00%		8.00%
7-1-2005	8.00%	4.00% for Plan Members	8.00% for System Members	8.00%
7-1-2013	8.00%	2.00% for Plan Members	8.00% for System Members	8.00%

B. At the beginning of each fiscal year interest is credited to the retirement account of each member on the June 30 that marks the end of the fiscal year based on the balance in the member's account as of the previous June 30. The balance on which interest is credited includes:

1. Employer and employee contributions;
2. Voluntary additional contributions made by members pursuant to A.R.S. §§ 38-742, 38-743, 38-744, and 38-745, if applicable;
3. Amounts credited by transfer under A.R.S. § 38-924; and
4. Interest credited in previous years.

Historical Note

Former Rule, Retirement System Regulation 4; Amended effective July 1, 1975 (Supp. 75-1). Amended effective June 23, 1976 (Supp. 76-3). Former Section R2-8-18 renumbered and amended as Section R2-8-118 effective May 21, 1982 (Supp. 82-3). Amended by final rulemaking at 11 A.A.R. 1416, effective April 5, 2005 (Supp. 05-2). Amended by final rulemaking at 19 A.A.R. 764, effective June 1, 2013 (Supp. 13-2). Amended by final rulemaking at 22 A.A.R. 79, effective March 6, 2016 (Supp. XX).

R2-8-119. Expired

Historical Note

Former Rule, Retirement System Regulation 5; Amended effective July 1, 1975 (Supp. 75-1). Amended effective June 23, 1976 (Supp. 76-3). Former Section R2-8-19 renumbered and amended as Section R2-8-119 effective May 21, 1982 (Supp. 82-3). Section R2-8-119 and Appendix A and B expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-120. Designating a Beneficiary; Spousal Consent to Designation

- A. The following definitions apply to this Section unless otherwise specified:
1. "DRO" means the same as "domestic relations order" in A.R.S. § 38-773(H)(1).
 2. "Joint and survivor annuity" means an optional form of retirement benefits described in A.R.S. § 38-760(B)(1).
 3. "Period certain and life annuity" means an optional form of retirement benefits described in A.R.S. § 38-760(B)(2).
 4. "Spouse" means the individual to whom a member is married under Arizona law.
- B. Effective July 1, 2013, a married member:
1. Who is not retired shall name and maintain the member's current spouse as primary beneficiary of at least 50 percent of the member's retirement account unless:
 - a. Naming or maintaining the current spouse as beneficiary violates another law, existing contract, or court order; or
 - b. The spouse consents to an alternate beneficiary; and
 2. Who retires shall choose a joint and survivor annuity and name the member's current spouse as contingent annuitant of at least 50 percent of the member's retirement benefit unless the spouse consents to an alternative.
- C. Application of subsection (B).
1. The ASRS shall honor a beneficiary designation last made or a retirement election submitted before July 1, 2013, even if the beneficiary designation or retirement election fails to comply with subsection (B).
 2. The ASRS shall not apply subsection (B) to a lump-sum retirement authorized under A.R.S. § 38-764.
 3. The ASRS shall not apply subsection (B) if a member submits a letter to the ASRS in which the member affirms under penalty of perjury that spousal consent is not required because of one of the reasons specified in A.R.S. § 38-776(C).
- D. Changing a beneficiary designation:
1. If a married member changes a beneficiary designation on or after July 1, 2013, the member shall ensure that the new beneficiary designation is consistent with the requirements specified in subsection (B);
 2. If a married member who retired before July 1, 2013, and:

- a. Chose a straight-life annuity wishes to change the member's beneficiary, the member shall ensure that the new beneficiary designation is consistent with subsection (B); or
 - b. Chose a period certain and life annuity or joint and survivor annuity wishes to change either the annuity option or the contingent annuitant, the member shall ensure that the new beneficiary designation is consistent with subsection (B).
- E. Re-retirement. A married member who re-retires, as described in A.R.S. § 38-766:
 - 1. Within 60 months of the member's previous retirement date, shall elect the same annuity option and beneficiary as the member made at the time of the previous retirement; or
 - 2. More than 60 months after the member's previous retirement date, shall comply with subsection (B).
- F. Involuntary cancellation of retirement. If a married member retires on or after July 1, 2013, and is issued one or more estimate checks but fails to comply with subsection (B) within 30 days after the member's effective retirement date, the member shall submit a signed letter to ASRS stating that the member's spouse refuses to consent to the chosen alternative and asking that the retirement be cancelled. The member may submit another retirement application that complies with subsection (B). The member's new effective retirement date is the date ASRS receives the new application. ASRS shall not issue additional estimate checks to a member whose retirement was involuntarily cancelled.
- G. Survivor benefits:
 - 1. If a married member last made a beneficiary designation before July 1, 2013, the ASRS shall, at the time of the member's death, honor the beneficiary designation even if the beneficiary designation is not consistent with the requirements specified in subsection (B); and
 - 2. If a married member made a beneficiary designation on or after July 1, 2013, that is not consistent with the requirements specified in subsection (B), the ASRS shall, at the time of the member's death:
 - a. Notify both the spouse and designated beneficiary and:
 - i. Provide the spouse with an opportunity to waive the right under subsection (B); and
 - ii. Provide the designated beneficiary with an opportunity to provide documentation that revokes the spouse's right under subsection (B); and
 - b. Designate 50 percent of the member's retirement benefit to the spouse if neither the spouse nor designated beneficiary respond under subsection (G)(2)(a) within 30 days after notification.
- H. Effect of legal documents. In general, a legal document such as a QDRO or prenuptial agreement will supersede the requirements in subsection (B). The ASRS shall ask the Office of the Attorney General to review the legal document before the ASRS decides how to disburse the retirement benefit.
- I. Spousal waiver and consent; consent revocation
 - 1. The current spouse of a member has a right to:
 - a. Be designated as primary beneficiary of at least 50 percent of the member's retirement account, and
 - b. Have the member choose a joint and survivor annuity with the spouse as contingent annuitant of at least 50 percent of the retirement benefit.
 - 2. To waive the right described in subsection (I)(1) and consent to an alternative, the current spouse shall complete and have notarized a spousal consent form, which is available from the ASRS. If the current spouse is not capable of completing the spousal consent form because of a documented incapacitating mental or physical condition, a person with power of attorney or a conservator may complete the spousal consent form on behalf of the current spouse.
 - 3. A spouse may revoke a waiver and consent by sending written notice to ASRS and ensuring the written notice is received no later than the earlier of one day before the member dies or ASRS disburses a retirement benefit to the member.

Historical Note

Former Rule, Social Security Regulation 6; Amended effective June 19, 1975 (Supp. 75-1). Amended effective July 13, 1979 (Supp. 79-4). Former Section R2-8-20 renumbered and amended as Section R2-8-120 effective May 21, 1982 (Supp. 82-3). Repealed effective July 24, 1985 (Supp. 85-4). New Section made by final rulemaking at 20 A.A.R. 2236, effective October 4, 2014 (Supp. 14-X). Amended...

R2-8-121. Repealed

Historical Note

Former Rule, Retirement System Regulation 7; Amended effective April 15, 1980 (Supp. 80-2). Former Section R2-8-21 renumbered as Section R2-8-121 without change effective May 21, 1982 (Supp. 82-3). Amended subsection (A) effective May 30, 1985 (Supp. 85-3). Section repealed by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (05-1).

R2-8-122. Remittance of contributions

- A. Remittance of employee member contributions: Each state department and employer member of the ASRS, including, any county, municipality or political subdivision, shall certify on each payroll the amount to be contributed by each one of their employee members of the ASRS and shall remit the amount of employee member contributions to the ASRS, together with such detailed report as may be required by the ASRS to identify the individual owner of each such member contribution, not later than 14 calendar days after the last day of each payroll period. Payments of employee member contributions not received in the offices of the ASRS by the 14th calendar day after the last day of the applicable payroll period shall become

delinquent after that date and shall be increased, by interest at the rate of eight percent per annum from and after the date of delinquency until payment is received by the ASRS.

- B. Remittance of employer contributions: Each state department and employer member of the ASRS, including, any county, municipality or political subdivision, shall remit the amount of employer contributions to the ASRS not later than 14 calendar days after the last day of each payroll period. Payments of employer contributions not received in the offices of the ASRS by the 14th calendar day after the last day of the applicable payroll period shall become delinquent after that date and shall be increased, by interest at the rate of eight percent per annum from and after the date of delinquency until payment is received by the ASRS.

Historical Note

Former Rule, Retirement System Regulation 8; Amended effective Dec. 8, 1978 (Supp. 78-6). Former Section R2-8-122 renumbered as Section R2-8-122 without change effective May 21, 1982 (Supp. 82-3). Section amended by Final Rulemaking at 22 A.A.R. 79, effective March 6, 2016, (Supp. XX)

R2-8-123. Actuarial Assumptions and Actuarial Value of Assets

- A. For the purposes of this Section, “market value” means an estimated monetary worth of an asset based on the current demand for the asset and the amount of that type of asset available for sale.
- B. The Board adopts the following actuarial assumptions and asset valuation method:
1. The interest and investment return rate assumptions are determined by the Board.
 2. The actuarial value of assets equals the market value of assets:
 - a. Minus a 10-year phase-in of the excess for years in which actual investment return exceeds expected investment return; and
 - b. Plus a 10-year phase-in of the shortfall for years in which actual investment return falls short of expected investment return.

Historical Note

Adopted effective July 1, 1975 (Supp. 75-1). Amended effective June 23, 1976 (Supp. 76-3). Amended effective December 20, 1977 (Supp. 77-6). Former Section R2-8-23 renumbered and amended as Section R2-8-123 effective May 21, 1982 (Supp. 82-3). Emergency amendments effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency amendments adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent amendments adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Amended by emergency rulemaking under A.R.S. § 41-1026 at 9 A.A.R. 1006, effective February 24, 2003 for a period of 180 days (Supp. 03-1). Emergency rulemaking renewed at 9 A.A.R. 3963, effective August 21, 2003 for a period of 180 days (Supp. 03-3). Amended by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3). New Section made by final rulemaking at 20 A.A.R. 3043, effective January 3, 2015 (Supp. 15-X). Amended...

Table 1. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments to Table 1 adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 2. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments to Table 2 adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 3. Repealed**Historical Note**

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Emergency amendments to Table 3 adopted effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Permanent amendments adopted effective September 12, 1997 (Supp. 97-3). Table 3 repealed; new Table 3 renumbered from Table 4 by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 3A. Expired**Historical Note**

New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). New Table made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 3B. Expired**Historical Note**

New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). New Table made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 4. Expired**Historical Note**

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table 4 renumbered as Table 3 by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). New Table made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 4A. Repealed**Historical Note**

New Table made by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 4B. Repealed**Historical Note**

New Table made by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 4C. Repealed**Historical Note**

New Table made by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Table 5. Expired**Historical Note**

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table 5 repealed, new Table 5 adopted by emergency action effective January 30, 1997, pursuant to A.R.S. § 41-1026 for a maximum of 180 days (Supp. 97-1). Emergency expired. Table 5 repealed, new Table 5 adopted by regular rulemaking action effective September 12, 1997 (Supp. 97-3). Table 5 repealed; new Table 5 renumbered from Table 6 and amended by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed; new Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Former Table 5 renumbered

to Table 6; new Table 5 made by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 6. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table repealed, new Table adopted effective September 12, 1997 (Supp. 97-3). Former Table 6 renumbered to Table 5; new Table 6 renumbered from Table 7 and amended by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). Table repealed; new Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Former Table 6 renumbered to Table 7; new Table 6 renumbered from Table 5 and amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

Table 7. Expired

Historical Note

Emergency adoption effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Table repealed, new Table adopted effective September 12, 1997 (Supp. 97-3). Renumbered to Table 6 by final rulemaking at 9 A.A.R. 4614, effective December 6, 2003 (Supp. 03-4). New Table made by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Table 7 renumbered from Table 6 and amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Table expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-124. Repealed

Historical Note

Adopted as an emergency effective August 25, 1975 (Supp. 75-1). Former Section R2-8-24 renumbered as Section R2-8-124 without change effective May 21, 1982 (Supp. 82-3). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-125. Repealed

Historical Note

Adopted as an emergency effective July 30, 1975 (Supp. 75-1). Former Section R2-8-25 renumbered as Section R2-8-125 without change effective May 21, 1982 (Supp. 82-3). Section repealed by final rulemaking at 10 A.A.R. 669, effective February 3, 2004 (Supp. 04-1).

R2-8-126. Calculating Benefits

- A. For the purposes of this Section, “prior service credit” means a “service credit” listed in R2-8-501(24), credited service that is earned pursuant to A.R.S. § 38-739, or a service credit that is transferred or redeemed pursuant to A.R.S. §§ 38-730, 38-771, or 38-921 et seq.
- B. An individual who is 104 years of age or older at the time of retirement is not eligible to select an option of life annuity with a term certain.
- C. An individual who is 93 years of age or older at the time of retirement is not eligible to select the options of life annuity with ten years certain or life annuity with 15 years certain.
- D. An individual who is 85 years of age or older at the time of retirement is not eligible to select the option of life annuity with 15 years certain.
- E. As authorized under A.R.S. § 38-764(F), if the life annuity of any Plan member is less than a monthly amount determined by the Board, the ASRS shall not pay the annuity. Instead, the ASRS shall make a lump sum payment in the amount determined by using appropriate actuarial assumptions.
- F. The ASRS shall calculate a member’s or beneficiary’s benefits, based on the attained age of the member or beneficiary, determined in years and full months, as of the effective date of the benefit payment.
- G. The ASRS shall add any prior service credit benefit that is payable to a member to the life annuity of the member before the ASRS applies any optional payment plan calculation provided for in A.R.S. § 38-760.
- H. A member who is ten or more years older than the member’s non-spousal contingent annuitant is not eligible to participate in a 100% joint-and-survivor option. A member who is 24 or more years older than the member’s non-spousal contingent annuitant is not eligible to participate in a 66 2/3% joint-and-survivor option.
- I. Notwithstanding subsection (H), a member who is ten or more years older than the member’s ex-spouse contingent annuitant is eligible to participate in a 100% joint-and-survivor option, if:
 1. The member selected the ex-spouse as the contingent annuitant prior to divorce from the ex-spouse; and
 2. The member submits a DRO to the ASRS which requires the ex-spouse to be the contingent annuitant on the member’s account.

- J. Notwithstanding subsection (H), a member who is 24 or more years older than the member's ex-spouse contingent annuitant is eligible to participate in a 66 2/3% joint-and-survivor option, if:
1. The member selected the ex-spouse as the contingent annuitant prior to divorce from the ex-spouse; and
 2. The member submits a DRO to the ASRS which requires the ex-spouse to be the contingent annuitant on the member's account.

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Amended effective July 13, 1979 (Supp. 79-4). Former Section R2-8-26 renumbered and amended as Section R2-8-126 effective May 21, 1982 (Supp. 82-3). Amended subsections (A) through (D) effective October 18, 1984 (Supp. 84-5). Amended subsections (A) through (D) effective July 24, 1985 (Supp. 85-4). Amended by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Emergency amendments adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Amended by emergency rulemaking at 7 A.A.R. 1621, effective March 21, 2001 (Supp. 01-1). Amended by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Amended by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3). Amended by final rulemaking at 19 A.A.R. 332, effective April 6, 2013 (Supp. 13-1). Amended by final rulemaking at 22 A.A.R. 79, effective March 6, 2016 (Supp. X-X).

Table 1. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 1 repealed, new Table 1 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 2. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 2 repealed, new Table 2 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 3. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 3 repealed, new Table 3 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 4. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 4 repealed, new Table 4 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 5. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 5 repealed, new Table 5 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 6. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 6 repealed, new Table 6 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 7. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 7 repealed, new Table 7 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 8. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 8 repealed, new Table 8 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 9. Repealed

Historical Note

Adopted effective September 12, 1977 (Supp. 77-5). Table 9 repealed, new Table 9 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 10. Repealed

Historical Note

Adopted effective October 18, 1984 (Supp. 84-5). Table 10 repealed, new Table 10 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Table 11. Repealed

Historical Note

Adopted effective October 18, 1984 (Supp. 84-5). Table 11 repealed, new Table 11 adopted effective July 24, 1985 (Supp. 85-4). Repealed by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed again by emergency effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Repealed effective December 22, 1993 (Supp. 93-4).

Exhibit A. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit B, Table 1. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit B, Table 2. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit B, Table 3. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking

Exhibit L, Table 7. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Amended by emergency rulemaking at 7 A.A.R. 1621, effective March 21, 2001 (Supp. 01-1). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 1. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 2. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 3. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 4. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 5. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

Exhibit M, Table 6. Repealed

Historical Note

Adopted by emergency effective July 6, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3).
Emergency rule adopted again effective September 29, 1993, pursuant to A.R.S. § 41-1026, valid for only 90 days (Supp. 93-3). Permanent rule adopted effective December 22, 1993 (Supp. 93-4). Repealed by emergency rulemaking under A.R.S. § 41-1026 at 10 A.A.R. 2496, effective August 2, 2004 for 180 days (Supp. 04-2). Repealed by final rulemaking at 10 A.A.R. 4012, effective November 13, 2004 (Supp. 04-3).

ARTICLE 2. STATE RETIREMENT DEFINED CONTRIBUTION PROGRAM

Article 2, consisting of R2-8-201 through R2-8-207, made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2).

R2-8-201. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). **Section expired under A.R.S. § 41-1056(E) at**

R2-8-202. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Amended by emergency rulemaking at 10 A.A.R. 4259, effective September 30, 2004 (Supp. 04-3). Amended by final rulemaking at 10 A.A.R. 4346, effective October 5, 2004 (Supp. 04-3). Section amended and Table 1 repealed by final rulemaking at 13 A.A.R. 4581, effective February 2, 2008 (Supp. 07-4). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-203. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-204. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-205. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-206. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). Section expired under A.R.S. § 41-1056(E) at 16 A.A.R. 1765, effective July 14, 2010 (Supp. 10-3).

R2-8-207. Expired

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1962, effective May 4, 2004 (Supp. 04-2). **Section expired under A.R.S. § 41-1056(E) at**

ARTICLE 3. RESERVED

ARTICLE 4. PRACTICE AND PROCEDURE BEFORE THE BOARD

R2-8-401. Definitions

“Appealable agency action” means the same as in A.R.S. § 41-1092(3).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1). Amended by final rulemaking at 21 A.A.R. 2515, effective December 5, 2015 (**Supp. XX**)

R2-8-402. General Procedures

In computing any time period, parties shall exclude the day from which the designated time period begins to run. Parties shall include the last day of the period unless it falls on a Saturday, Sunday, or legal holiday. When the time period is 10 days or less, parties shall exclude Saturdays, Sundays, and legal holidays.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

R2-8-403. Request for a Hearing of an Appealable Agency Action

A. A person who is not satisfied with a decision by the Director that is an appealable agency action may file a Request for a Hearing, in writing, with the Director. The request shall include the following:

1. The name and mailing address of the member, employer, or other person filing the request;
2. The name and mailing address of the attorney for the person filing the request, if applicable;
3. A concise statement of the reasons for the appeal.

- B. The person requesting a hearing shall file the Request for a Hearing with the ASRS Office of the Director within 30 days after receiving a decision of the Director and a Notice of an Appealable Agency Action. The date the request is filed is established by the Director's date stamp on the face of the first page of the request.
- C. Upon receipt of the Request for a Hearing, the ASRS shall notify the Office of Administrative Hearings as required in A.R.S. § 41-1092.03.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

R2-8-404. Board Decisions on Hearings before the Office of Administrative Hearings

A recommended decision from the Office of Administrative Hearings that is sent to ASRS at least 30 days before the Board's next regular monthly meeting, shall be reviewed by the Board at that monthly meeting. At the monthly meeting, the Board shall render a decision to accept, reject, or modify the findings of fact, conclusions of law and recommendations in whole or in part. If the Board modifies or rejects a recommended decision, the Board shall state the reasons for the modification or rejection. The Board shall deliver the Board's final decision to the Office of Administrative Hearings within five days after the monthly meeting at which the Board made the final decision.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

R2-8-405. Rehearing; Review of a Final Decision

- A. Except as provided in subsection (H), any party in an appealable agency action aggrieved by a final decision may file with the Board a written motion for rehearing or review of the final decision specifying the particular grounds not later than 30 days after service of the decision.
- B. A party may amend a motion for rehearing or review at any time before the Board rules on the motion. A party may file a response within 15 days after the motion or amended motion is filed. The Board may require the filing of written briefs upon the issues raised in the motion and may provide for oral argument.
- C. The Board may grant a rehearing or review of a decision for any of the following causes materially affecting the moving party's rights:
 1. Irregularity in the administrative proceedings of the agency or the hearing officer, or any order or abuse of discretion that deprives the moving party of a fair hearing;
 2. Misconduct of the Board, the hearing officer, or the prevailing party;
 3. Accident or surprise that could not have been prevented by ordinary prudence;
 4. Newly discovered material evidence that could not with reasonable diligence have been discovered and produced at the original hearing;
 5. Excessive or insufficient penalties;
 6. Error in the admission or rejection of evidence or other errors of law occurring at the administrative hearing; or
 7. That the decision is not justified by the evidence or is contrary to law.
- D. The Board may affirm or modify the decision or grant a rehearing or review to all or any of the parties on all or part of the issues for any of the reasons in subsection (C). An order granting a rehearing or review shall specify with particularity the grounds for the order.
- E. Not later than 10 days after the decision, the Board may, after giving each party notice and an opportunity to be heard, order a rehearing or review of its decision for any reason for which it might have granted a rehearing or review on motion of a party. After giving the parties or their counsel notice and an opportunity to be heard on the matter, the Board may grant a motion for rehearing or review for a reason not stated in the motion. In either case, the order granting a rehearing or review shall specify the grounds on which it is granted.
- F. When a motion for rehearing or review is based upon an affidavit, the affidavit shall be filed with the motion. An opposing party may, within 15 days after filing, file an opposing affidavit. The Board may extend the period for filing an opposing affidavit for not more than 20 days for good cause shown or by written stipulation of the parties. The Board may permit a reply affidavit.
- G. The Board shall rule on the motion within 15 days after the response to the motion is filed or if a response is not filed, within five days of the expiration of the response period.
- H. If the Board makes a specific finding that the immediate effectiveness of a particular decision is necessary for the preservation of the public peace, health, and safety and that a rehearing or review of the decision is impracticable, unnecessary, or contrary to the public interest, the decision may be issued as a final decision without an opportunity for a rehearing or review. If a decision is issued as a final decision without an opportunity for rehearing or review, an application for judicial review of the decision may be made within the time limits permitted for applications for judicial review of the Board's final decisions.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 444, effective January 4, 2005 (Supp. 05-1).

ARTICLE 5. PURCHASING SERVICE CREDIT

R2-8-501. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "Active duty" means full-time duty in a branch of the United States uniformed service, other than active reserve duty.
2. "Active duty termination date" means the day a member:
 - a. Separates from active military duty;
 - b. Is released from active duty-related hospitalization or one year after initiation of active duty-related hospitalization, whichever date is earlier; or
 - c. Dies as a result of active military duty.
3. "Active reserve duty" means participating in required meetings and annual training in a Reserve or National Guard branch of the United States uniformed service.
4. "Actuarial present value" means an amount in today's dollars of a member's future retirement benefit calculated using appropriate actuarial assumptions and the:
 - a. Member's current years of credited service to the nearest month;
 - b. Member's age to the nearest day;
 - c. Amount of service credit the member wishes to purchase to the nearest month, except for the calculation in R2-8-506(A)(2); and
 - d. Member's current annual compensation.
5. "Authorized representative" means an individual who has been delegated the authority to act on behalf of a custodian, trustee, plan administrator, or, if applicable, a member.
6. "Current years of credited service" means the amount of credited service a member has earned or purchased, and the amount of service credit for which an Irrevocable Payroll Deduction Authorization is in effect for which the member has not yet completed payment, but does not include any current requests to purchase service credit for which the member has not yet paid.
7. "Custodian" means a financial institution that holds financial assets for guaranteed safekeeping.
8. "Direct rollover" means distribution of eligible funds made payable to the ASRS as a contribution for the benefit of an eligible member from a retirement plan listed in A.R.S. § 38-747(H)(2) or (H)(3).
9. "Eligible funds" means payments listed in A.R.S. § 38-747(H)(2) and (H)(3).
10. "Eligible member" means an active member of the Plan or a Plan member who is receiving benefits under the Long Term Disability Program established by A.R.S. Title 38, Chapter 5, Article 2.1.
11. "Forms of payment" means check, cashier's check, money order, Irrevocable Payroll Deduction Authorization, direct rollover, indirect IRA rollover, indirect rollover, trustee-to-trustee transfer, IRA rollover and termination pay distribution.
12. "Forfeited service" means credited service for which the ASRS has returned retirement contributions to the member under A.R.S. § 38-740.
13. "Immediate family member" means:
 - a. A member's spouse or life partner;
 - b. A member's natural, step, or adopted sibling;
 - c. A member's natural, step, or adopted child;
 - d. A member's natural, step, or adoptive parent; or
 - e. An individual for whom the member has legal guardianship.
14. "Indirect IRA rollover" means funds already distributed to the eligible member from a retirement plan listed in A.R.S. § 38-747(H)(3) that are then paid by the eligible member to the ASRS as a contribution for the benefit of the eligible member.
15. "IRC" means the same as "Internal Revenue Code" in A.R.S. § 38-711(18).
16. "Irrevocable Payroll Deduction Authorization" means an irrevocable contract between an eligible member, an ASRS employer, and the ASRS that requires the ASRS employer to withhold payments from a member's pay for a specified amount and for a specified number of payments, as provided in A.R.S. § 38-747.
17. "Life partner" means an individual who lives with a member as a spouse, but without being legally married.
18. "Military Call-up" means a member is called to active duty in a branch of the United States uniformed services.
19. "Military service" means active duty or active reserve duty with any branch of the United States uniformed services or the Commissioned Corps of the National Oceanic and Atmospheric Administration.
20. "Military service record" means a United States uniformed services or National Oceanic and Atmospheric Administration document that provides the following information:
 - a. The member's full name;
 - b. The member's Social Security number;
 - c. Type of discharge the member received; and
 - d. Active duty dates, if applicable; or
 - e. Active reserve duty dates, if applicable; and
 - f. Point history for reserve duty dates, if applicable.
21. "Other public service" means previous employment listed in A.R.S. § 38-743(A).
22. "PDA pay-off letter" means written correspondence from the ASRS to a member that specifies the amount necessary to be paid by the member to complete an Irrevocable Payroll Deduction Authorization and receive the credited service specified in the Irrevocable Payroll Deduction Authorization.
23. "Plan Administrator" means the person authorized to represent a specific eligible plan as addressed in IRC § 414(g).

24. "Service credit" means forfeited service under A.R.S. § 38-742, leave of absence under A.R.S. § 38-744, military service and Military Call-up service under A.R.S. § 38-745, and other public service under A.R.S. § 38-743 that an eligible member may purchase.
25. "SP invoice" means a written correspondence from the ASRS informing an eligible member of the amount of money required to purchase a specified amount of service credit.
26. "Termination pay distribution" means an ASRS employer's payment to the ASRS of an eligible member's termination pay to purchase service credit as specified in A.R.S. § 38-747(B)(2).
27. "Three full calendar months" means the first day of the first full month through the last day of the third consecutive full month.
28. "Transfer employment" means to terminate employment with one ASRS employer with which a member has an Irrevocable Payroll Deduction Authorization:
 - a. After accepting an offer to work for a new ASRS employer, or
 - b. While working as an active member for a different ASRS employer.
29. "Trustee-to-trustee transfer" means a transfer of assets to the ASRS as authorized in A.R.S. § 38-747(I), from a retirement program listed in R2-8-515(A) from which, at the time of the transfer, a member is not eligible to receive a distribution.
30. "Uniformed services" means the United States Army, Army Reserve, Army National Guard, Navy, Navy Reserve, Air Force, Air Force Reserve, Air Force National Guard, Marine Corps, Marine Corps Reserve, Coast Guard, Coast Guard Reserves, and the Commissioned Corps of the Public Health Service.
31. "Window credit" means overpayments made on previously purchased service credit by eligible members of the ASRS as provided by Laws 1997, Ch. 280, § 21, and Laws 2003, Ch. 164, § 3.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4). Amended by final rulemaking at 19 A.A.R. 764, effective June 1, 2013 (Supp. 13-2). Amended by final rulemaking at 21 A.A.R. 2515, effective December 5, 2015 (Supp. XX)

R2-8-502. Request to Purchase Service Credit and Notification of Cost

- A. An eligible member may request to purchase service credit verbally, in writing, or electronically. The eligible member shall provide the eligible member's mailing address and designate which category of service credit the eligible member is requesting to purchase.
- B. The ASRS shall send a letter acknowledging the request to purchase service credit to the mailing address provided by the eligible member. The ASRS shall provide, with the acknowledgment letter, any form specified in this Article that corresponds to the category of service credit the eligible member requests to purchase and indicate in the acknowledgment letter the deadline for providing supporting documentation of service credit to the ASRS.
- C. Except as provided in R2-8-519(A), the eligible member shall provide documentation of service credit as required by this Article within 90 days of the eligible member's request to purchase service credit. If the ASRS has not received complete and correct documents within 90 days of the request to purchase service credit, the ASRS shall cancel the eligible member's request to purchase service credit. The eligible member may make a new request to purchase service credit.
- D. Upon receipt of the documentation required by this Article from the eligible member and if the eligible member's request to purchase service credit meets the requirements of this Article, the ASRS shall provide the following to the eligible member:
 1. A SP invoice stating the cost to purchase the amount of service credit the member is eligible to purchase and the date payment is due;
 2. A Service Purchase Payment Request form requesting the following information:
 - a. The member's name;
 - b. The member's Social Security number;
 - c. The member's mailing address;
 - d. The member's daytime telephone number;
 - e. ID number listed on the SP invoice;
 - f. Either the number of years or partial years of service credit the member wishes to purchase or the cost for the number of years or partial years of service the member wishes to purchase, not exceeding the years or partial years and cost specified on the SP Invoice;
 - g. If the member elects to pay for the service credit by trustee-to-trustee transfer, IRA rollover, distributed rollover contribution, or direct rollover, the anticipated number of rollovers or transfers;
 - h. If the member elects to pay by Irrevocable Payroll Deduction Authorization, the amount of money the member wishes to pay per pay period;
 - i. If the member elects to pay for the service credit by check, the check number and amount of the check;
 - j. If the member elects to pay any cost remaining at retirement or termination of employment with a termination pay distribution, the retirement date or last date of work;
 - k. The member's signature and date of the signature; and
 3. Other forms the member may need to complete the request for service credit purchase.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-503. Requirements Applicable to All Service Credit Purchases

- A. To purchase service credit at the amount provided in an SP invoice, an eligible member shall purchase the service credit by check or money order, or request an Irrevocable Payroll Deduction Authorization, rollover, transfer or termination pay distribution as specified in this Article, by the due date specified on the SP invoice.
- B. An eligible member may purchase all of the service credit or a portion of the service credit. If the eligible member wishes to purchase only a portion of the service credit, the eligible member shall specify, on the Service Purchase Payment Request form identified in R2-8-502(D)(2):
 - 1. The dollar amount the eligible member wishes to purchase, up to the amount specified on the SP invoice, or
 - 2. The number of years or partial years the eligible member wishes to purchase, not exceeding the years or partial years specified on the SP invoice.
- C. If the eligible member elects to purchase only a portion of the service credit, the cost and amount of service credit the eligible member identifies on the Service Purchase Payment Request form is only an estimate and may be more or less than the actual cost or amount of service credit purchased by the eligible member.
- D. The eligible member shall not request to purchase additional service credit based on the SP invoice until the member has completed the purchase of the previously requested portion of service credit or cancel the request as specified in subsection (F).
- E. ASRS shall not consider more than one active request at a time from a member to purchase service credit in a single category. The categories are:
 - 1. Leave of absence,
 - 2. Military service,
 - 3. Presidential Call-up service,
 - 4. Forfeited service, and
 - 5. Other public service.
- F. An eligible member may cancel an active request to purchase a specific category of service credit verbally or in writing, and submit a new request in the same category of service credit for a different amount of service credit.
- G. If an eligible member is entitled to a window credit, the eligible member may apply the window credit to purchase service credit. To apply a window credit to a purchase of service credit, the eligible member shall make a request to the ASRS in writing by the due date specified on the SP invoice and include the following information:
 - 1. The amount the member wants to apply,
 - 2. The member's signature, and
 - 3. The date of the member's signature.
- H. The amount of service credit an eligible member may purchase and the benefits an eligible member may receive are subject to the limitations prescribed in A.R.S. § 38-747(E).
- I. On or before the due date specified on the SP Invoice, ASRS shall extend the time for an eligible member to respond to an SP invoice as follows:
 - 1. If the member notifies the ASRS of an ASRS error, the time is extended 30 days after the date the ASRS sends notification to the eligible member that the ASRS has corrected the error;
 - 2. If an ASRS internal review is made of the member's service credit purchase request, the time is extended 30 days after the date ASRS sends notification to the member that the review is completed;
 - 3. If the member appeals an issue regarding the SP invoice under Article 4 of this Chapter, the time is extended 30 days after the date ASRS sends notification to the member that a decision on the appeal has been made; or
 - 4. If an unforeseeable event occurs that is outside of the member's control, such as an incapacitating illness of the member or death of an immediate family member, and the member notifies the ASRS of the event, the ASRS shall extend the time by up to six months, after a review of the unforeseeable event to determine the length of the extension.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-504. Service Credit Calculation for Purchasing Service Credit

An eligible member who purchases service credit shall receive one month of credited service for one or more days of service in a calendar month.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-505. Restrictions on Purchasing Overlapping Service Credit; Transfers

- A. The ASRS shall not permit an eligible member to purchase service credit that, when added to credited service earned in any plan year, results in more than:
 - 1. One year of credited service in any plan year, or

2. One month of credited service in any one calendar month.
- B. The restrictions in subsection (A) do not apply to service credit that an eligible member transfers from another retirement system to the ASRS as authorized in A.R.S. § 38-730 or A.R.S. Title 38, Chapter 5, Article 7, whether the eligible member requests the transfer before or after purchasing other service credit.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-506. Cost Calculation for Purchasing Service Credit

- A. For leave of absence service credit, military service credit, and other public service credit, the ASRS shall calculate, as of the date of the request to purchase service credit:
 1. The actuarial present value of the future retirement benefit for the member including the service credit that the eligible member requests to purchase, and
 2. The actuarial present value of the future retirement benefit for the member without the service credit that the eligible member requests to purchase.
- B. The cost for purchasing the service credit that the member requests to purchase is the difference between the actuarial present value in subsection (A)(1) and the actuarial present value in subsection (A)(2).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

R2-8-507. Required Documentation and Calculations for Forfeited Service Credit

- A. An eligible member who requests to purchase service credit for forfeited service under A.R.S. § 38-742 shall provide to the ASRS:
 1. The eligible member's:
 - a. Full name and, if applicable, other names used while working for an ASRS employer for which the eligible member is requesting to purchase service credit;
 - b. Mailing address;
 - c. Telephone number, if applicable;
 - d. Social Security number;
 2. The name of each ASRS employer, if known, for which the eligible member is requesting to purchase service credit for forfeited service;
 3. The year the eligible member began working for each ASRS employer and the year the eligible member left each employment, if known; and
 4. The year the eligible member believes the ASRS returned retirement contributions to the member.
- B. The amount the eligible member shall pay to purchase service credit for previously forfeited service is the amount of retirement contributions that the ASRS returned to the eligible member, plus interest on that amount from the date on the return of retirement contributions check to the date of redeposit at the interest rate determined by the Board as specified in A.R.S. § 38-742.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-508. Required Documentation and Calculations for Leave of Absence Service Credit

- A. An eligible member may request to purchase service credit for an approved leave of absence from an ASRS employer under A.R.S. § 38-744. To request to purchase service credit for an approved leave of absence the eligible member shall provide to the ASRS:
 1. An Approved Leave of Absence form that includes:
 - a. The following information completed by the eligible member:
 - i. The eligible member's full name and, if applicable, other names used while working for the ASRS employer;
 - ii. The eligible member's Social Security number;
 - iii. The eligible member's mailing address;
 - iv. The eligible member's daytime telephone number;
 - v. A statement that the eligible member understands that up to one year of leave of absence service credit may be purchased for each approved leave of absence, if the eligible member returns to work for the employer that approved the leave of absence unless employment could not be resumed because of disability or nonavailability of a position;
 - vi. A statement that the eligible member understands that the ASRS uses the actuarial present value calculation method to determine the cost of the service purchase request;
 - vii. A statement that the eligible member authorizes the ASRS employer to provide any necessary personal information to ASRS in order to process this request; and
 - viii. The member's dated signature; and
 - b. The following information completed by the ASRS employer:
 - i. The beginning date and ending date of the approved leave of absence;

- ii. The date the eligible member returned to work or a statement of why employment was not resumed;
 - iii. Name of the employer;
 - iv. The authorized employer representative's name;
 - v. The authorized employer representative's telephone number and, if applicable, fax number; and
 - vi. The authorized employer representative's dated signature verifying that the approved leave of absence benefited or was in the best interest of the employer; and
2. A copy of the guidelines referenced in A.R.S. § 38-744, if applicable.
- B. The amount the member shall pay to purchase service credit for leave of absence is determined as provided in R2-8-506.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-509. Required Documentation and Calculations for Military Service Credit

- A. An eligible member may request to purchase military service credit under A.R.S. § 38-745(A) and (B). To request to purchase military service credit, the eligible member shall provide to the ASRS:
- 1. The items listed in R2-8-507(A)(1);
 - 2. A copy of the eligible member's military service record; and
 - 3. A completed, signed, dated, and notarized Affidavit of Military Service form that contains:
 - a. The member's full name;
 - b. The member's Social Security number;
 - c. The branch of the uniformed services the member was in;
 - d. Whether the member was active duty or active reserve duty;
 - e. The years and months by fiscal year that the member was in active duty or active reserve duty for which the member wishes to purchase service credit;
 - f. Acknowledgement that the member has attached:
 - i. Proof of honorable discharge for each type of military service listed on the form; and
 - ii. The member's military service record that supports all of the service listed on the affidavit;
 - g. The following statements of understanding initialed by the member:
 - i. I understand that any person who knowingly makes any false statement or who falsifies or permits to be falsified any record of the retirement plan with an intent to defraud the plan is guilty of a class 6 felony per Arizona Revised Statutes Section 38-793;
 - ii. I understand this transaction is subject to audit and if any errors or misrepresentations are discovered as a result of this audit, my total credited service with the ASRS will be adjusted as necessary and if I am retired, my retirement benefit will also be adjusted;
 - iii. I understand that the service listed on this affidavit does not include time that I either volunteered or was ordered into active duty military service as part of a Presidential Call-up. This service is purchased under Presidential Call-up and requires a Presidential Call-up form to be completed by your employer; and
 - iv. I understand that any time I have listed on this affidavit for Reserve or National Guard time reflects the months that I attended at least one drill or assembly for each month listed.
- B. The amount the eligible member pays to purchase military service credit is determined as provided in R2-8-506.
- C. ASRS determines the amount of service credit an eligible member receives for active duty and active reserve duty time by the time listed on the Affidavit of Military Service form, if the service listed is supported by the information contained in the member's military service record.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-510. Required Documentation and Calculations for Presidential Call-up Service Credit

- A. An eligible member or the eligible member's beneficiary who meets the requirements under A.R.S. § 38-745(C) shall receive up to 60 months of Presidential Call-up service under A.R.S. § 38-745(C) through (I). In order to determine the amount of contributions the ASRS employer owes to purchase service credit for Presidential Call-up service, the eligible member's ASRS employer shall provide to the ASRS a copy of the eligible member's military service record and a completed Military Call-up form that includes the following:
- 1. The member's full name;
 - 2. The member's Social Security number;
 - 3. The start date of Presidential Call-up Service;
 - 4. The end date of Presidential Call-up Service;
 - 5. Whether the member received paid leave while on Presidential Call-up;
 - 6. The date the member returned to work for the ASRS employer;
 - 7. The salary for each fiscal year while the member is on Presidential Call-up, including any salary increases the eligible member would have received had the member not left employment due to Presidential Call-up, if applicable;
 - 8. The ASRS employer's name and address;

9. The name of a contact individual for the ASRS employer, and that individual's business and fax telephone numbers;
 10. The contact individual's signature and date of signature;
 11. If applicable, the earlier of:
 - a. The date that the member was released from the hospital for injuries sustained as a result of participating in a Presidential Call-up; or
 - b. The date that the member was hospitalized for one year for injuries sustained as a result of participating in a Presidential Call-up; and
 12. A copy of the member's death certificate, if applicable.
- B. An ASRS employer shall make the request to purchase service credit for Presidential Call-up service within 30 days after the member's active duty termination date.
 - C. The ASRS calculates the amount the ASRS employer pays to purchase Presidential Call-up service by multiplying the eligible member's salary at the time active duty commences, by the contribution rate in effect for the period of active duty, and by the years or partial years of service elapsing from the active duty commencement date through the active duty termination date. Included in the calculation are any salary increases the member would have received if the member had not left work to participate in a Presidential Call-up.
 - D. The ASRS shall send the ASRS employer a statement of cost for purchase of the Presidential Call-up service credit, based on the calculation in subsection (B). Within 90 days from the date on the ASRS statement of cost, the ASRS employer shall pay to the ASRS the amount on the statement. If the ASRS employer fails to make full payment within the 90 days, interest shall accrue on the unpaid balance at the assumed actuarial investment earnings rate approved by the Board in effect on the date of the statement of cost.
 - E. If an ASRS employer deducts retirement and long-term disability contributions from an eligible member's pay while the eligible member is on Presidential Call-up service, the ASRS shall return the contributions to the ASRS employer after the ASRS receives the information in subsection (A).
 - F. If an ASRS employer deducts retirement contributions from an eligible member's pay while the eligible member is on Presidential Call-up service, and the eligible member does not return to the ASRS employer after separation from active military service, the ASRS shall apply the retirement contributions to the member's credited service.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-511. Required Documentation and Calculations for Other Public Service Credit

- A. An eligible member who requests to purchase other public service credit under A.R.S. § 38-743 shall provide to the ASRS a completed Affidavit of Other Public Service form, signed and dated by the member, and notarized, that includes the following:
 1. The member's full name;
 2. The member's Social Security number;
 3. Other names used by the member during employment with the other public service employer, if applicable;
 4. The name and mailing address of the other public service employer;
 5. The position the member held while working for the other public service employer;
 6. A contact name and telephone number of an individual in the other public service employer's human resources department who can verify employment, if known;
 7. The years and months by fiscal year of other public service the member worked and wishes to purchase;
 8. If the other public service employer was a non-ASRS employer, a statement of whether the member participated in the non-ASRS employer's retirement plan;
 9. If the member participated in a non-ASRS public service employer's retirement plan, the name of the retirement plan, identifying whichever one of the following applies:
 - a. The approximate date the member took a return of retirement contributions;
 - b. The plan is non-contributory and the member is not eligible for benefits from the plan; or
 - c. That, if not using all of the retirement contributions as a pre-tax rollover, the member will request a return of retirement contributions and forfeit all rights to any benefits from the plan and provide the ASRS with documentation that the member has forfeited all rights to benefits from the plan no later than the due date specified on the SP invoice; and
10. Acknowledgement that:
 - a. Knowingly making a false statement or falsifying or permitting falsification of any record of the ASRS with an intent to defraud ASRS is a Class 6 felony, pursuant to A.R.S. § 38-793;
 - b. The service purchase transaction is subject to audit and if any errors are discovered, the ASRS shall adjust a member's total credited service with the ASRS, or if the member is already retired, adjustments to the member's credited service will affect the member's retirement benefit; and
 - c. If an audit determines that the member is eligible for a benefit from the other public service employer's retirement plan, the member is required to take necessary steps to forfeit the benefit, and if the forfeiture is not completed within 90 days of being notified of the audit results, the service credit purchase listed on this application will be revoked and any funds paid to purchase the service credit will be refunded to the member.

B. The amount the member shall pay to purchase other public service credit is determined as provided in R2-8-506.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-512. Purchasing Service Credit by Check, Cashier's Check, or Money Order

- A. An eligible member may purchase service credit by check, cashier's check, or money order.
- B. Within 30 days of the issue date on the SP invoice or PDA pay-off letter, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form with the information specified in R2-8-502(D)(2) and a check, cashier's check, or money order made to the order of the Arizona State Retirement System in the amount to purchase the requested service credit.
- C. If an eligible member purchases service credit by check, cashier's check, or money order in conjunction with one or more rollovers, trustee-to-trustee transfers, or termination pay, the member shall make payment within 30 days after the date the ASRS sends written confirmation that the ASRS received the final rollover, trustee-to-trustee transfer, or termination pay payment.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-513. Purchasing Service Credit by Irrevocable Payroll Deduction Authorization

- A. An eligible member may purchase service credit by Irrevocable Payroll Deduction Authorization.
- B. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form with the information specified in R2-8-502(D)(2).
- C. If the eligible member elects to pay for service credit by Irrevocable Payroll Deduction Authorization, ASRS shall prepare an Irrevocable Payroll Deduction Authorization and send it to the eligible member for signature. The member shall ensure that the ASRS receives the signed Irrevocable Payroll Deduction Authorization within 30 days after the date on the Irrevocable Payroll Deduction Authorization. The signed Irrevocable Payroll Deduction Authorization becomes irrevocable upon receipt by the ASRS.
- D. At the time the eligible member signs the Irrevocable Payroll Deduction Authorization the eligible member may elect to use termination pay towards the balance of the Irrevocable Payroll Deduction Authorization if the eligible member terminates employment. If the eligible member chooses this option, the eligible member shall complete the Termination Pay Addendum to the Irrevocable Payroll Deduction Authorization and return it to the ASRS along with the remainder of the Irrevocable Payroll Deduction Authorization that includes the following:
 - 1. A statement that the member:
 - a. Understands and agrees that the member must continue working at least three full calendar months after the date of submission of the form before termination pay may be used on a pre-tax basis;
 - b. Understands that if the termination payment exceeds the balance owed on the Irrevocable Payroll Deduction Authorization, the overage will be returned to the ASRS employer to be distributed to the member; and
 - c. Elects to irrevocably agree to have termination pay that may be payable to the member upon termination of employment sent to the ASRS on a pre-tax basis and used toward any remaining balance of the Irrevocable Payroll Deduction Authorization if all scheduled payroll deductions have not been completed upon termination of service; and
 - 2. A statement that either all termination pay or a specified amount of termination pay is to be applied to the balance of the Irrevocable Payroll Deduction Authorization.
- E. The ASRS shall:
 - 1. Charge interest on the unpaid balance at the assumed actuarial investment earnings rate approved by the Board in effect at the time the authorization was entered into;
 - 2. Limit the payroll deduction time period to a maximum of 20 years; and
 - 3. Require a minimum payment of \$10.00 per payroll period, or payment in an amount to purchase at least .001 year of service credit per payroll period, whichever is greater.
- F. The ASRS shall transmit the Irrevocable Payroll Deduction Authorization to the active member's ASRS employer, and the ASRS employer shall implement the deduction on the first pay period after receiving the Irrevocable Payroll Deduction Authorization.
- G. If a deduction is not made under an Irrevocable Payroll Deduction Authorization within six months after the member signs the authorization, the authorization lapses and the member may make another request, which is recalculated based on the new request date unless the failure to begin deductions is due to an ASRS error.
- H. A period of leave of absence, long-term disability, or Presidential Call-up shall not cancel the Irrevocable Payroll Deduction Authorization. The ASRS employer shall resume deductions immediately upon the member's return to that employment. The period during which the member is on leave of absence, on long-term disability, or leaves work because of a Presidential Call-up is not included in the 20-year payment time limitation under subsection (E)(2). If the member does not return to active working status, whether due to termination of employment or retirement, the member may elect to purchase

the balance of unpaid service under the Irrevocable Payroll Deduction Authorization at the time of termination or retirement as specified in this Section.

- I. Deductions made pursuant to an Irrevocable Payroll Deduction Authorization continue until the:
 - 1. Irrevocable Payroll Deduction Authorization is completed;
 - 2. Member retires, whether or not the member continues employment as allowed in A.R.S. §§ 38-766.01 and 38-764(J); or
 - 3. Member terminates all ASRS employment without transferring employment.
- J. If a member retires or terminates employment from all ASRS employers without transferring employment as stated in R2-8-513.01 before all deductions are made as authorized by the Irrevocable Payroll Deduction Authorization, the member's purchase of service credit is canceled unless the member notifies the ASRS in writing during the period 14 days before to 14 days after retirement or termination from all ASRS employment of the intent to purchase the remaining amount due in a lump sum.
- K. When the member notifies ASRS of retirement or termination from all ASRS employment and requests to pay off the Irrevocable Payroll Deduction Authorization, the ASRS shall send the member a PDA pay-off letter to the mailing address given by the member. The ASRS shall calculate the amount owed by the member and reduce the amount owed by any excess interest that the member has paid.
- L. Within 30 days of the date of the PDA pay-off letter, the member shall ensure that the ASRS receives the completed SP Payment Request form with the information specified in R2-8-502(D)(2). The member may purchase the remaining service credit by one or more of the following methods:
 - 1. By check, cashier's check, or money order made out to the ASRS under R2-8-512;
 - 2. By making a request to the ASRS for a rollover or transfer under R2-8-514 and completing the rollover or transfer within 90 days of the date of the PDA pay-off letter; or
 - 3. By termination pay distribution under R2-8-519, if the member authorized this option at the time the member signed the Irrevocable Payroll Deduction Authorization.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-513.01. Irrevocable Payroll Deduction Authorization and Transfer of Employment to a Different ASRS Employer

- A. An Irrevocable Payroll Deduction Authorization continues if a member transfers employment.
- B. An Irrevocable Payroll Deduction Authorization ends if a member terminates employment without having accepted an offer to work for a new ASRS employer, and the member is not already an active member working for a different ASRS employer. The member shall then pay off the Irrevocable Payroll Deduction Authorization as specified in R2-8-513(J).
- C. If a retirement contribution is due from the new ASRS employer within 120 days from the member's termination date with the previous employer, there is a rebuttable presumption that there is a transfer of employment. If a retirement contribution is not received within 120 days, the Irrevocable Payroll Deduction Authorization terminates.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-513.02 Termination Date

For the purpose of an Irrevocable Payroll Deduction Authorization, the date a member is considered terminated from an ASRS employer is:

- 1. For a member terminating employment, the member's last pay period end date with that ASRS employer;
- 2. For a member on Presidential Call-up who does not return to the same ASRS employer:
 - a. Ninety days from the date of separation from Presidential Call-up service;
 - b. Ninety days from the date released from the hospital, if injured while on Presidential Call-up service;
 - c. The date the member has been hospitalized for one year for injuries sustained as a result of participating in a Presidential Call-up; or
 - d. The date of the member's death as a result of participating in a Presidential Call-up;
- 3. For a member on leave of absence without pay who does not return to the same ASRS employer, the date the ASRS employer required the member to return to work;
- 4. For a member who is unable to work because of a disability, the later of:
 - a. The date the member's request for long-term disability benefits are denied;
 - b. The date the member no longer has sick leave and annual leave; or
 - c. For a member on long-term disability who does not return to the same ASRS employer or transfer employment, the date long-term disability benefits are terminated.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-514. Purchasing Service Credit by Direct Rollover

- A. An eligible member may purchase service credit or pay off an Irrevocable Payroll Deduction Authorization by direct rollover at retirement or termination of employment without transferring employment.

- B. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form with the information specified in R2-8-502(D)(2).
- C. Upon receipt of the completed Service Purchase Payment Request form, the ASRS shall provide a Direct Rollover/Transfer Certification to Purchase Service Credit form, if the ASRS has not already provided the member with the form.
- D. The member shall ensure that the ASRS receives the Direct Rollover/Transfer Certification to Purchase Service Credit form completed by the member and the plan making the distribution within 90 days after the issue date of the SP Invoice.
- E. The information requested on the Direct Rollover/Transfer Certification to Purchase Service Credit form includes:
 - 1. Member's full name;
 - 2. Member's Social Security number;
 - 3. Member's mailing address;
 - 4. Member's daytime telephone number;
 - 5. The amount of each rollover or transfer, if applicable;
 - 6. The account number of each plan, if applicable;
 - 7. The member's signature certifying that the member understands the requirements, limitations, and entitlements for the rollover/transfer that is being used to purchase service credit, and has read and understands the Direct Rollover/Transfer Certification to Purchase Service Credit form and any accompanying instructions and information sheets;
 - 8. The date the member signs the form;
 - 9. The authorized representative's name and title;
 - 10. The authorized representative's address;
 - 11. The authorized representative's telephone number;
 - 12. Certification by the authorized representative that:
 - a. The plan is either:
 - i. A qualified pension, profit sharing, or 401(k) plan described in IRC § 401(a), or a qualified annuity plan described in IRC § 403(a);
 - ii. A deferred compensation plan described in IRC § 457(b) maintained by a state of the United States, a political subdivision of a state of the United States, or an agency or instrumentality of a state of the United States;
 - iii. An annuity contract described in IRC § 403(b); or
 - iv. An IRA described in A.R.S. § 38-747(H)(3);
 - b. The rollover/transfer specified on the form from which the pre-tax funds are being rolled over or transferred is intended to satisfy the requirements of the applicable section of the Internal Revenue Code;
 - c. The authorized representative is not aware of any plan provision or any other reason that would cause the plan/IRA not to satisfy the applicable section of the Code; and
 - d. The funds will be sent to the ASRS as a direct plan rollover, IRA rollover, or a trustee-to-trustee transfer; and
 - 13. The date and signature of the authorized representative.
- F. The ASRS shall provide the member with written notification regarding the eligibility of the rollover.
- G. The member shall contact the plan administrator to have the funds distributed and transferred to the ASRS. Except as provided in subsection (H), unless the ASRS receives a check for the correct amount from the plan within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).
- H. At the written request of the member, the ASRS shall provide an extension of 60 days in which the check may be received by the ASRS from the plan at the written request of the member, if:
 - 1. The member has followed the procedure in this Article for requesting to purchase service credit,
 - 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 - 3. The eligible plan has not provided to the ASRS the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 - 4. The member makes the written request for extension before expiration of the 90 days.
- I. The member shall ensure that the ASRS receives a check from the plan, made payable to the ASRS, for an amount that does not exceed the amount specified on the SP Invoice.
- J. If the payment from the eligible plan exceeds the amount specified on the SP Invoice, the ASRS shall return the entire payment to the member.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-515. Purchasing Service Credit by Trustee-to-Trustee Transfer

- A. An eligible member may purchase service credit or pay off an Irrevocable Payroll Deduction Authorization at retirement or termination of employment without transferring employment by a trustee-to-trustee transfer if the member participates in:
 - 1. A deferred compensation plan described in IRC § 457 that is maintained by:
 - a. The state of Arizona;
 - b. A political subdivision, agency, or instrumentality of the state of Arizona; or
 - c. A political subdivision entity of the state of Arizona;
 - 2. An annuity contract described in IRC § 403(b); or

3. A retirement program qualified under IRC § 401(a) or 403(a).
- B. By the due date specified on the SP invoice, the ASRS shall receive from the member the completed Service Purchase Payment Request form described in R2-8-502(D)(2).
- C. Upon receipt of the completed Service Purchase Payment Request form, the ASRS shall provide a Direct Rollover/Transfer Certification to Purchase Service Credit form, if the ASRS has not already provided the member with the form.
- D. The member shall ensure that the member and the plan administrator complete the Direct Rollover/Transfer Certification to Purchase Service Credit form, containing all of the applicable information identified in R2-8-514(E), and ensure that the ASRS receives the form within 90 days after the issue date on the SP Invoice.
- E. The ASRS shall provide the member with written notification regarding the eligibility of the transfer.
- F. The member shall contact the plan administrator to have the funds transferred to the ASRS. Except as provided in subsection (G), unless the ASRS receives the check for the correct amount from the plan within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).
- G. The ASRS shall provide an extension of 60 days in which the check may be received by the ASRS from the plan at the written request of the member, if:
 1. The member has followed the procedure under this Article for requesting to purchase service credit,
 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 3. The eligible plan has not provided to the ASRS the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 4. The member makes the written request for extension before expiration of the 90 days.
- H. The member shall ensure that the ASRS receives a check from the plan, made payable to the ASRS, for an amount that does not exceed the amount specified on the SP Invoice.
- I. If the payment from the eligible plan exceeds the amount specified on the SP Invoice, the ASRS shall return the entire payment to the member and notify the member of the correct amount due.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-516. Purchasing Service Credit by Indirect IRA Rollover

- A. An eligible member may purchase service credit, or pay off an Irrevocable Payroll Deduction Authorization at retirement or termination of employment without transferring employment, by an indirect IRA rollover if the rollover purchase is completed within 60 days of the date of distribution of funds from the IRA account, as required by IRC § 408(d)(3)(A). The 60-day time limitation is exclusive of any other time limitations prescribed in this Article and the ASRS shall not extend the 60-day period.
- B. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form described in R2-8-502(D)(2).
- C. Upon the receipt of the completed Service Purchase Payment Request form and upon the member's request, the ASRS shall provide to the member an Indirect IRA Rollover Contribution form. The member shall complete the Indirect IRA Rollover Contribution form and ensure that the ASRS receives the form within 90 days after the issue date on the SP Invoice, along with:
 1. A copy of the distribution statement or check stub identifying it as an IRA distribution, showing the date of distribution and amount distributed; or
 2. The distribution check endorsed by the member made payable to the ASRS with documentation that it is an IRA distribution.
- D. The information requested on the Indirect IRA Rollover Contribution form includes:
 1. The member's full name,
 2. The member's Social Security number,
 3. The member's mailing address,
 4. The member's daytime telephone number,
 5. The member's signature certifying that the member understands the statements on the form regarding the distribution the member has received from the IRA and the requirements for an IRA rollover to the ASRS and agrees to the statements, and
 6. The date the member signs the form.
- E. The ASRS shall provide the member with written notification regarding the eligibility of the rollover contribution.
- F. After receiving notice from the ASRS that the rollover is an eligible rollover contribution, if the member has not sent payment for the purchase of service credit, the member shall submit payment for the service credit purchase. The member shall make payment by:
 1. The distribution check from the IRA made payable to the member and endorsed by the member to make it payable to the ASRS; or
 2. Direct payment by the member by check or money order to the ASRS, after the IRA distribution is deposited to the member's account.
- G. Except as provided in subsection (H), unless the ASRS receives payment from the member within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).

- H. The ASRS shall provide an extension of 60 days in which the check may be received by the ASRS under subsection (G) at the written request of the member, if:
 - 1. The member has followed the procedure under this Article for requesting to purchase service credit,
 - 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 - 3. The eligible plan has not provided the member with the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 - 4. The member makes the written request for extension before expiration of the 90 days.
- I. The member shall ensure that the ASRS receives a check made payable to the ASRS for an amount that does not exceed the amount specified on the SP Invoice.
- J. If the payment exceeds the amount specified on the SP Invoice, the ASRS shall return the entire payment to the member.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-517. Purchasing Service Credit by Distributed Rollover Contribution

- A. An eligible member may purchase service credit with a distribution from a prior employer's eligible plan that has already been distributed to the member if the rollover purchase is completed within 60 days of the date of distribution to the member, as required by IRC §§ 402(c)(3)(A), 403(b)(8)(B), and 457(e)(16)(B). The 60-day time limitation is exclusive of any other time limitations prescribed in this Article, and the ASRS shall not extend the 60-day period. Eligible plans are:
 - 1. A pension, profit sharing, or other qualified plan described in IRC § 401(a) and (k);
 - 2. A qualified annuity plan described in IRC § 403(a);
 - 3. A deferred compensation plan described in IRC § 457 and maintained by a state of the United States, or a political subdivision, agency, or instrumentality of a state of the United States; and
 - 4. A tax deferred annuity described in IRC § 403(b).
- B. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form described in R2-8-502(D)(2).
- C. When the ASRS receives the completed Service Purchase Payment Request form and upon the member's request, the ASRS shall provide a Certification by Eligible Plan Rollover Contribution form and Rollover Contribution form.
- D. The information requested on the Certification by Eligible Plan Rollover Contribution form includes:
 - 1. The member's dated signature;
 - 2. Member's full name;
 - 3. Member's Social Security number;
 - 4. Member's mailing address;
 - 5. Certification by the plan administrator that the plan is one of the plans described in subsection (A);
 - 6. Certification by the plan administrator that:
 - a. If the plan is described in either IRC § 401(a) or 403(a), the plan has received a determination letter from the Internal Revenue Service indicating that the plan is qualified under either IRC § 401(a) or 403(a);
 - b. If the plan is described in either IRC § 401(a) or 403(a), but has not received a determination letter from the Internal Revenue Service, the plan satisfies the requirements of IRC § 401(a) or 403(a) or is intended to satisfy the requirements of IRC § 401(a) or 403(a) and the plan administrator is not aware of any plan provision or any other reason that would disqualify the plan; or
 - c. If the plan is a deferred compensation plan described in IRC § 457 or an annuity contract described in IRC § 403(b), the plan or annuity satisfies the applicable requirements of IRC § 457 or 403(b) and the plan administrator is not aware of any plan provision or any other reason that would cause the plan or annuity to not satisfy the applicable provisions of IRC § 457 or 403(b);
 - 7. Certification by the plan administrator that the plan permits a direct rollover of an eligible rollover distribution to a defined benefit plan;
 - 8. The full name, title, and signature of the plan administrator;
 - 9. The plan administrator's business address and telephone number; and
 - 10. Date of the signature of the plan administrator.
- E. The information requested on the Rollover Contribution form includes:
 - 1. The member's Social Security number;
 - 2. The member's full name;
 - 3. The member's mailing address;
 - 4. The member's daytime telephone number;
 - 5. The member's signature certifying that:
 - a. The member has read the statements on the Rollover Contribution form regarding requirements for a rollover contribution, understands all the statements, and believes the statements, certifications, and any documents attached to the form to be true and correct to the best of the member's knowledge and belief; and
 - b. The member understands that:
 - i. The ASRS assumes no responsibility for ensuring that the member makes a timely rollover contribution to the ASRS or that the amount rolled over constitutes a valid rollover contribution;

- ii. The member accepts full responsibility for ensuring that the rollover contribution is an eligible rollover contribution before making the contribution to the ASRS;
 - iii. If the ASRS accepts the rollover contribution and it is later determined that the contribution was an invalid rollover contribution, the ASRS will distribute the invalid contribution directly to the member; and
 - iv. Any invalid rollover contributions returned to the member may decrease the member's benefits and the Internal Revenue Service and state taxing authorities may require the member to pay taxes, penalties, and interest on the returned contributions; and
- 6. The date the member signed the form.
- F. The member shall ensure that the ASRS receives the Certification by Eligible Plan Rollover Contribution form signed and dated by the plan administrator, the Rollover Contribution form signed and dated by the member, and a copy of the distribution statement showing the:
 - 1. Date of the distribution;
 - 2. Amount of the distribution; and
 - 3. Amount of taxes withheld, if any.
- G. The ASRS shall provide the member with written notification regarding the eligibility of the rollover.
- H. The member shall make payment by:
 - 1. The distribution check from the eligible plan made payable to the member and endorsed by the member to make it payable to the ASRS; or
 - 2. Direct payment by the member by check or money order to the ASRS, after the eligible plan distribution is deposited to the member's personal financial account.
- I. Except as provided in subsection (J), unless the ASRS receives the check from the plan within 90 days of the issue date on the SP invoice, the ASRS shall cancel the request to purchase service credit as specified in R2-8-502(C).
- J. At the written request of the member, the ASRS shall provide an extension of 60 days in which the check may be received by the ASRS from the plan under subsection (I), if:
 - 1. The member has followed the procedure under this Article for requesting to purchase service credit,
 - 2. The member has responded to the ASRS correspondence within the time-frame set forth in this Article,
 - 3. The eligible plan has not provided to the member with the check to pay for the requested service credit purchase within 90 days of the date of the SP invoice, and
 - 4. The member makes the written request for extension before expiration of the 90 days.
- K. The member shall ensure that the ASRS receives a check, made payable to the ASRS, for an amount that does not exceed the amount specified in the written notification identified in subsection (G).
- L. If the payment from the eligible plan exceeds the amount specified in the written notification identified in subsection (G) the ASRS shall return the entire payment to the member.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-518. Repealed

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4). Repealed by final rulemaking at 18 A.A.R. 3130, effective January 6, 2013 (Supp. 12-4).

R2-8-519. Purchasing Service Credit by Termination Pay Distribution

- A. To purchase service credit using termination pay distribution, an eligible member shall, no more than six months before the date the eligible member plans to retire or terminate employment, request to purchase service credit as specified in R2-8-502 and specify that the member wants to use termination pay distribution to pay for the service credit. Upon receipt of the acknowledgement letter identified in R2-8-502, the eligible member shall provide documentation for service credit as required by this Article, within 30 days of the eligible member's request to purchase service credit.
- B. Upon receipt of the documentation required by this Article from the eligible member and if the eligible member's request to purchase service credit meets the requirements of this Article, the ASRS shall provide a:
 - 1. SP invoice stating the cost to purchase the requested amount of service credit and the date the payment is due, and
 - 2. Service Purchase Payment Request form as described in R2-8-502(D)(2).
- C. By the due date specified on the SP invoice, the member shall ensure that the ASRS receives the completed Service Purchase Payment Request form.
- D. Upon receipt of the Service Purchase Request form, if the member indicates the member wishes to purchase service credit by termination pay distribution, the ASRS shall send the member a Termination Pay Authorization for the Purchase of Service Credit form to complete and return within the time limitation specified in subsection (E) that includes:
 - 1. Member's full name,
 - 2. Member's Social Security number,
 - 3. Member's daytime telephone number,
 - 4. The Request ID number listed on the SP invoice,

5. Name of ASRS employer,
6. Whether the member elects to use all termination pay or a specific amount of termination pay to purchase service credit,
7. Signature of the member, certifying that the member understands that:
 - a. The member is required to continue working at least three full calendar months after the date the member submits the Termination Pay Authorization for the Purchase of Service Credit form before termination pay may be used on a pre-tax basis;
 - b. If the member terminates employment more than six months after the date on the SP invoice, the member may purchase the service credit at a newly calculated rate and possibly at a higher cost;
 - c. The Termination Pay Authorization for the Purchase of Service Credit form is binding and irrevocable;
 - d. The member's employer is required to make payment directly to the ASRS after mandatory deductions are made, and the member does not have the option of receiving the funds directly from the employer;
 - e. The ASRS shall apply service credit to the member's account upon the receipt of payments authorized by the member by the Termination Pay Authorization for the Purchase of Service Credit form;
 - f. If the member elects to purchase with termination pay only a portion of the service credit that the member is entitled to purchase, the member may be eligible to use other forms of payment to purchase additional service credit. However, using other forms of payment to purchase additional service credit does not alter, amend, or revoke the terms of the Termination Pay Authorization for the Purchase of Service Credit form;
 - g. It is the member's responsibility to ensure that the member's employer properly deducts termination pay, as provided the Termination Pay Authorization for the Purchase of Service Credit form; and
 - h. The amount of termination pay the member is allowed to apply to purchase service credit is subject to federal laws.
- E. In addition to the other time limitations in this Section, to apply termination pay to a service purchase the eligible member shall complete and sign the Termination Pay Authorization for the Purchase of Service Credit form, and the member shall ensure that the ASRS receives the Termination Pay Authorization for the Purchase of Service Credit form at least three full calendar months before the member retires or terminates employment.
- F. The ASRS shall not apply a termination pay distribution to a service credit purchase covered by an Irrevocable Payroll Deduction Authorization in effect at the time of termination unless the eligible member signed a Termination Pay Addendum to the Irrevocable Payroll Deduction Authorization specified in R2-8-513(D) at the time the member signed the Irrevocable Payroll Deduction Authorization.
- G. If a member elects to use all of the member's available termination pay to purchase service credit, ASRS shall not apply any other form of payment to the service credit purchase until the ASRS receives the termination pay.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-520. Termination of Employment and Request Return of Retirement Contributions or Death of Member While Purchasing Service Credit by an Irrevocable Payroll Deduction Authorization

- A. If a member terminates employment without transferring employment as specified in R2-8-513.01 while purchasing service credit by an Irrevocable Payroll Deduction Authorization and requests return of retirement contributions, the ASRS shall return any payments made for the purchase of service credit including interest earned on those payments as determined by the Board.
- B. If a member dies while purchasing service credit, the ASRS shall credit the member's account with:
 1. The service credit for which the ASRS received payment before the member's death,
 2. Interest earned on payment through the date of distribution at the valuation rate established by the Board, and
 3. All service purchase payments.
- C. If a member dies while purchasing service credit, the ASRS shall not permit the survivor to purchase the remaining balance.
- D. The ASRS shall not refund interest charged as part of an Irrevocable Payroll Deduction Authorization as specified in R2-8-513(E)(1).

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2). Amended by final rulemaking at 12 A.A.R. 4667, effective December 5, 2006 (Supp. 06-4).

R2-8-521. Adjustment of Errors

- A. If the ASRS determines an error has been made in the information provided by the member or in the calculations made by the ASRS, the ASRS shall make an adjustment, including, but limited to, increasing or decreasing a member's total credited service with the ASRS and increasing or decreasing the payment amount.
- B. If the ASRS determines that a member is receiving or is eligible to receive retirement benefits from another public employee retirement system that makes the member ineligible to purchase service credit for the same period, the ASRS shall revoke that purchase of service credit, and return any payments made, less any interest payments made, if applicable.
- C. The ASRS shall notify the member in writing of any adjustments.

Historical Note

New Section made by final rulemaking at 11 A.A.R. 2640, effective June 30, 2005 (Supp. 05-2).

ARTICLE 6. PUBLIC PARTICIPATION IN RULEMAKING

R2-8-601. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "Rulemaking record" means a file the ASRS maintains as specified in A.R.S. § 41-1029.
2. "Oral proceeding" means a public gathering the ASRS holds for the purpose of receiving comment and answering questions about a proposed rule as specified in A.R.S. § 41-1023.
3. "Presiding officer" means an individual selected by the ASRS Director to oversee oral proceedings.
4. "Substantive policy statement" means the same as in A.R.S. § 41-1001(22).

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1). Amended by final rulemaking at 21 A.A.R. 2515, effective December 5, 2015 (Supp. XX)

R2-8-602. Reviewing Agency Rulemaking Record and Directory of Substantive Policy Statements

Except on a state holiday, an individual may review a rulemaking record or the directory of substantive policy statements at the Phoenix office of the ASRS, Monday through Friday, from 8:00 a.m. until 5:00 p.m.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-603. Petition for Rulemaking

- A. An individual submitting a petition to the ASRS to make or amend a rule under A.R.S. § 41-1033 shall include the following in the petition:
1. The name and current address of the individual submitting the petition;
 2. An identification of the rule to be made or amended;
 3. The suggested language of the rule;
 4. The reason why a new rule should be made or a current rule should be amended with supporting information, including:
 - a. An identification of the persons who would be affected by the rule and how the persons would be affected; and
 - b. If applicable, statistical data with references to attached exhibits;
 5. The signature of the individual submitting the petition; and
 6. The date the individual signs the petition.
- B. The ASRS shall send a written notice of the ASRS's decision regarding the Petition for Rulemaking to the individual within 30 days of receipt of the petition.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-604. Review of a Rule, Agency Practice, or Substantive Policy Statement

- A. An individual submitting a petition to the ASRS under A.R.S. § 41-1033 requesting that the ASRS review an agency practice or substantive policy statement that the individual alleges constitutes a rule shall include the following in the petition:
1. The name and current address of the individual submitting the petition,
 2. The reason the individual alleges that the agency practice or substantive policy statement constitutes a rule,
 3. The signature of the individual submitting the petition, and
 4. The date the individual signs the petition.
- B. The individual who submits a petition under subsection (A) shall attach a copy of the substantive policy statement or a description of the agency practice to the petition.
- C. The ASRS shall send a written notice of the ASRS's decision regarding the petition to the individual within 30 days of receipt of the petition.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-605. Objection to Rule Based Upon Economic, Small Business and Consumer Impact

- A. An individual submitting an objection to a rule based upon the economic, small business and consumer impact under A.R.S. § 41-1056.01 shall include the following in the objection:
1. The name and current address of the individual submitting the objection;
 2. Identification of the rule;
 3. Either evidence that the actual economic, small business and consumer impact:
 - a. Significantly exceeded the impact estimated in the economic, small business and consumer impact statement submitted during the making of the rule with supporting information attached as exhibits; or
 - b. Was not estimated in the economic, small business and consumer impact statement submitted during the making of the rule and that actual impact imposes a significant burden on persons subject to the rule with supporting information attached as exhibits;
 4. The signature of the individual submitting the objection; and
 5. The date the individual signs the objection.
- B. The ASRS shall respond to the objection as specified in A.R.S. § 41-1056.01(C).

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-606. Oral Proceedings

- A. An individual requesting an oral proceeding under A.R.S. § 41-1023(C) shall submit a written request to the ASRS that includes:
1. The name and current address of the individual making the request;
 2. If applicable, the name of the public or private organization, partnership, corporation or association, or the name of the governmental entity the individual represents; and
 3. Reference to the proposed rule including, if known, the date and issue of the Arizona Administrative Register in which the Notice of Proposed Rulemaking was published.
- B. The ASRS shall record an oral proceeding by either electronic or stenographic means and any CDs, cassette tapes, transcripts, lists, speaker slips, and written comments received shall become part of the official record.
- C. A presiding officer shall perform the following acts on behalf of the ASRS when conducting an oral proceeding as prescribed under A.R.S. § 41-1023:
1. Provide a method for individuals who attend the oral proceeding to voluntarily note their attendance;
 2. Provide a speaker slip that includes space for:
 - a. An individual's name,
 - b. The person the individual represents, if applicable,
 - c. The rule the individual wishes to comment on or has a question about, and
 - d. The approximate length of time the individual wishes to speak;
 3. Open the proceeding by identifying the rules to be considered, the location, date, time, purpose of the proceeding, and the agenda;
 4. Explain the background and general content of the proposed rulemaking;
 5. Provide for public comment as specified in A.R.S. § 41-1023(D); and
 6. Close the oral proceeding by announcing the location where written public comments are to be sent and specifying the close of record date and time.
- D. A presiding officer may limit comments to a reasonable time period, as determined by the presiding officer. Oral comments may be limited to prevent undue repetition.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

R2-8-607. Petition for Delayed Effective Date

- A. An individual who wishes to delay the effective date of a rule under A.R.S. § 41-1032 shall file a petition with the ASRS prior to the proposed rule's close of record date identified in the Notice of Proposed Rulemaking. The petition shall contain the:
1. Name and current address of the individual submitting the petition;
 2. Identification of the proposed rule;
 3. Need for the delay, specifying the undue hardship or other adverse impact that may result if the request for a delayed effective date is not granted;
 4. Reason why the public interest will not be harmed by the delayed effective date;
 5. Signature of the individual submitting the petition; and
 6. Date the individual signs the petition.
- B. The ASRS shall send a written notice of the ASRS's decision to the individual within 30 days of receipt of the Petition for Delayed Effective Date.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 964, effective March 7, 2006 (Supp. 06-1).

ARTICLE 7. CONTRIBUTIONS NOT WITHHELD

R2-8-701. Definitions

The following definitions apply to this Article unless otherwise specified:

1. "218 agreement" means a written agreement between the state, political subdivision, or political subdivision entity and the Social Security Administration, under the provisions of § 418 of the Social Security Act, to provide Social Security and Medicare or Medicare-only coverage to employees of the state, political subdivision, or political subdivision entity.
2. "Documentation" means a pay stub, completed W-2 form, completed Verification of Contributions Not Withheld form, employer letter or spreadsheet, completed State Personnel Action Form, Social Security Earnings Report, employment contract, payroll record, timesheet, or other ASRS employer-provided form that includes:
 - a. Whether the employee was covered under the ASRS employer's 218 agreement prior to July 24, 2014,
 - b. The number of hours worked or length of time the member was employed by the ASRS employer, or
 - c. The compensation paid to the member by the ASRS employer.
3. "Eligible service" means employment with an ASRS employer:

- a. That is no more than 15 years before the date the ASRS receives written credible evidence that less than the correct amount of contributions were paid into the ASRS or the ASRS otherwise determines that less than the correct amount of contributions were made as specified in A.R.S. § 38-738(C); and
- b. In which the member worked a minimum of 20 hours per week for at least 20 weeks in a service year for at least one ASRS employer from 7/1/1999 to the present.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4). Amended by final rulemaking at 21 A.A.R. 2515, effective December 5, 2015 (Supp. XX)

R2-8-702. General Information

- A. Verified eligible service that occurred more than 15 years before the date ASRS receives the information identified in R2-8-704(A)(1) is considered public service credit as provided in A.R.S. § 38-738(D), and is not applied under this Article.
- B. The ASRS employer shall pay the ASRS employer's portion of the contributions the ASRS determines is owed under R2-8-706 whether or not:
 - 1. The member has withdrawn contributions as specified in R2-8-115; or
 - 2. The member pays the member's portion of the contributions.
- C. The person who initiates the claim that contributions were not withheld for eligible service has the burden to prove a contribution error was made.
- D. ASRS shall not waive payment of contributions or interest owed under this Article.
- E. If a member is not able to establish eligibility for service credit for which contributions were not withheld, but is able to establish a period of employment by an ASRS employer the member may request to purchase service credit for that period under A.R.S. § 38-743 and Article 5 of this Chapter.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-703. ASRS Employer's Discovery of Error

If an ASRS employer determines that contributions have not been withheld for a member for a period of eligible service, the ASRS employer shall notify ASRS in writing, and shall provide ASRS with the member's full name, Social Security number, months, years, and hours per week worked, the compensation each fiscal year for the time periods worked, and the member's position title and status at the time contributions should have been withheld.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-704. Member's Discovery of Error

- A. If a member believes that an ASRS employer has not withheld contributions for the member for a period of eligible service, the member shall:
 - 1. Provide the ASRS employer with documentation of the member's claim and request that the ASRS employer provide a letter that includes the information in the Verification of Contributions Not Withheld form or complete a Verification of Contributions Not Withheld form that includes:
 - a. The member's full name;
 - b. Other names used by the member;
 - c. The member's Social Security number;
 - d. Whether the position was covered under the ASRS employer's 218 agreement;
 - e. The position title the member held at the time the contributions should have been withheld;
 - f. The eligibility of the member at the time the contributions should have been withheld;
 - g. The following statements of understanding and agreements to be initialed by the authorized employer representative filling out the form:
 - i. I understand it is my responsibility to verify the accuracy of the information I am providing on this form. I understand any individual who knowingly makes a false statement, or who falsifies or permits to be falsified any record of the ASRS with an intent to defraud the ASRS, is guilty of a Class 6 felony pursuant to A.R.S. § 38-793; and
 - ii. I understand that, based on the information provided on this form, the ASRS may determine that contributions are owed on behalf of the member listed on this form, and the ASRS employer may incur a substantial financial obligation;
 - h. The months worked, the hours per week worked, and the compensation earned by the member, by fiscal year;
 - i. The name of the ASRS employer;
 - j. The printed name and signature of the authorized employer representative;
 - k. The daytime telephone number of the authorized employer representative;
 - l. The title of the authorized employer representative; and
 - m. The date the authorized employer representative signed the form;
 - 2. Provide the ASRS with the completed Verification of Contributions Not Withheld form; and

3. If the ASRS employer refuses to fill out the Verification of Contributions Not Withheld form, or if the member disputes the information the ASRS employer completes on the form, provide the ASRS with the documentation the member believes supports the allegation that contributions should have been withheld, that includes proof:
 - a. That the employee was covered under the ASRS employer's 218 agreement,
 - b. Of the number of hours worked,
 - c. Of the length of time the member was employed by the ASRS employer, and
 - d. Of the compensation paid to the member by the ASRS employer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-705. ASRS' Discovery of Error

If the ASRS determines, as specified in A.R.S. § 38-738(B)(7), that contributions have not been withheld for a member for a period of eligible service, the ASRS shall notify the member and the ASRS employer in writing and shall request the following information:

1. The months, years and hours per week worked;
2. The compensation earned by the member each fiscal year for the time periods worked; and
3. The member's position title at the time contributions should have been withheld.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-706. Determination of Contributions Not Withheld

- A. Upon receipt of the information listed in R2-8-703, R2-8-704, or R2-8-705, the ASRS shall review the information to determine whether or not member contributions should have been withheld by the ASRS employer, the length of time those contributions should have been withheld, and the amount of contributions that should have been withheld.
- B. Except for returning to work under A.R.S. § 38-766.01, the presence of a contract between a member and the ASRS employer does not alter the contribution requirements of A.R.S. §§ 38-736 and 38-737.
- C. If there is any discrepancy between the documentation provided by the ASRS employer and the documentation provided by the member, a document used in the usual course of business prepared at the time in question is controlling.
- D. The ASRS shall provide to the ASRS employer and the member a written statement that includes:
 1. The dates of eligible service for which contributions were not withheld,
 2. The dollar amount of contributions that should have been made,
 3. The dollar amount of the contributions to be paid by the ASRS employer,
 4. The interest on the ASRS employer contributions and member contributions to be paid by the ASRS employer,
 5. The dollar amount of contributions to be paid by the member, and
 6. To the member, the various payment options that may apply, as specified in R2-8-512 through R2-8-519.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-707. Submission of Payment

- A. Within 90 calendar days after the ASRS notifies the ASRS employer in writing of the amount due, the ASRS employer shall pay all ASRS employer contributions, including accrued interest on both the ASRS employer and member contributions, from the date the contributions were due to the date the ASRS notifies the ASRS employer of the amount due. An ASRS employer who makes payment under A.R.S. § 38-738(B)(3) is not liable for additional interest that may accrue as a result of a member's failure to remit payment required by A.R.S. § 38-738(B)(1). If the ASRS does not receive full payment of the ASRS employer's amount due within 90 calendar days after the ASRS notifies the ASRS employer of the amount due, interest on the amount not paid, as provided in A.R.S. § 38-738(B)(3), will accrue from the 91st day until the ASRS employer pays the full amount.
- B. An ASRS employer may pay the amount the ASRS employer believes may be due at any time before ASRS's notification of the amount due in order to prevent the accrual of interest after the date of the payment. Any amount the ASRS employer pays that the ASRS determines is not owed shall be refunded to the ASRS employer.
- C. A member may purchase eligible service for which contributions were not withheld in accordance with the requirements of Article 5 of this Chapter for purchase of service credit. If the ASRS does not receive full payment of the ASRS employee's amount due within 90 calendar days after the ASRS notifies the member that the ASRS received the ASRS employer's full payment, interest on the amount not paid, as provided in A.R.S. § 38-738(B)(1), will accrue from the 91st day until the member pays the full amount.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-708. Dispute of an ASRS Determination Regarding Contributions Not Withheld

- A. If a member or the ASRS employer disputes an ASRS determination regarding contributions not withheld, that party may request in writing that the Director review the ASRS determination. Within 30 calendar days of receiving the request for the

review of the ASRS determination, the Director shall review and either approve or amend the ASRS determination, and send to the member and the ASRS employer written notice of the Director's decision.

- B. If the member or the ASRS employer disputes the Director's decision, that party may obtain a hearing by filing a Request for a Hearing with the Board, in accordance with Article 4 of this Chapter, within 30 calendar days after receiving notice of the Director's determination. The party filing the request shall provide the name of the other party.
- C. The burden of producing evidence is on the party challenging the determination.
- D. If the ASRS Board determines that the service is eligible, the ASRS shall send both the ASRS employer and the member a written statement, as specified in R2-8-706(D), and the:
 - 1. Decision of the Board;
 - 2. Correct amount due as determined by the Board, if applicable;
 - 3. Additional amount of interest due from the losing party, from the 91st day after the initial notification of the amount due to the date of the decision; and
 - 4. Notification that interest shall continue to accrue on the total amount due at the rate specified in A.R.S. § 38-738(B) until the date payment is received by the ASRS.
- E. If the ASRS Board determines that the service is not eligible, ASRS shall send both the ASRS employer and the member the decision of the Board.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

R2-8-709. Nonpayment of Contributions

- A. A member receives service credit only for the portion of service the ASRS has determined is eligible and that the member has paid for.
- B. A member does not receive service credit until both the ASRS employer and member portions of the contributions have been paid.
- C. If the ASRS employer does not pay, the ASRS shall take any steps legally authorized to collect payment. Any steps the ASRS may take to collect payment are separate from any action a member may elect to take against the ASRS employer.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 4793, effective December 5, 2006 (Supp. 06-4).

38-711. Definitions

In this article, unless the context otherwise requires:

1. "Active member" means a member as defined in paragraph 23, subdivision (b) of this section who satisfies the eligibility criteria prescribed in section 38-727 and who is currently making member contributions as prescribed in section 38-736.
2. "Actuarial equivalent" means equality in value of the aggregate amounts expected to be received under two different forms of payment, based on mortality and interest rate assumptions approved from time to time by the board.
3. "ASRS" means the Arizona state retirement system established by this article.
4. "Assets" means the resources of ASRS including all cash, investments or securities.
5. "Average monthly compensation" means:
 - (a) For a member whose membership in ASRS commenced before January 1, 1984 and who left the member's contributions on deposit or reinstated forfeited credited service pursuant to section 38-742 for a period of employment that commenced before January 1, 1984, the higher of either:
 - (i) The monthly average of compensation that is calculated pursuant to subdivision (b) of this paragraph.
 - (ii) The monthly average of compensation on which contributions were remitted during a period of sixty consecutive months during which the member receives the highest compensation within the last one hundred twenty months of credited service. Any month for which no contributions are reported to ASRS or that falls within a period of nonpaid or partially paid leave of absence or sabbatical leave shall be excluded from the computation. The sixty consecutive months may entirely precede, may be both before and after or may be completely after any excluded months. If the member was employed for less than sixty consecutive months, the average monthly compensation is based on the total consecutive months worked. Payments for accumulated vacation or annual leave, sick leave, compensatory time or other forms of termination pay that, before August 12, 2005, constitute compensation for members whose membership in ASRS commenced before January 1, 1984, do not cease to be included as compensation if paid in the form of nonelective employer contributions under a 26 United States Code section 403(b) plan if all payments of employer and employee contributions are made at the time of termination. Contributions shall be made to ASRS on these amounts pursuant to sections 38-735, 38-736 and 38-737.
 - (b) For a member whose membership in ASRS commenced on or after January 1, 1984 but before July 1, 2011, the monthly average of compensation on which contributions were remitted during a period of thirty-six consecutive months during which a member receives the highest compensation within the last one hundred twenty months of credited service. Any month for which no contributions are reported to ASRS or that falls within a period of nonpaid or partially paid leave of absence or sabbatical leave shall be excluded from the computation. The thirty-six consecutive months may entirely precede, may be both before and after or may be completely after any excluded months. If the member was employed for less than thirty-six consecutive months, the average monthly compensation shall be based on the total consecutive months worked.
 - (c) For a member whose membership in ASRS commenced on or after July 1, 2011, the monthly average of compensation on which contributions were remitted during

a period of sixty consecutive months during which a member receives the highest compensation within the last one hundred twenty months of credited service. Any month for which no contributions are reported to ASRS or that falls within a period of nonpaid or partially paid leave of absence or sabbatical leave shall be excluded from the computation. The sixty consecutive months may entirely precede, may be both before and after or may be completely after any excluded months. If the member was employed for less than sixty consecutive months, the average monthly compensation shall be based on the total consecutive months worked.

6. "Board" means the ASRS board established in section 38-713.

7. "Compensation" means the gross amount paid to a member by an employer as salary or wages, including amounts that are subject to deferred compensation or tax shelter agreements, for services rendered to or for an employer, or that would have been paid to the member except for the member's election or a legal requirement that all or part of the gross amount be used for other purposes, but does not include amounts paid in excess of compensation limits established in section 38-746. Compensation includes amounts paid as salary or wages to a member by a second employer if the member meets the requirements prescribed in paragraph 23, subdivision (b) of this section with that second employer.

Compensation, as provided in paragraph 5, subdivision (b) or (c) of this section, does not include:

(a) Lump sum payments, on termination of employment, for accumulated vacation or annual leave, sick leave, compensatory time or any other form of termination pay whether the payments are made in one payment or by installments over a period of time.

(b) Damages, costs, attorney fees, interest or other penalties paid pursuant to a court order or a compromise settlement or agreement to satisfy a grievance or claim even though the amount of the payment is based in whole or in part on previous salary or wage levels, except that, if the court order or compromise settlement or agreement directs salary or wages to be paid for a specific period of time, the payment is compensation for that specific period of time. If the amount directed to be paid is less than the actual salary or wages that would have been paid for the period if service had been performed, the contributions for the period shall be based on the amount of compensation that would have been paid if the service had been performed.

(c) Payment, at the member's option, in lieu of fringe benefits that are normally paid for or provided by the employer.

(d) Merit awards pursuant to section 38-613 and performance bonuses paid to assistant attorneys general pursuant to section 41-192.

(e) Amounts that are paid as salary or wages to a member for which employer contributions have not been paid.

8. "Contingent annuitant" means the person named by a member to receive retirement income payable following a member's death after retirement as provided in section 38-760.

9. "Credited service" means, subject to section 38-739, the number of years standing to the member's credit on the books of ASRS during which the member made the required contributions.

10. "Current annual compensation" means the greater of:

(a) Annualized compensation of the typical pay period amount immediately before the date of a request to ASRS to purchase credited service pursuant to section 38-743, 38-744 or 38-745. The typical pay period amount shall be determined by taking the five pay periods immediately before the date of a request, disregarding the highest and lowest compensation amount pay periods and averaging the three remaining pay periods.

(b) Annualized compensation of the partial year, disregarding the first compensation amount pay period, if the member has less than twelve months total compensation on the date of a request to purchase credited service pursuant to section 38-743, 38-744 or 38-745.

(c) The sum of the twelve months of compensation immediately before the date of a request to ASRS to purchase credited service pursuant to section 38-743, 38-744 or 38-745.

(d) The sum of the thirty-six months of compensation immediately before the date of a request to ASRS to purchase credited service pursuant to section 38-743, 38-744 or 38-745 divided by three.

(e) If the member has retired one or more times from ASRS, the average monthly compensation that was used for calculating the member's last pension benefit times twelve.

11. "Early retirement" means retirement before a member's normal retirement date after five years of total credited service and attainment of age fifty.

12. "Effective date" means July 1, 1970, except with respect to employers and members whose contributions to ASRS commence thereafter, the effective date of their membership in ASRS is as specified in the applicable joinder agreement.

13. "Employer" means:

(a) This state.

(b) Participating political subdivisions.

(c) Participating political subdivision entities.

14. "Employer contributions" means all amounts paid into ASRS by an employer on behalf of a member.

15. "Fiscal year" means the period from July 1 of any year to June 30 of the following year.

16. "Inactive member" means a member who previously made contributions to ASRS and who satisfies each of the following:

(a) Has not retired.

(b) Is not eligible for active membership in ASRS.

(c) Is not currently making contributions to ASRS.

(d) Has not withdrawn contributions from ASRS.

17. "Interest" means the assumed actuarial investment earnings rate approved by the board.

18. "Internal revenue code" means the United States internal revenue code of 1986, as amended.

19. "Investment manager" means the persons, companies, banks, insurance company investment funds, mutual fund companies, management or any combinations of those entities that are appointed by ASRS and that have responsibility and authority for investment of the monies of ASRS.

20. "Late retirement" means retirement after normal retirement.

21. "Leave of absence" means any unpaid leave authorized by the employer, including leaves authorized for sickness or disability or to pursue education or training.
22. "Life annuity" means equal monthly installments payable during the member's lifetime after retirement.
23. "Member":
- (a) Means any employee of an employer on the effective date.
 - (b) Means all employees of an employer who are eligible for membership pursuant to section 38-727 and who are engaged to work at least twenty weeks in each fiscal year and at least twenty hours each week.
 - (c) Means any person receiving a benefit under ASRS.
 - (d) Means any person who is a former active member of ASRS and who has not withdrawn contributions from ASRS pursuant to section 38-740.
 - (e) Does not include any employee of an employer who is otherwise eligible pursuant to this article and who begins service in a limited appointment for not more than eighteen months on or after July 1, 1979. If the employment exceeds eighteen months, the employee shall be covered by ASRS as of the beginning of the nineteenth month of employment. In order to be excluded under this subdivision, classifications of employees designated by employers as limited appointments must be approved by the director.
 - (f) Does not include any leased employee. For the purposes of section 414(n) of the internal revenue code, "leased employee" means an individual who:
 - (i) Is not otherwise an employee of an employer.
 - (ii) Pursuant to a leasing agreement between the employer and another person, performs services for the employer on a substantially full-time basis for at least one year.
 - (iii) Performs services under the primary direction or control of the employer.
24. "Member contributions" means all amounts paid to ASRS by a member.
25. "Normal costs" means the sum of the individual normal costs for all active members for each fiscal year. The normal cost for an individual active member is the cost that is assigned to the fiscal year, through June 29, 2016, using the projected unit credit method and, beginning June 30, 2016, using the actuarial cost method determined by the board pursuant to section 38-714.
26. "Normal retirement age" means the age at which a member reaches the member's normal retirement date.
27. "Normal retirement date" means the earliest of the following:
- (a) For a member whose membership commenced before July 1, 2011:
 - (i) A member's sixty-fifth birthday.
 - (ii) A member's sixty-second birthday and completion of at least ten years of credited service.
 - (iii) The first day that the sum of a member's age and years of total credited service equals eighty.
 - (b) For a member whose membership commenced on or after July 1, 2011:
 - (i) A member's sixty-fifth birthday.
 - (ii) A member's sixty-second birthday and completion of at least ten years of credited service.
 - (iii) A member's sixtieth birthday and completion of at least twenty-five years of credited service.

(iv) A member's fifty-fifth birthday and completion of at least thirty years of credited service.

28. "Political subdivision" means any political subdivision of this state and includes a political subdivision entity.

29. "Political subdivision entity" means an entity:

(a) That is located in this state.

(b) That is created in whole or in part by political subdivisions, including instrumentalities of political subdivisions.

(c) Where a majority of the membership of the entity is composed of political subdivisions.

(d) Whose primary purpose is the performance of a government related service.

30. "Retired member" means a member who is receiving retirement benefits pursuant to this article.

31. "Service year" means fiscal year, except that:

(a) If the normal work year required of a member is less than the full fiscal year but is for a period of at least nine months, the service year is the normal work year.

(b) For a salaried member employed on a contract basis under one contract, or two or more consecutive contracts, for a total period of at least nine months, the service year is the total period of the contract or consecutive contracts.

(c) In determining average monthly compensation pursuant to paragraph 5 of this section, the service year is considered to be twelve months of compensation.

32. "State" means this state, including any department, office, board, commission, agency, institution or other instrumentality of this state.

33. "Vested" means that a member is eligible to receive a future retirement benefit.

38-714. [Powers and duties of ASRS and board](#)

A. ASRS shall have the powers and privileges of a corporation, shall have an official seal and shall transact all business in the name "Arizona state retirement system", and in that name may sue and be sued.

B. The board is responsible for supervising the administration of this article by the director of ASRS.

C. The board is responsible for the performance of fiduciary duties and other responsibilities required to preserve and protect the retirement trust fund established by section 38-712.

D. The board shall not advocate for or against legislation providing for benefit modifications, except that the board shall provide technical and administrative information regarding the impact of benefit modification legislation.

E. The board may:

1. Determine the rights, benefits or obligations of any person under this article and afford any person dissatisfied with a determination a hearing on the determination. The board may delegate the duty and authority to act on the board's behalf to a committee of the board for the purposes of this paragraph and title 41, chapter 6, article 10 relating to any decision made under this paragraph by that committee of the board.

2. Determine the amount, manner and time of payment of any benefits under this article.

3. Recommend amendments to this article and articles 2.1 and 7 of this chapter that are required for efficient and effective administration.
4. Adopt, amend or repeal rules for the administration of the plan, this article and articles 2.1 and 7 of this chapter.
- F. Beginning June 30, 2016, the board shall determine which of the generally accepted actuarial cost methods shall be used in the annual actuarial valuation of the plan.
- G. The board and ASRS are not subject to title 41, chapter 6, except title 41, chapter 6, article 10, for actuarial assumptions and calculations, investment strategy and decisions and accounting methodology.
- H. The board shall submit to the governor and legislature for each fiscal year no later than eight months after the close of the fiscal year a report of its operations and the operations of ASRS. The report shall follow generally accepted accounting principles and generally accepted financial reporting standards and shall include:
 1. A report on an actuarial valuation of ASRS assets and liabilities.
 2. Any other statistical and financial data that may be necessary for the proper understanding of the financial condition of ASRS and the results of board operations.
 3. On request of the governor or the legislature, a list of investments owned. This list shall be provided in an electronic format.
 4. An estimate of the aggregate fees paid for private equity investments, including management fees and performance fees.
- I. The board shall:
 1. Prepare and publish a synopsis of the annual report for the information of ASRS members.
 2. Contract for a study of the mortality, disability, service and other experiences of the members and employers participating in ASRS. The study shall be conducted for fiscal year 1990-1991 and for at least every fifth fiscal year thereafter. A report of the study shall be completed within eight months after the close of the applicable fiscal year and shall be submitted to the governor and the legislature.
 3. Conduct an annual actuarial valuation of ASRS assets and liabilities.
- J. The auditor general may make an annual audit of ASRS and transmit the results to the governor and the legislature.

38-764. Commencement of retirement; payment of retirement benefits; lump sum payments

- A. Retirement is deemed to commence on a date elected by the member. That date shall not be earlier than the day following the date of termination of employment, the date ASRS receives the member's completed retirement application or the date specified by the member pursuant to subsection I of this section.
- B. Except as provided in subsection C of this section, all retirement benefits:
 1. Are normally payable in monthly installments beginning on the commencement of retirement as prescribed in subsection A of this section.
 2. Continue to and include the first day of the month in which death occurs or continue until the date of their cessation in accordance with any optional method of payment that may have been elected.

C. In the case of incapacity of a retired member or contingent annuitant, or in the case of any other emergency, as determined by the board, the board may make the payment to or on behalf of the retired member or contingent annuitant or to another person or persons the board determines to be lawfully entitled to receive payment. The payment is payment for the account of the retired member or contingent annuitant and all persons entitled to payment and, to the extent of the payment, is a full and complete discharge of all liability of the board or ASRS, or both, under or in connection with ASRS.

D. Except as provided in subsection E of this section, at the request of a retired member, a retired member's guardian or a court appointed conservator, the board may pay any increase in retirement benefits or the entire retirement benefit in a lump sum payment based on the actuarial present value of the benefit or the increase in the benefit if the payment of the benefits would result in ineligibility, reduction or elimination of social service programs provided to the member by this state, its political subdivisions or the federal government.

E. The board may pay the entire retirement benefit in a lump sum pursuant to subsection D of this section only if continued membership in ASRS will result in additional requests for lump sum payments based on cost of living adjustments or the establishment of minimum benefit awards.

F. If any benefit that is payable as a series of periodic payments amounts to less than a threshold amount determined by the board, the board, in its sole discretion and based on uniform rules it establishes, may order the amount to be paid in a lump sum. A member who receives a lump sum payment pursuant to this subsection remains a member of ASRS and is eligible for the coverage provided pursuant to section 38-782 and the payment pursuant to section 38-783, but is not eligible for a benefit increase pursuant to section 38-767.

G. All distributions of retirement benefits to a member shall be distributed within the required distribution provisions of section 401(a)(9) of the internal revenue code and the regulations that are issued under that section by the United States secretary of the treasury as prescribed in section 38-775.

H. A member may elect to cancel the effective date of retirement within thirty days of retirement or before the member's receipt of retirement benefits, whichever is later.

I. A member who attains a normal retirement date may retire at any time without terminating employment if the member is employed for less than the hours required for active membership pursuant to section 38-711, paragraph 23, subdivision (b).

38-769. Maximum retirement benefits; termination; definitions

A. Notwithstanding any other provision of this article, except as provided in subsection C of this section, the employer provided portion of a member's annual benefit payable in the form of a straight life annuity, at any time within a limitation year, shall not exceed one hundred sixty thousand dollars or a larger amount that is effective as of January 1 of each calendar year, is prescribed by the board and is due to any cost of living adjustment announced by the United States secretary of the treasury pursuant to section 415(d) of the internal revenue code. The board shall increase the amount pursuant to this subsection as of the effective date of the

increase as prescribed by the United States secretary of the treasury. Benefit increases provided in this section resulting from the increase in the limitations of section 415(b) of the internal revenue code as amended by the economic growth and tax relief reconciliation act of 2001 shall be provided to all current and former members who have benefits that are limited by section 415(b) of the internal revenue code and who have an accrued benefit under ASRS immediately before July 1, 2001, other than an accrued benefit resulting from a benefit increase solely as a result of the increases provided by this section resulting from the increase in the limitations of section 415(b) of the internal revenue code as amended by the economic growth and tax relief reconciliation act of 2001.

B. Notwithstanding the limitations of subsection A of this section, the benefits payable to a member are deemed not to exceed the limitations determined under subsection A of this section if the retirement benefits payable to the member under this article do not exceed ten thousand dollars for the limitation year and if an employer has not at any time maintained a defined contribution plan in which the member has participated.

C. The limitations determined under subsection A of this section are subject to the following adjustments:

1. If a member has less than ten years of membership in ASRS, the maximum dollar limitation determined under subsection A of this section shall be multiplied by a fraction, the numerator of which is the number of years, or partial years, of membership in ASRS and the denominator of which is ten. The reduction provided in this paragraph also applies to the ten thousand dollar floor limitation provided in subsection B of this section, except that the reduction applies to years of service with an employer rather than to years of membership in ASRS. The reduction in this paragraph does not reduce the limitations determined under subsection A of this section to an amount less than one-tenth of the limitations as determined without regard to this paragraph.

2. If the member's benefit under ASRS commences before the member reaches sixty-two years of age, the benefit will be limited to:

(a) If the annuity starting date is in a limitation year beginning before July 1, 2007, the annual amount of a benefit payable in the form of a straight life annuity commencing at the member's annuity starting date that is the actuarial equivalent of the dollar limitation under section 415(b)(1)(A) of the internal revenue code as adjusted in subsection A of this section, with actuarial equivalence computed using whichever of the following produces the smaller annual amount:

(i) The interest rate and mortality table or other tabular factor specified by the board for determining actuarial equivalence for early retirement purposes.

(ii) A five per cent interest rate assumption and the applicable mortality table.

(b) If the annuity starting date is in a limitation year beginning on or after July 1, 2007 and ASRS does not have an immediately commencing straight life annuity payable at both age sixty-two and the age of benefit commencement, the annual amount of a benefit payable in the form of a straight life annuity commencing at the member's annuity starting date that is the actuarial equivalent of the dollar limitation under section 415(b)(1)(A) of the internal revenue code as adjusted in subsection A of this section, with actuarial equivalence computed using a five per cent interest rate assumption and the applicable mortality table and expressing the member's age based on completed calendar months as of the annuity start date.

(c) If the annuity starting date is in a limitation year beginning on or after July 1, 2007 and ASRS has an immediately commencing straight life annuity payable at both age sixty-two and the age of benefit commencement, the lesser of:

(i) The adjusted dollar limitation determined in accordance with subdivision (b) of this paragraph, determined without applying the limitations of section 415 of the internal revenue code.

(ii) The product of the dollar limitation under section 415(b)(1)(A) of the internal revenue code as adjusted in subsection A of this section, multiplied by the ratio of the annual amount of the immediately commencing straight life annuity under ASRS at the member's annuity starting date to the annual amount of the immediately commencing straight life annuity under ASRS at age sixty-two, determined without applying the limitations of section 415 of the internal revenue code.

3. If the retirement benefit under ASRS commences after the member reaches sixty-five years of age, the dollar limitation under section 415(b)(1)(A) of the internal revenue code as adjusted in subsection A of this section on that benefit is increased to:

(a) If the annuity starting date is in a limitation year beginning before July 1, 2007, the annual amount of a benefit payable in the form of a straight life annuity commencing at the member's annuity starting date that is the actuarial equivalent of the dollar limitation under section 415(b)(1)(A) as adjusted under section 415(d) of the internal revenue code, with actuarial equivalence computed using whichever of the following produces the smaller annual amount:

(i) The interest rate and mortality table or other tabular factor specified by the board for determining actuarial equivalence for delayed retirement purposes.

(ii) A five per cent interest rate assumption and the applicable mortality table.

(b) If the annuity starting date is in a limitation year beginning on or after July 1, 2007 and ASRS does not have an immediately commencing straight life annuity payable at both age sixty-five and the age of benefit commencement, the annual amount of a benefit payable in the form of a straight life annuity commencing at the member's annuity starting date that is the actuarial equivalent of the dollar limitation under section 415(b)(1)(A) of the internal revenue code as adjusted in subsection A of this section, with actuarial equivalence computed using a five per cent interest rate assumption and the applicable mortality table and expressing the member's age based on completed calendar months as of the annuity starting date.

(c) If the annuity starting date is in a limitation year beginning on or after July 1, 2007 and ASRS has an immediately commencing straight life annuity payable at both age sixty-five and the age of benefit commencement, the lesser of:

(i) The adjusted dollar limitation determined in accordance with subdivision (b) of this paragraph, determined without applying the limitations of section 415 of the internal revenue code.

(ii) The product of the dollar limitation under section 415(b)(1)(A) of the internal revenue code as adjusted in subsection A of this section, multiplied by the ratio of the annual amount of the immediately commencing straight life annuity under ASRS at the member's annuity starting date to the annual amount of the immediately commencing straight life annuity under ASRS at age sixty-five, determined without applying the limitations of section 415 of the internal revenue code.

4. For purposes of applying the limits of section 415 of the internal revenue code, a retirement benefit that is payable in any form other than a straight life annuity and that is not subject to section 417(e)(3) of the internal revenue code must be adjusted to an actuarially equivalent straight life annuity that equals either:

(a) For limitation years beginning on or after July 1, 2007, the greater of the annual amount of the straight life annuity, if any, payable under ASRS at the same annuity starting date, and the annual amount of a straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the member's form of benefit computed using an interest rate of five per cent and the applicable mortality table under section 417(e)(3) of the internal revenue code.

(b) For limitation years beginning before July 1, 2007, the annual amount of a straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the member's form of benefit computed using whichever of the following produces the greater annual amount:

(i) The interest rate and mortality table or other tabular factor specified by the board for adjusting benefits in the same form.

(ii) A five per cent interest rate assumption and the applicable mortality table.

5. For the purpose of applying the limits of section 415 of the internal revenue code, a retirement benefit that is payable in any form other than a straight life annuity to which section 417(e)(3) of the internal revenue code would apply if that section of the internal revenue code were applicable to ASRS must be adjusted to an actuarially equivalent straight life annuity that equals:

(a) If the annuity starting date is in a plan year beginning on or after July 1, 2006, the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the member's form of benefit, using whichever of the following produces the greater annual amount:

(i) The interest rate and mortality table or other tabular factor specified by the board for adjusting benefits in the same form.

(ii) A five and one-half per cent interest rate assumption and the applicable mortality table.

(iii) The applicable interest rate under section 417(e)(3) of the internal revenue code and the applicable mortality table, divided by 1.05. The stability period during which the applicable interest rate remains constant is the plan year. The look-back month that is used to determine the applicable interest rate during the stability period is the third full calendar month preceding the first day of the stability period. For the purposes of this item, "applicable interest rate" means the annual interest rate on thirty-year treasury securities as specified by the commissioner of the United States internal revenue service for a month in revenue rulings or notices or another guidance published by the commissioner in the internal revenue bulletin.

(b) If the annuity starting date is in a plan year beginning in July 1, 2004 or July 1, 2005, the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the member's form of benefit payable, using whichever of the following produces the greater annual amount:

(i) The interest rate and mortality table or other tabular factor specified by the board for adjusting benefits in the same form.

(ii) A five and one-half per cent interest assumption and the applicable mortality table.

(c) If the annuity starting date is on or after July 1, 2004 and before December 31, 2004, and ASRS applies the transition rule in section 101(d)(3) of the pension funding equity act of 2005 in lieu of the rule in subdivision (b) of this paragraph, the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the member's form of benefit, determined in accordance with internal revenue service notice 2004-78.

6. When calculating the limitations of paragraph 4 or 5 of this subsection, the portion of any joint or survivor annuity that constitutes a qualified joint and survivor annuity as defined in section 417 of the internal revenue code shall be disregarded.

D. Subsection C, paragraphs 1 and 2 of this section do not apply to income received from ASRS as a pension, annuity or similar allowance as a result of the recipient developing a disability by personal injury or sickness or to amounts received from ASRS by beneficiaries, survivors or the estate of a member as a result of the death of the member.

E. Notwithstanding any other provision of this section, the annual benefit payable under this article may be reduced to the extent necessary, as determined by the board, to prevent disqualification of ASRS under section 415 of the internal revenue code that imposes additional limitations on the annual benefits payable to members who also may be participating in another tax qualified pension or savings plan of this state. An employer shall not provide employee retirement or deferred benefits if the benefits authorized by this section and as required by federal law result in the failure of ASRS to meet federal qualification standards as applied to public pension plans. The board shall advise affected members of any additional information concerning their annual benefits required by this subsection. All benefits payable pursuant to this subsection shall comply with the limitations of benefits contained in section 415 of the internal revenue code and the final treasury regulations issued under that section. Notwithstanding any provision of this article to the contrary, if the annual benefits within the meaning of section 415 of the internal revenue code for any member exceed the limits of section 415(b) of the internal revenue code and this section, ASRS may only correct the excess pursuant to the employee plans compliance resolution system prescribed in internal revenue service revenue procedure 2008-50 or any future guidance by the internal revenue service, including the preamble of the final treasury regulations issued under section 415 of the internal revenue code.

F. If the maximum amount of benefit allowed under section 415 of the internal revenue code is increased after the commencement date of a member's benefit due to any cost of living adjustment announced by the United States secretary of the treasury pursuant to the provisions of section 415(d) of the internal revenue code, the amount of the monthly benefit payable under ASRS to a member whose benefit is restricted due to the provisions of section 415(d) of the internal revenue code shall be increased by the board as of the date prescribed by the United States secretary of the treasury on which the increase shall become effective. The increase shall reflect the increase in the amount of retirement income that may be payable under this article as a result of the cost of living adjustment.

G. In determining the adjustments to the defined benefit dollar limitation authorized by subsection A of this section, the board shall prescribe a larger defined benefit dollar limitation if prescribed by the United States secretary of the treasury

pursuant to section 415(d) of the internal revenue code. An adjustment to the defined benefit dollar limitation prescribed in subsection A of this section is not effective before the first calendar year for which the United States secretary of the treasury publishes the adjustment. After it is prescribed by the board, the new defined benefit dollar limitation applies to the limitation year ending with or within the calendar year for which the secretary of the treasury makes the adjustment.

H. For the purposes of the limitations prescribed by this section, all member and employer contributions made to ASRS to provide a member benefits pursuant to section 38-771 or 38-771.01 and all member contributions that are not treated as picked up by the employer under section 414(h)(2) of the internal revenue code shall be treated as made to a separate defined contribution plan.

I. On termination or partial termination of ASRS, the accrued benefit of each member is, as of the date of termination or partial termination, fully vested and nonforfeitable to the extent then funded.

J. If ASRS terminates, the benefit of any highly compensated employee as defined in section 414(q) of the internal revenue code and any highly compensated former employee is limited to a benefit that is nondiscriminatory under section 401(a)(4) of the internal revenue code and as follows:

1. Benefits distributed to any of the twenty-five active and former highly compensated employees with the greatest compensation in the current or any prior fiscal year are restricted so that the annual payments are no greater than an amount equal to the payment that would be made on behalf of the member under a straight life annuity that is the actuarial equivalent of the sum of the member's accrued benefit, the member's other benefits under ASRS, excluding a social security supplement as defined in 26 Code of Federal Regulations section 1.411(a)-7(C)(4)(ii), and the amount the member is entitled to receive under a social security supplement.

2. Paragraph 1 of this subsection does not apply if either:

(a) After payment of the benefit to a member described in paragraph 1 of this subsection, the value of ASRS assets equals or exceeds one hundred ten per cent of the value of the current liabilities, as defined in section 412(l)(7) of the internal revenue code, of ASRS.

(b) The value of the benefits for a member described in paragraph 1 of this subsection is less than one per cent of the value of the current liabilities, as defined in section 412(l)(7) of the internal revenue code, of ASRS before distribution.

(c) The value of the benefits payable by ASRS to a member described in paragraph 1 of this subsection does not exceed three thousand five hundred dollars.

K. For the purposes of subsection J of this section, "benefit" includes loans in excess of the amount prescribed in section 72(p)(2)(A) of the internal revenue code, any periodic income, any withdrawal values payable to a living member and any death benefits not provided for by insurance on the member's life.

L. On retirement of a member who was a retired member, who resumed active membership and who subsequently retires, the limitations of this section in effect on the member's subsequent retirement apply to the member's retirement benefit payable as recomputed pursuant to section 38-766. In addition, the sum of the present value of the member's recomputed retirement benefits plus the present value of the benefits the member received during the member's prior retirement shall not exceed the present value of the limitations in effect on the member's

subsequent retirement. The limitations prescribed in this subsection shall not reduce a member's retirement benefit below the retirement benefit the member was receiving before the member resumed active membership. For the purposes of determining present value under this subsection, the board shall use the actuarial equivalent assumptions provided in section 38-711, paragraph 2.

M. For the purposes of this section:

1. The following adjustments shall be made to the definition of compensation prescribed in subsection O of this section:

(a) Compensation shall be adjusted for the types of compensation that are prescribed in this paragraph and that are paid after a member's severance from employment with an employer. Amounts described in subdivisions (b), (c) and (d) of this paragraph may be included only as compensation to the extent the amounts are paid by the later of two and one-half months after severance from employment or by the end of the limitation year that includes the date of the severance from employment. Any other payment of compensation paid after severance of employment that is not described in the types of compensation prescribed in this paragraph is not considered compensation for purposes of this section, even if payment is made within the time period prescribed in this subdivision.

(b) Compensation shall include regular pay after severance of employment if the payment is regular compensation for services performed during the member's regular working hours or compensation for services performed outside the member's regular working hours, such as overtime or shift differential, commission, bonus or other similar payments, and the payment would have been paid to the member before a severance from employment if the member had continued in employment with the employer.

(c) Leave cash-outs shall be included in compensation if those amounts would have been included in compensation if they were paid before the member's severance from employment and the amounts are payment for unused accrued bona fide sick, vacation or other leave, but only if the member would have been able to use the leave if employment had continued.

(d) Deferred compensation shall be included in compensation if the compensation would have been included in compensation if it had been paid before the member's severance from employment and the compensation is received pursuant to a nonqualified unfunded deferred compensation plan, but only if the payment would have been paid at the same time if the member had continued in employment with the employer and only to the extent that the payment is includable in the member's gross income.

(e) Compensation does include payments to an individual who does not currently perform services for an employer by reason of qualified military service as defined in section 414(u)(5) of the internal revenue code to the extent those payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the employer rather than entering qualified military service.

(f) Compensation does not include compensation paid to a member who is a person with a permanent and total disability as defined in section 22(e)(3) of the internal revenue code.

(g) Compensation shall include amounts that are includable in the gross income of a member as required by section 409A or section 457(f)(1)(A) of the internal revenue code or because the amounts are constructively received by the member.

2. Compensation for a limitation year shall not include amounts earned but not paid during the limitation year solely because of the timing of pay periods and pay dates.

3. Payments awarded by an administrative agency or court or pursuant to a bona fide agreement by an employer to compensate a member for lost wages are compensation for the limitation year to which the back pay relates, but only to the extent the payments represent wages and compensation that would otherwise be included in compensation under this section.

N. The definition of limitation year prescribed in subsection O of this section may only be changed by an amendment to subsection O, except that if ASRS is terminated effective as of a date other than the last day of the limitation year, the termination shall be treated as if this section has been amended to change the definition of limitation year.

O. For the purposes of this section:

1. Annual additions shall be determined as provided in section 38-747, subsection O.

2. "Annual benefit" means a benefit, including any portion of a member's retirement benefit payable to an alternate payee under a qualified domestic relations order that satisfies the requirements prescribed in section 414(p)(1)(A)(i) of the internal revenue code and section 38-773, payable annually in the form of a straight life annuity, disregarding the portion of a joint and survivor annuity that constitutes a qualified joint and survivor annuity as defined in section 417 of the internal revenue code, with no ancillary or incidental benefits or rollover contributions and excluding any portion of the benefit derived from member contributions or other contributions that are treated as a separate defined contribution plan under section 415 of the internal revenue code but including any of those contributions that are picked up by the employer under section 414(h) of the internal revenue code, or that otherwise are not treated as a separate defined contribution plan. If the benefit is payable in another form, the determination as to whether the limitation described in subsection A of this section has been satisfied shall be made by the board by adjusting the benefit so that it is actuarially equivalent to the annual benefit described in this paragraph in accordance with the regulations promulgated by the United States secretary of the treasury. In addition, for determining the annual benefit attributable to member contributions, the factors described in section 411(c)(2)(B) of the internal revenue code and the regulations promulgated under the internal revenue code shall be used by the board regardless of whether section 411 of the internal revenue code applies to ASRS. The factors described in section 411(c)(2)(B) of the internal revenue code shall be those factors described under section 417(e)(3) of the internal revenue code and determined on the basis of the 417(e) mortality table and an interest rate as prescribed in subsection C, paragraph 5 of this section.

3. "Applicable mortality table" means the mortality table described in internal revenue service revenue ruling 2001-62.

4. "Compensation" means the member's earned income, wages, salaries, fees for professional service and other amounts received for personal services actually

rendered in the course of employment with the employer and includes amounts described in sections 104(a)(3) and 105(a) of the internal revenue code, but only to the extent that these amounts are includable in the gross income of the member. Compensation also includes any elective deferral as defined in section 402(g)(3) of the internal revenue code and any amount that is contributed or deferred by an employer at the election of a member and that is not includable in the gross income of the member by reason of section 125, 132(f)(4) or 457 of the internal revenue code. Compensation does not mean:

(a) Employer contributions to a plan of deferred compensation to the extent the contributions are not included in the gross income of the employee for the taxable year in which contributed and any distributions from a plan of deferred compensation, regardless of whether the amounts are includable in gross income of the employee when distributed, except that any amount received by a member pursuant to an unfunded nonqualified plan may be considered as compensation for the purposes of this section in the year the amounts are includable in the gross income of the member under the internal revenue code.

(b) Other amounts that receive special tax benefits, such as premiums for group term life insurance, but only to the extent that the premiums are not includable in the gross income of the employee, qualified transportation fringe benefits as defined in section 132 of the internal revenue code and, effective for plan years beginning from and after December 31, 1987, any amounts under section 125 of the internal revenue code that are not available to a member in cash in lieu of group health coverage because the member is unable to certify that the member has other health coverage.

5. "Defined benefit dollar limitation" means the dollar limitation determined under subsection A of this section.

6. "Defined benefit plan" has the same meaning prescribed in section 414(j) of the internal revenue code.

7. "Defined contribution plan" has the same meaning prescribed in section 414(i) of the internal revenue code.

8. "Limitation year" and "years of service" mean the fiscal year.

38-771. Benefit options for transferred defined contribution program members: definitions

A. On or before December 31, 1995 a nonretired ASRS member who was a member of the defined contribution program administered by ASRS and who was transferred to the defined benefit program established by this article on July 1, 1981 shall elect to receive either retirement benefits provided under this section or retirement benefits as otherwise provided by this article. An election under this subsection is irrevocable. A member who fails to make an election under this subsection is deemed to have elected to receive retirement benefits provided under this section.

B. A member who elects to receive retirement benefits provided under this section is eligible only for those benefits.

C. If a member elects to receive retirement benefits provided under this section, the member shall elect to receive retirement benefits based on either of the following:

1. The contributions paid by the member and member's employer, plus all earnings attributed to the member's retirement account, through the member's retirement date.

2. Except as provided in subsections E and F of this section, contributions paid by the member and member's employer at the contribution rate in effect before July 1, 1975 and an employee and employer contribution rate of seven per cent calculated from July 1, 1975, plus all earnings attributed to the member's retirement account, through the member's retirement date.

D. Notwithstanding sections 38-736 and 38-737, members who elect to receive retirement benefits provided under this section and their employers shall each make contributions at a rate of seven per cent of the member's compensation and, beginning on July 1, 1998, employers shall make contributions to ASRS on behalf of their respective members who have elected to receive retirement benefits provided under this section to pay the actuarially determined amount necessary to provide the group health and accident insurance benefits for those retired members and their dependents as provided under section 38-783. Member contributions pursuant to this subsection shall be salary reduction contributions pursuant to section 38-747, subsections C and D.

E. Subject to subsection F of this section, if a member desires to receive retirement benefits based on subsection C, paragraph 2 of this section, the member shall make the election on or before June 30, 1999 and during the member's active employment. The election shall be made in accordance with section 38-747, subsections C, D and H. If a member elects to receive retirement benefits based on subsection C, paragraph 2 of this section, both the member and the member's employer shall pay to ASRS the difference between the contributions made and seven per cent of the member's gross compensation from July 1, 1984 through December 31, 1995. If a member elects to have the member's employer make payments for all or a portion of the contributions pursuant to section 38-747, subsection D, the member's employer shall make the contributions as required by section 38-747, subsection D. If a member elects to make contributions pursuant to section 38-747, subsection H, both the member and the member's employer shall pay to ASRS the portion of the difference between the total required contributions and that portion of the required contributions that the member has elected to have the member's employer pay pursuant to section 38-747, subsection D. The member's employer shall make the employer's contributions attributable to a member's period of employment before July 1, 1999 in a single lump sum payment at the time and computed in the manner prescribed in section 38-771.01, subsections G and H. If a member elects pursuant to subsection C, paragraph 2 of this section to have contributions made or to make contributions pursuant to section 38-747, subsection D or H for less than the full amount permitted by this subsection the member's benefits shall be computed only with reference to the contributions actually made. A member shall make an election pursuant to this section with respect to contributions to be made by the member before July 1, 1999. This election shall remain in full force and effect on and after July 1, 1999 and may be modified or revoked by the member only if the modification or revocation is specifically authorized in section 38-747. Section 38-771.01 governs any elections made by a member with respect to contributions to be made by the member to ASRS on or after July 1, 1999.

F. Contributions made to ASRS by a member and the member's employer pursuant to subsections D and E of this section shall not exceed, in any one limitation year, the limits of section 38-747, subsection E. If for any reason, the member and employer contributions to ASRS made pursuant to subsections D and E of this section would, at the time such contributions are due, taking into account other employer and member contributions due to ASRS for the limitation year, exceed the limits of section 38-747, the amount to be paid by the member and the member's employer under subsection E of this section shall be proportionately reduced and such reduction shall be carried into the succeeding limitation year and paid by the member and the member's employer within thirty days of the beginning of such limitation year, unless the limits of section 38-747 would again be exceeded, in which event this procedure will be repeated until all such contributions have been made. If more than one employer is contributing on behalf of a member, the reduction and contributions in succeeding years shall be proportionately allocated among the employers. If a member retires prior to making all contributions under subsections D and E of this section because of the limitations of section 38-747, the member's benefits under this section shall be calculated only with reference to the contributions actually made. For purposes of this subsection, "limitation year" has the same meaning prescribed in section 38-769.

G. A member who elects to receive retirement benefits provided under this section is subject to the provisions of section 38-771.01, subsection K that are equivalent to those imposed before the member's transfer from the defined contribution program administered by ASRS to the defined benefit program established by this article.

H. ASRS shall handle all retirement accounts of members who elect retirement benefits provided under this section and all member and employer contributions attributable to those members in the same manner as retirement accounts and contributions that are part of the defined contribution program administered by ASRS. Retirement accounts of members who elect to receive retirement benefits provided under this section are eligible for interest and supplemental credits on the same basis as members who retired under the defined contribution program administered by ASRS.

I. The election of retirement benefits by a member pursuant to this section is a waiver of all claims and demands by the member that the retirement benefits are less than the amount of retirement benefits payable to the member under the defined contribution program administered by ASRS if the member had remained a member of the defined contribution program administered by ASRS.

J. For purposes of this section:

1. "Member's employer" means an employer who compensated the member during a period when the member's contributions were less than seven per cent.
2. "Retirement account" means the combined member and employer contributions with interest or earnings on the contributions including any allocations credited as employer contributions.

[38-771.01. Alternative benefits for transferred defined contribution program members; definitions](#)

A. A retired or nonretired ASRS member who was a member of the defined contribution program administered by ASRS, who was transferred to the defined benefit program established by this article on July 1, 1981, who is determined by ASRS to qualify under paragraph 1 of this subsection and who is not excluded under paragraph 2 of this subsection shall receive defined contribution benefits pursuant to this section, or, if greater, defined benefit retirement benefits pursuant to this article. A retired or nonretired ASRS member qualifies or is excluded under this section based on the following criteria:

1. A member is entitled to receive benefits under this section only if the member satisfies at least one of the following requirements:

(a) Is not retired as of July 1, 1999 even though the member may have previously elected to receive benefits under the defined benefit program established by this article, may have transferred employment between or among employers on or after July 1, 1981 or may have terminated employment on or after July 1, 1981 and after that termination date returned to employment with an employer.

(b) Retired on or after July 1, 1984 and elected to receive benefits under the defined benefit program established by this article.

(c) Retired on or after July 1, 1984 and is receiving benefits under the defined contribution program administered by ASRS.

2. Even if the member otherwise qualifies under paragraph 1 of this subsection, a member is not entitled to receive benefits under this section if any of the following applies to the member:

(a) The member retired before July 1, 1984.

(b) The member is entitled to receive benefits pursuant to section 38-771 and has paid to ASRS pursuant to section 38-771 before July 1, 1999 the entire amount that is attributable to service performed on or after July 1, 1984 and that is equal to the contribution rate of seven per cent of compensation, the contribution has been matched by an equal contribution to ASRS by the member's employers and all applicable earnings and supplemental credits have been credited for the member's account.

(c) The member withdrew the member's contributions from the defined contribution program administered by ASRS and, as of July 1, 1999, is not entitled to any benefit under the defined contribution program administered by ASRS.

(d) The member transferred the member's benefits under either the defined benefit program established by this article or the defined contribution program administered by ASRS to any other retirement system.

B. A beneficiary is entitled to receive benefits pursuant to this section only if the beneficiary satisfies the requirements of paragraph 1 of this subsection and is not excluded under paragraph 2 of this subsection based on the following criteria:

1. The beneficiary is a beneficiary of a retired or nonretired member who qualifies for benefits under subsection A, paragraph 1 of this section, is not excluded under subsection A, paragraph 2 of this section and as of July 1, 1999 either:

(a) Is receiving a monthly benefit from the defined benefit program established by this article or the defined contribution program administered by ASRS.

(b) Is living, is a survivor of a deceased retired or nonretired member and elected to receive a lump sum distribution of the survivor benefit that was payable on the death of the member.

2. Even if the beneficiary satisfies the requirements of paragraph 1 of this subsection, a beneficiary is not entitled to receive benefits under this section if the beneficiary is a beneficiary of a deceased retired member who elected a form of benefit under either the defined benefit program established by this article or the defined contribution program administered by ASRS that did not provide for survivor benefits after the death of the retired member.

C. A member or a deceased member's beneficiary who receives benefits pursuant to this section shall receive benefits based on the sum of the following:

1. Contributions paid by the member and the member's employer at the contribution rates in effect before July 1, 1984, together with all applicable earnings and supplemental credits on those contributions.

2. Contributions paid by the member's employer at the contribution rates in effect beginning on July 1, 1984 through the earlier of June 30, 1999 or the member's retirement or death, together with all applicable earnings and supplemental credits on those contributions computed through the earlier of June 30, 1999 or the member's retirement or death.

3. The excess of employer contributions computed at the rate of seven per cent of compensation beginning on July 1, 1984 through June 30, 1999 over the actual contributions paid by the member's employer as described in paragraph 2 of this subsection, together with all earnings and supplemental credits that would have been earned on those excess contributions computed from the date the contributions would have been paid to ASRS.

4. Contributions paid by the member at the contribution rate in effect on and after July 1, 1984, together with all earnings on those contributions.

5. With respect to member contributions that were not paid to ASRS before July 1, 1999 pursuant to section 38-771, subsection C, paragraph 2, forty per cent of the earnings that would have been credited on those contributions through the earlier of June 30, 1999 or the member's retirement or death as if those member contributions had been paid.

6. Contributions paid by the member to ASRS before July 1, 1999 pursuant to an election under section 38-771, subsection C, paragraph 2 and subsection E, together with all earnings on those contributions.

7. Contributions paid by the member to ASRS on or after July 1, 1999 pursuant to an election under section 38-771, subsection C, paragraph 2 and subsection E, together with earnings on those contributions.

8. Contributions paid by the member to ASRS on or after July 1, 1999 pursuant to this section, together with earnings on those contributions.

9. Contributions paid by the member's employer to ASRS on or after July 1, 1999 pursuant to this section, together with all applicable earnings and supplemental credits on those contributions.

D. Effective on July 1, 1999, ASRS shall adjust the retirement account reserves under the defined contribution program administered by ASRS for retired members and the beneficiaries of deceased retired members entitled to benefits pursuant to this section to give effect to additional contributions, earnings and supplemental credits for those retired members prescribed in subsection C, paragraphs 1 through 6 of this section for the periods of the members' employment before July 1, 1999 and to give effect to the recomputation, adjustment and payment of benefits pursuant to subsection G of this section. After this recomputation, adjustment and

payment, ASRS shall credit and charge these retirement account reserves with the amounts prescribed under the defined contribution program administered by ASRS based on the adjustments prescribed in this section.

E. Effective on July 1, 1999, ASRS shall adjust each nonretired member's accounts under the defined contribution program administered by ASRS to equal the sum of the contribution amounts prescribed in subsection C, paragraphs 1 through 6 of this section with respect to periods of a member's employment before July 1, 1999. After the adjustment, these accounts shall accrue applicable interest and supplemental credits based on the entire amounts credited to the accounts.

F. For periods of a nonretired member's employment on or after July 1, 1999, a nonretired member who is entitled to receive benefits pursuant to this section and the nonretired member's employer shall each make contributions to ASRS at the rates established pursuant to sections 38-736 and 38-737, except as follows:

1. If a nonretired member made an election pursuant to section 38-771, subsection C, paragraph 2 and section 38-747, subsections C and D before July 1, 1999, the member's employer shall continue to make pickup contributions to ASRS on behalf of the member pursuant to the member's election, except that with respect to employer contributions that are required pursuant to section 38-771, subsection E for periods of a member's employment before July 1, 1999, the employer shall make a lump sum payment to ASRS as computed pursuant to subsection G of this section and required to be paid to ASRS pursuant to subsection H of this section.

2. If a nonretired member elected or was deemed to have elected benefits pursuant to section 38-771 before December 31, 1995, for periods of a member's employment from and after the election or deemed election the nonretired member's employer and the member shall each continue to pay to ASRS an amount equal to seven per cent of the member's compensation in lieu of the rates established pursuant to sections 38-736 and 38-737.

3. A nonretired member who is entitled to receive benefits pursuant to this section and who never elected to receive benefits pursuant to section 38-771 may elect pursuant to section 38-747, subsections C and D to make contributions at the rate of seven per cent of the member's compensation for periods of a member's employment on or after July 1, 1999. If a member makes an election pursuant to this paragraph, the election is irrevocable as provided in section 38-747, subsection D and the member and the member's employer shall each make contributions at a rate of seven per cent of the member's compensation beginning on the effective date of the election.

4. A nonretired member who is entitled to receive benefits pursuant to this section may elect pursuant to section 38-747, subsections C, D and H to make contributions with respect to member contributions that were not made to ASRS but that could have been made pursuant to section 38-771, subsection C, paragraph 2 for periods of employment before July 1, 1999 other than member contributions for which an irrevocable election pursuant to section 38-747, subsections C and D was in effect before July 1, 1999.

5. In addition to any other employer contributions required pursuant to this section, a nonretired member's employer shall make contributions to ASRS on behalf of the nonretired member who will receive retirement benefits pursuant to this section to pay the actuarially determined amount necessary to provide the group health and

accident insurance benefits for the nonretired member and the nonretired member's dependents as provided under section 38-783.

6. Notwithstanding any other provision of this article, an election permitted pursuant to this section shall not revoke, amend or alter any irrevocable election made by a member before July 1, 1999 pursuant to sections 38-747 and 38-771.

G. Effective on July 1, 1999, ASRS shall recompute the monthly and annual benefits for retired members entitled to receive benefits pursuant to this section and the monthly or lump sum survivor's benefits payable to beneficiaries entitled to receive benefits pursuant to this section. The recomputation of benefits shall be as if the member's retirement account or retirement reserve account on the date of retirement or death had been computed based on the amounts that would have been credited to the account as of that date based on the contribution amounts prescribed in subsection C, paragraphs 1 through 6 of this section. In addition and after recomputing benefits described in this subsection, with respect to members who retired on or after July 1, 1984, ASRS shall recompute the annual payments that would have been made to the member or beneficiary of a deceased member entitled to receive benefits under this section in excess of the annual payments actually made. The recomputation shall be calculated and paid as follows:

1. The recomputation shall be calculated and paid based on the member's and, if applicable, the member's beneficiary's age, the benefit option selected at the date of the initial benefit payments and the actuarial assumptions used by ASRS at the time the initial benefit payments were computed.

2. Before July 1, 2000, ASRS shall pay to the retired member or beneficiary in a lump sum the difference between the recomputed amount and the actual distributions paid to the member or beneficiary through July 1, 1999, together with interest at the rate of eight per cent a year, compounded monthly, computed from the date each excess payment should have been paid through the date of payment to the retired member or beneficiary.

3. If the retired member is living, ASRS shall pay the lump sum payment to the member. If the member is deceased and is survived by a beneficiary who is then living and receiving a monthly benefit on account of the deceased member, ASRS shall pay the lump sum payment to the beneficiary. The payment to the beneficiary shall include the recomputed amount that is payable pursuant to this section and that would have been paid to the member through the date of the member's death plus the recomputed amount that is payable pursuant to this section and that would have been payable to the beneficiary from the member's date of death. Section 38-770 applies to a payment to a member or the member's beneficiary who is the surviving spouse of the member, if the payment is substantially larger or smaller than the monthly benefit payable by ASRS to the member.

4. With respect to a beneficiary who is a survivor of a deceased nonretired member who would have been entitled to benefits under this section and who elected a lump sum distribution of the survivor benefit that was payable on the death of the nonretired member, ASRS shall pay the recomputed amount in a lump sum to the beneficiary. If the beneficiary is the surviving spouse of the member, section 38-770 applies to the payment.

5. Effective on July 1, 1999, ASRS shall increase the member's or beneficiary's monthly and annual benefit to the recomputed amount. After that adjustment,

ASRS shall adjust the member's or beneficiary's annual benefit as otherwise provided under the defined contribution program administered by ASRS.

H. Before July 1, 2002, the employer of each nonretired or retired member or deceased member who has a beneficiary entitled to adjustments and payments pursuant to subsections E and G of this section for periods of a member's employment before July 1, 1999 shall pay to ASRS in one or more installments those amounts required by ASRS to make the recomputations and adjustments pursuant to this section. ASRS shall determine the amount to be paid by the employer to ASRS as of July 1, 1999, plus interest at the rate of eight per cent a year, compounded monthly, from July 1, 1999 through the date the payment is made by the employer to ASRS. Any payments by the employer shall first be applied to accrued and unpaid interest and then to the amount to be paid by the employer to ASRS. ASRS shall allocate the payment to the assets maintained under the defined contribution program administered by ASRS. When determining the amounts required to be paid by employers for the recomputations and adjustments pursuant to this section, ASRS first shall transfer on July 1, 1999 from the assets maintained by ASRS under the defined benefit program established by this article to the assets maintained by ASRS under the defined contribution program administered by ASRS an amount equal to the sum of the defined benefit program equity balances of the retired and nonretired members or their beneficiaries whose benefits are transferred from the defined benefit program to the defined contribution program pursuant to this section, except that the amount transferred for any member or beneficiary shall not be more than the amount required to fund the recomputations and adjustments required by this section for the member or beneficiary. The defined benefit program equity balance for a member or beneficiary of a deceased member shall equal the sum of the member's employee and employer account balances on the earlier of June 30, 1999 or the member's retirement or death, less the monthly annuity payments to a retired member or beneficiary, plus the earnings on the average balance of that amount for a plan year.

I. If a member retired before July 1, 1999, elected to receive benefits pursuant to section 38-771, subsection C, paragraph 2 and did not make all contributions pursuant to section 38-771, subsection E because of the limitations prescribed in section 38-747, subsection E, the member has the option of receiving the employer contributions prescribed in subsection C, paragraphs 3 and 5 of this section in a lump sum payment. If the retired member elects to receive a lump sum payment, ASRS shall pay the amount on or before July 1, 2000 and the amount shall be deducted from the member's account when computing the annuity benefits to which the member is otherwise entitled pursuant to this section. In no case shall the payment under this subsection duplicate the payment under subsection G of this section. Section 38-770 applies to a payment to a member under this subsection if the payment is substantially larger or smaller than the monthly benefit payable by ASRS to the member.

J. Contributions made to ASRS by a member and the member's employer pursuant to subsection F of this section, other than employer contributions required pursuant to subsections G and H of this section, shall not exceed, in any one limitation year, the limits prescribed in section 38-747, subsection E. If for any reason the member and applicable employer contributions made pursuant to subsection F of this section

would at the time the contributions are due, taking into account other annual additions due to ASRS for the limitation year, exceed the limits prescribed in section 38-747, subsection E, the amount to be paid by the member and the member's employer pursuant to subsection F of this section, other than employer contributions required pursuant to subsections G and H of this section, shall be proportionately reduced and the reduction shall be carried into the succeeding limitation year and paid by the member and the member's employer within thirty days after the beginning of that limitation year, unless the limits prescribed in section 38-747, subsection E would again be exceeded. If the limits are exceeded again, the procedure prescribed in this subsection shall be repeated until all of the contributions are made. If more than one employer is contributing on behalf of a member, the reduction and contributions in succeeding years shall be proportionately allocated among the employers. If a member retires before making all contributions pursuant to this section because of the limitations prescribed in section 38-747, subsection E, the member's benefits pursuant to this section shall be computed only with reference to the contributions actually made. For the purposes of this subsection, "limitation year" has the same meaning prescribed in section 38-769.

K. Unless otherwise provided in this section, a member who receives retirement benefits pursuant to this section and section 38-771 is subject to conditions that are equivalent to those imposed before the member's transfer from the defined contribution program administered by ASRS to the defined benefit program established by this article. Those conditions include the following:

1. A member who attains sixty-five years of age may retire and, on application, shall receive a life annuity derived from the member's prior service credit, if any, together with a life annuity derived from the member's retirement account. The annuity is payable in equal monthly installments. The amount of the installments is based on the age of the member at the date of commencement of retirement and is determined by the interest and life expectancy tables applicable at the date of the commencement of retirement.
2. If a retired member who is receiving retirement benefits pursuant to this section dies before receipt of annuity payments in an amount equal to the member's retirement account balance immediately before retirement, ASRS shall pay the member's designated beneficiary or estate in a lump sum the difference between the retirement account balance and the total amount of annuity payments received.
3. A member who attains sixty-five years of age with at least five years of creditable service may retire and, on application, may elect to receive in lieu of the annuity payments from the member's prior service, if any, together with a life annuity derived from the member's retirement account as provided in paragraph 1 of this subsection, the actuarial equivalent of those retirement benefits under one of the options established by the board.
4. A member who attains sixty years of age with at least five years of creditable service may retire and, on application, may receive a life annuity derived from the actuarial equivalent of the member's prior service credit, if any, together with a life annuity derived from the member's retirement account. The annuity shall be determined and paid in the manner set forth in paragraph 1 of this subsection.

5. In lieu of the retirement benefits pursuant to paragraph 4 of this subsection, on application, a member may elect to receive the actuarial equivalent of those retirement benefits under one of the options established by the board.

6. If a retired member who is receiving retirement benefits pursuant to this section is engaged to work by an employer for twenty or more weeks in a fiscal year and twenty hours or more a week, the member's retirement benefit payments pursuant to this section are suspended until the member terminates employment. On return to employment, the member shall accrue benefits pursuant to this section, unless the member elects to be covered by the defined benefit program established by this article. If a formerly retired member elects to be covered by the defined benefit program established by this article, the formerly retired member shall be an active member in the defined benefit program with respect to all service performed after the member's return to work and shall not accrue additional benefits pursuant to this section. Notwithstanding the other provisions of this paragraph, if a retired member begins or returns to employment as an elected official or to any other type of service or employment that does not require the retired member to begin active membership in the defined contribution program administered by ASRS or the defined benefit program established by this article, the payment of retirement benefits pursuant to this section shall not be terminated, withheld or interrupted because of beginning or returning to the service or employment or holding the elected office, unless the formerly retired member actually elects to recommence active participation in the defined benefit program established by this article or pursuant to this section.

7. On termination of employment of a retired member previously receiving retirement benefits pursuant to this section, ASRS shall reinstate the member's retirement benefits pursuant to this section and, on reinstatement of retirement benefits, the benefit shall be recomputed on the basis of the member's attained age and shall be adjusted for retirement benefits previously received and additional contributions, interest and supplemental credits accrued during the period of employment. On this reinstatement of retirement benefits, if the member elected to be covered by the defined benefit program established by this article on the member's return to employment, the member is also entitled to receive retirement benefits pursuant to the defined benefit program established by this article for the credited service earned by the member after the member's active membership in the defined benefit program established by this article began.

L. ASRS shall handle all retirement accounts of members who elect retirement benefits provided pursuant to this section and all member and employer contributions attributable to those members in the same manner as retirement accounts and contributions that are part of the defined contribution program administered by ASRS. Retirement accounts of members who elect to receive retirement benefits pursuant to this section are eligible for interest and supplemental credits on the same basis as members who retired under the defined contribution program administered by ASRS.

M. The receipt of retirement benefits by a member pursuant to this section is a waiver of all claims and demands by the member that the retirement benefits are less than the amount of retirement benefits payable to the member under the defined contribution program administered by ASRS if the member had remained a member of the defined contribution program administered by ASRS.

N. The board may administer and interpret this section in order to prevent any duplication of benefits provided by ASRS and the defined contribution program administered by ASRS and to provide all eligible members and beneficiaries with the benefits they are entitled to under the laws of this state.

O. For purposes of this section:

1. "Beneficiary" means the individual designated by the member in writing on forms approved by ASRS to receive benefits pursuant to this article after the death of the member.
2. "Creditable service" means service after April 8, 1953 in a position not subject to the defined contribution program administered by ASRS, prior service and membership service.
3. "Member's employer" means an employer who compensated the member during a period when the member's contributions were less than seven per cent.
4. "Pension" means equal monthly installments that are derived from a member's prior service credits and that are payable during the member's lifetime after retirement.
5. "Prior service" means service for this state or a political subdivision before membership in the defined contribution program administered by ASRS.
6. "Prior service credits" means the amount that is allowed for services before membership in the defined contribution program administered by ASRS and that is payable as a pension on retirement.
7. "Retirement account" means the combined member and employer contributions with applicable interest and supplemental credits on the contributions as computed pursuant to subsection C of this section.
8. "Service" means any compensated employment by the state or a political subdivision and includes periods of nonpaid leave, including military leave, provided employment has not been terminated at the commencement of the leave period and employment is state service for retirement purposes or service for any political subdivision establishing a defined contribution program administered by ASRS.

38-774. [Excess benefit arrangement](#)

A. A separate unfunded governmental excess benefit arrangement is established outside of and apart from the trust fund established by section 38-712 to pay members benefits that are otherwise payable by ASRS and that exceed the limitations on benefits imposed by section 415 of the internal revenue code. The board shall administer this excess benefit arrangement as a qualified governmental excess benefit arrangement pursuant to section 415(m) of the internal revenue code.

B. The board may adopt rules to implement this section subject to the following:

1. Benefits under this section are subject to section 38-773 and section 38-791, subsections D and F and are exempt from execution to the same extent as provided in section 38-792.
2. Contributions to this arrangement are not held in trust and shall not be commingled with other monies of ASRS.

C. A member is entitled to a monthly benefit under this section in an amount equal to the amount that the member's benefit that is payable by ASRS has been reduced by the limitation on benefits imposed by section 38-769 and section 415 of the

internal revenue code. The benefit that is payable by this arrangement shall be paid at such time or times and in such form as the benefit under ASRS would be paid.

D. The benefit that is payable under this section shall be paid with employer contributions that would otherwise be made to ASRS under section 38-737. In lieu of the employer contributions being paid to the trust fund established by section 38-712, an amount determined by ASRS as necessary to pay benefits under this section shall be paid on a monthly basis to a separate account established by the board for this arrangement and may include amounts needed to pay reasonable and necessary expenses of this arrangement. The director may invest the monies in this account in suitable short-term investments between receipt of the monies and disbursement of the monies. The amount shall be paid to the account at least fifteen days before a disbursement is to be made under this section.

E. A member shall not directly or indirectly elect to defer compensation to purchase benefits provided under this section.

F. This section shall not be construed as requiring an employer or ASRS to purchase any investment or any contract to secure any obligations under this section. If an employer or ASRS purchases an investment or contract that the employer or ASRS earmarks to pay benefits under this section, title to and beneficial ownership of the investment or contract remain at all times in the employer or ASRS, and the member and the member's beneficiaries, if any, do not have any proprietary interest in any specific assets of the employer or ASRS. Any rights of the member and the member's beneficiaries, if any, to payment of any amounts under this section shall be those of general unsecured creditors of the employer or ASRS. This section and any action taken pursuant to this section by the employer or ASRS do not create and shall not be construed to create an irrevocable trust of any kind.

38-775. Required distributions; definitions

A. This section applies for purposes of determining required minimum distributions for calendar years beginning on and after January 1, 2006. In applying the requirements of this section, the following operational provisions govern:

1. Except as provided in the following sentence, the requirements of this section take precedence over any inconsistent provisions of this article. The rules of this section shall not restrict any form, calculation, adjustment or payment of benefit provided under this article in effect on April 17, 2002, if the form, calculation, adjustment or payment of benefit satisfied section 401(a)(9) of the internal revenue code based on a reasonable and good faith interpretation of that section.

2. All distributions required under this section shall be determined and made pursuant to section 401(a)(9) of the internal revenue code and the regulations that are issued under that section by the United States secretary of the treasury.

3. Notwithstanding this section, other than paragraph 2 of this subsection, distributions may be made under a designation made before January 1, 1984, pursuant to section 242(b)(2) of the tax equity and fiscal responsibility act of 1982 (P.L. 97-248) and the provisions of this article that relate to that section.

B. The member's entire interest shall be distributed, or begin to be distributed, to the member no later than the member's required beginning date.

C. If the member dies before distributions begin, the member's entire interest shall be distributed, or begin to be distributed, no later than as follows:

1. If the member's surviving spouse is the member's sole designated beneficiary, except as provided in paragraph 6 of this subsection, distributions to the surviving spouse shall begin by December 31 of the calendar year immediately following the calendar year in which the member died, or by December 31 of the calendar year in which the member would have attained seventy and one-half years of age, if later.

2. If the member's surviving spouse is not the member's sole designated beneficiary, except as provided in paragraph 6 of this subsection, distributions to the designated beneficiary shall begin by December 31 of the calendar year immediately following the calendar year in which the member died.

3. If there is no designated beneficiary as of September 30 of the year following the year of the member's death, the member's entire interest shall be distributed by December 31 of the calendar year containing the fifth anniversary of the member's death.

4. If the member's surviving spouse is the member's sole designated beneficiary and the surviving spouse dies after the member but before distributions to the surviving spouse begin, this subsection, other than paragraph 1 of this subsection, applies as if the surviving spouse were the member.

5. For purposes of this subsection and subsection G, distributions are considered to begin on the member's required beginning date or, if paragraph 4 of this subsection applies, the date distributions are required to begin to the surviving spouse under paragraph 1 of this subsection. If annuity payments irrevocably commence to the member before the member's required beginning date, or to the member's surviving spouse before the date distributions are required to begin to the surviving spouse under paragraph 1 of this subsection, the date distributions are considered to begin is the date distributions actually commence.

6. If the member dies before distributions begin and there is a designated beneficiary, distribution to the designated beneficiary is not required to begin by the date prescribed in paragraph 1 or 2 of this subsection as long as the member's entire interest will be distributed to the designated beneficiary by December 31 of the calendar year containing the fifth anniversary of the member's death. If the member's surviving spouse is the member's sole designated beneficiary and the surviving spouse dies after the member but before distributions to either the member or the surviving spouse begin, this paragraph applies as if the surviving spouse were the member.

D. Unless the member's interest is distributed in the form of an annuity purchased from an insurance company or in a single sum on or before the required beginning date, as of the first distribution, calendar year distributions shall be made pursuant to subsections E, F and G. If the member's interest is distributed in the form of an annuity purchased from an insurance company, distributions shall be made pursuant to the requirements of section 401(a)(9) of the internal revenue code and the regulations that are issued under that section by the United States secretary of the treasury. Any part of the member's interest that is in the form of an individual account described in section 414(k) of the internal revenue code shall be distributed in a manner satisfying the requirements of section 401(a)(9) of the internal revenue code and the regulations that are issued under that section by the United States secretary of the treasury that apply to individual accounts.

E. The following provisions govern the determination of the amount to be distributed each calendar year:

1. If the member's interest is paid in the form of annuity distributions, payments under the annuity shall satisfy the following requirements:

(a) The annuity distributions shall be paid in periodic payments made at intervals not longer than one year.

(b) The distribution period shall be over a life or lives or over a period certain not longer than the period described in subsection F or G.

(c) Once payments have begun over a period certain, the period certain shall not be changed even if the period certain is shorter than the maximum permitted.

(d) Payments shall either be nonincreasing or increase only as follows:

(i) By an annual percentage increase that does not exceed the annual percentage increase in a cost-of-living index that is based on prices of all items and issued by the bureau of labor statistics.

(ii) To the extent of the reduction in the amount of the member's payments to provide for a survivor benefit on death, but only if the beneficiary whose life was being used to determine the distribution period described in subsection F dies or is no longer the member's beneficiary pursuant to a qualified domestic relations order within the meaning of section 414(p) of the internal revenue code.

(iii) To provide cash refunds of employee contributions on the member's death.

(iv) To pay increased benefits that result from a plan amendment.

2. The amount that must be distributed on or before the member's required beginning date or, if the member dies before distributions begin, the date distributions are required to begin under subsection C, paragraph 1 or 2, is the payment that is required for one payment interval. The second payment need not be made until the end of the next payment interval even if that payment interval ends in the next calendar year. Payment intervals are the periods for which payments are received, such as bimonthly, monthly, semiannually or annually. All of the member's benefit accruals as of the last day of the first distribution calendar year shall be included in the calculation of the amount of the annuity payments for payment intervals ending on or after the member's required beginning date.

3. Any additional benefits accruing to the member in a calendar year after the first distribution calendar year shall be distributed beginning with the first payment interval ending in the calendar year immediately following the calendar year in which the amount accrues.

F. The following provisions govern annuity distributions that commence during a member's lifetime:

1. If the member's interest is being distributed in the form of a joint and survivor annuity for the joint lives of the member and a nonspouse beneficiary, annuity payments to be made on or after the member's required beginning date to the designated beneficiary after the member's death must not at any time exceed the applicable percentage of the annuity payment for the period that would have been payable to the member using the table set forth in question and answer number 2 of section 1.401(a)(9)-6 of the regulations issued by the United States secretary of the treasury. If the form of distribution combines a joint and survivor annuity for the joint lives of the member and a nonspouse beneficiary and a period certain annuity, the requirement in the preceding sentence applies to annuity payments to be made to the designated beneficiary after the expiration of the period certain.

2. Unless the member's spouse is the sole designated beneficiary and the form of distribution is a period certain and no life annuity, the period certain for an annuity

distribution commencing during the member's lifetime may not exceed the applicable distribution period for the member under the uniform lifetime table prescribed in section 1.401(a)(9)-9 of the regulations issued by the United States secretary of the treasury for the calendar year that contains the annuity starting date. If the annuity starting date precedes the year in which the member reaches seventy years of age, the applicable distribution period for the member is the distribution period for seventy years of age under the uniform lifetime table set forth in section 1.401(a)(9)-9 of the regulations issued by the United States secretary of the treasury plus the excess of seventy over the age of the member as of the member's birthday in the year that contains the annuity starting date. If the member's spouse is the member's sole designated beneficiary and the form of distribution is a period certain and no life annuity, the period certain may not exceed the longer of the member's applicable distribution period, as determined under this paragraph, or the joint life and last survivor expectancy of the member and the member's spouse as determined under the joint and last survivor table prescribed in section 1.401(a)(9)-9 of the regulations issued by the United States secretary of the treasury, using the member's and spouse's attained ages as of the member's and spouse's birthdays in the calendar year that contains the annuity starting date.

G. The following provisions govern minimum distributions if a member dies before the date distributions begin:

1. Except as provided in subsection C, paragraph 6, if the member dies before the date distribution of the member's interest begins and there is a designated beneficiary, the member's entire interest shall be distributed, beginning no later than the time prescribed in subsection C, paragraph 1 or 2, over the life of the designated beneficiary or over a period certain not exceeding either of the following:

(a) Unless the annuity starting date is before the first distribution calendar year, the life expectancy of the designated beneficiary determined using the beneficiary's age as of the beneficiary's birthday in the calendar year immediately following the calendar year of the member's death.

(b) If the annuity starting date is before the first distribution calendar year, the life expectancy of the designated beneficiary determined using the beneficiary's age as of the beneficiary's birthday in the calendar year that contains the annuity starting date.

2. If the member dies before the date distributions begin and there is no designated beneficiary as of September 30 of the year following the year of the member's death, distribution of the member's entire interest shall be completed by December 31 of the calendar year containing the fifth anniversary of the member's death.

3. If the member dies before the date distribution of the member's interest begins, the member's surviving spouse is the member's sole designated beneficiary and the surviving spouse dies before distributions to the surviving spouse begin, this subsection applies as if the surviving spouse were the member, except that the time by which distributions must begin shall be determined without regard to subsection C, paragraph 1.

H. For the purposes of this section:

1. "Designated beneficiary" means the individual who is designated as the member's beneficiary to receive benefits under this article and is the designated

beneficiary under section 401(a)(9) of the internal revenue code and question and answer number 1 of section 1.401(a)(9)-4 of the regulations issued by the United States secretary of the treasury.

2. "Distribution calendar year" means a calendar year for which a minimum distribution is required. For distributions beginning before the member's death, the first distribution calendar year is the calendar year immediately preceding the calendar year that contains the member's required beginning date. For distributions beginning after the member's death, the first distribution calendar year is the calendar year in which distributions are required to begin pursuant to subsection C.

3. "Life expectancy" means life expectancy as computed by use of the single life table in section 1.401(a)(9)-9 of the regulations issued by the United States secretary of the treasury.

4. "Required beginning date" means the date payment of a member's benefits shall commence, which shall not be later than the April 1 following the calendar year in which the member attains seventy and one-half years of age or the calendar year in which the member terminates employment, whichever occurs later.

E-3

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (R-16-1003)

Title 9, Chapter 22, Article 4, Penalty for Obtaining Eligibility by Fraud

New Article: Article 4

New Section: R9-22-401; R9-22-402; R9-22-403; R9-22-404; R9-22-405; R9-22-406;
R9-22-407; R9-22-408



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: E-3

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: Shama Thathi, Staff Attorney

DATE: September 16, 2016

SUBJECT: **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (R-16-1003)**
Title 9, Chapter 22, Article 4, Penalty for Obtaining Eligibility by Fraud

New Article: Article 4

New Section: R9-22-401; R9-22-402; R9-22-403; R9-22-404; R9-22-405;
R9-22-406; R9-22-407; R9-22-408

General Comments

Purpose of the Agency and Summary of What the Rulemaking Does

The Arizona Health Care Cost Containment System ("AHCCCS") is established "to promote a comprehensive health care system to eligible citizens of this state." Laws 2013, 1st S.S., Ch. 10, § 53. This system is managed by the Director of the AHCCCS Administration ("Administration"), which is established under A.R.S. § 36-2902(A). The Director has the powers and duties as outlined in A.R.S. §§ 36-2903 and 2903.01.

This rulemaking adds one new article and eight new rules to A.A.C. Title 9, Chapter 22. The Administration is promulgating these rules for the imposition and appeal of penalties resulting from eligibility fraud, including fraud associated with the Hospital Presumptive Eligibility (HPE) program.

Article Contents, Including the Subject Matter of Each Rule Affected

Article 4 contains eight rules, all of which are newly made by this rulemaking. The rules are related to penalty for obtaining eligibility by fraud, addressing definitions; determining the amount of the penalty; mitigating and aggravating circumstances; notice of intent; failure to respond to the notice of intent; request for state fair hearing; burden of proof; and rescission of the notice of intent.

Proposed Action

The Administration is adding eight new rules to A.A.C. Title 9, Chapter 22. Below is a brief summary of each rule.

- Section 401 lays out definitions for the article.
- Section 402 sets forth the criteria the Administration must utilize to determine the amount of the penalty.
- Section 403 sets forth the mitigating and aggravating circumstances that must be considered when determining the amount of penalty.
- Section 404 sets forth requirements for a notice of intent. One of the requirements is that the notice must be delivered to the person before imposing a penalty.
- Section 405 authorizes the Administration to impose the penalty if the person fails to respond to the notice of intent.
- Section 406 allows the individual to request a state fair hearing within 60 days after receiving the notice of intent.
- Section 407 sets forth the burdens of proof for both the Administration and the person.
- Section 408 allows the Administration to rescind the notice of intent any time before the state fair hearing, without prejudice.

Exemption or Request and Approval for Exception from the Moratorium

The Administration received an exception from Executive Order 2015-01 on June 9, 2015.

Substantive or Procedural Concerns

None.

1. Are the rules legal, consistent with legislative intent, and within the agency's statutory authority?

Yes. The Administration cites to A.R.S. § 36-2903.01(F) as general authority for the rules. Under A.R.S. § 36-2903.01(F), the director of the Administration "may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article." In addition, A.R.S. §§ 36-2905.04 and 36-2991 grant specific authority to the Administration to control and deter fraud relating to eligibility, including the HPE program, through the discretionary imposition of a civil penalty on those individuals who obtain eligibility fraudulently.

2. Are the rules written in a manner that is clear, concise, and understandable to the general public?

Yes. The rules are clear, concise, and understandable.

3. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Yes. The Administration indicates that it did not receive any written comments on the rulemaking.

4. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. The Administration only made minor grammatical and style corrections at the request of Council's staff.

5. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rules?

No. The Administration indicates that no study was reviewed or relied upon for the rules.

6. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority that allows the agency to exceed the requirements of federal law?

No. Under 42 CFR 455, the Administration must maintain a fraud protection and investigation program. The Administration indicates that the rules are not more stringent than the corresponding federal law.

7. Do the rules require a permit or license and if so, does the agency use a general permit or is any exception applicable under A.R.S. § 41-1037?

No. The rules do not require a permit or license.

8. Do the rules establish a new fee or contain a fee increase?

No. The rules do not establish a new fee or contain a fee increase.

9. Conclusion

The Administration requests an immediate effective date of October 4, 2016 for the rules. This analyst recommends approval of the rules.



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: E-3

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: GRRC Economic Team

DATE: September 16, 2016

SUBJECT: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (R-16-1003)
Title 9, Chapter 22, Article 4, Penalty for Obtaining Eligibility by Fraud

New Article: Article 4

New Section: R9-22-401; R9-22-402; R9-22-403; R9-22-404; R9-22-405;
R9-22-406; R9-22-407; R9-22-408

I reviewed the economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments. These comments are made to assist the Council in its review and may be used as the Council determines.

GRRC Economist Comments

In this rulemaking, the Arizona Health Care Cost Containment System (AHCCCS) is proposing to add a new article that will provide control and deterrence of fraud relating to AHCCCS eligibility. This rule permits the AHCCCS Administration ("Administration") to impose penalties, in addition to the actual losses to the system, in an amount not more than the amounts actually expended by the healthcare system.

1. **Costs and Benefits for:**

a. The implementing agency:

The Administration expects to experience minimal economic impact due to this rulemaking. These impacts arise from the additional effort required to determine, pursue and recover civil penalties. The estimated costs are expected to be minimal, as the Administration and Department of Economic Security staff already investigate eligibility fraud and most recovery efforts are resolved by agreement between parties rather than through the administrative hearing process.

In FY 2015, the AHCCCS Member Compliance section, through prosecutions and repayment agreements, recovered \$812,124.14 from persons who obtained eligibility through fraudulent means. In addition, the unit saved \$840,008.24 by discontinuing the eligibility of persons who were deemed ineligible due to non-residency in Arizona, unreported income, impermissible transference of resources and other misrepresentations. The Administration anticipates an increase of 10% to 25% above the existing recovery amounts within the next fiscal year as a result of this rulemaking, which represents a potentially positive economic impact for the implementing agency.

b. Political subdivisions:

This rulemaking does not provide any benefits or impose any costs on political subdivisions.

c. Businesses:

This rulemaking does not provide any benefits or impose any costs on businesses.

d. Small businesses:

This rulemaking does not provide any benefits or impose any costs on small businesses.

e. Consumers directly affected by the rulemaking:

This rulemaking does not directly affect private persons or consumers other than individuals who commit eligibility fraud.

2. Do the probable benefits outweigh the probable costs?

Based on the information provided, the Administration indicates that the benefit from the proposed amendments outweigh the costs. The Administration expects to recover approximately \$81,000 to \$200,000 annually from civil penalties imposed on persons who obtained eligibility through fraud.

3. Analysis of methods to reduce the small business impact:

An analysis was not submitted because the Administration estimated that there will be no economic impact to small businesses.

4. The probable effect on state revenues:

The proposed rulemaking will have no effect on state revenues.

5. **Analysis of any less intrusive or less costly alternative methods:**

The Administration believes this is the least costly and intrusive method because it will best comply with state statutes.

6. **Whether an analysis was submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states:**

No analysis was submitted that compares the rule's impact of the competitiveness of businesses in this state to the impact on businesses in other states.

7. **A description of any data on which a rule is based with an explanation of how the data was obtained and why the data is acceptable data, and the methods used by the agency to evaluate the costs and benefits in the EIS.**

The Administration indicates that no outside data or studies were used in the development of the proposed rule amendment.

8. **Conclusion:**

The submitted economic, small business and consumer impact statement is generally accurate, and contains the information required for compliance with A.R.S. §§ 41-1035, 41-1052(D)(1-3), and 41-1055. This analyst recommends that the proposed rule amendments be approved.

September 6, 2016

Ms. Nicole Ong, Chair
Governor's Regulatory Review Council
100 N. 15th Ave, Suite 402
Phoenix, AZ 85007



Dear Ms. Ong:

The Arizona Health Care Cost Containment System (AHCCCS) Administration is submitting the attached regular rule package for your consideration:

- 9 A.A.C. 22, Article 4, Penalty for Obtaining Eligibility by Fraud,

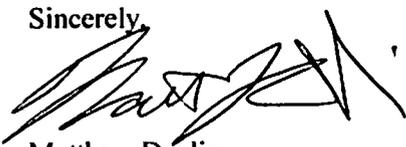
AHCCCS is providing the following information as required in A.A.C. R1-6-201:

- a. The close of record date was 5 p.m., June 20, 2016.
- b. Definitions of terms contained in statute or other rules and used in the rule are either cross-referenced or attached.
- c. The rulemaking does not relate to a 5-year-review.
- d. The rulemaking contains no new fees.
- e. The rulemaking contains no fee increase.
- f. Documents enclosed:
 - Notice of Final Rulemaking, including the preamble, table of contents for the rule, and text of the rule;
 - Economic, small business, and consumer impact statement;
 - If applicable, copy of definitions of terms, contained in statutes or other rules, used in the rule.
- g. All written comments submitted by the public concerning the proposed rule,
- h. The adopted rules contain no materials incorporated by reference,
- i. The adopted rules do not require a permit,
- j. The rule is not more stringent than federal law and the citation to the statutory authority does not exceed the requirements of federal law.
- k. A person has not submitted an analysis to the agency that compares the rule's impact of the competitiveness of businesses in this state to the impact on businesses in other states, and

- l. The AHCCCS Administration has not notified the Joint Legislative Budget Committee (JLBC) of a number of new full-time employees (FTE's) since none were required as a result of this rulemaking as required by A.R.S. § 41-1055.
- m. The AHCCCS Administration has requested and received approval to proceed with this rulemaking from the Governor's Office in reference to the rulemaking moratorium described under Executive Order 2015-01.

I certify that the information provided in number 7 of the Preamble is accurate. An immediate effective date is requested. I respectfully request that the Council consider and approve the adopted rules.

Sincerely,



Matthew Devlin
Assistant Director - Office of Legal Assistance
Attachments

NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION

PREAMBLE

1. Article, Part, or Section Affected (as applicable) Rulemaking Action:

ARTICLE 4.	New Article
R9-22-401	New Section
R9-22-402	New Section
R9-22-403	New Section
R9-22-404	New Section
R9-22-405	New Section
R9-22-406	New Section
R9-22-407	New Section
R9-22-408	New Section

2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statutes: A.R.S. § 36-2903.01(F)

Implementing statutes: A.R.S. § 36-2905.04; A.R.S. § 36-2991

3. The effective date of the rule:

The agency selected an immediate effective date upon filing with the Secretary of State as specified in A.R.S. § 41-1032(A).

4. Citations to all related notices published in the Register as specified in R1-1-409(A) that pertain to the record of the proposed rule:

Notice of Rulemaking Docket Opening: 22 A.A.R. 1293, May 20, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 1289, May 20, 2016

5. The agency's contact person who can answer questions about the rulemaking:

Name: James Maguire
Address: AHCCCS
Office of Administrative Legal Services
701 E. Jefferson, Mail Drop 6200
Phoenix, AZ 85034
Telephone: (602) 417-4693
Fax: (602) 253-9115
E-mail: AHCCCSRules@azahcccs.gov
Web site: www.azahcccs.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

A.R.S. §§ 36-2905.04 and 36-2991 provide for the control and deterrence of fraud relating to AHCCCS eligibility, including the Hospital Presumptive Eligibility (HPE) program, through the discretionary imposition of a civil penalty on those persons who obtain AHCCCS eligibility through fraudulent means. A.R.S. §§ 36-2905.04(E) and 36-2991(E) require the AHCCCS Director to adopt rules providing for the appeal of a decision to impose such a penalty. The Administration will promulgate rules necessary for the imposition and appeal of penalties resulting from eligibility fraud, including fraud associated with the HPE program.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

A study was not referenced or relied upon when adding these regulations as A.R.S. §§ 36-2905.04(E) and 36-2991(E) require AHCCCS to promulgate these rules.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

9. A summary of the economic, small business, and consumer impact:

The Administration anticipates a minimal economic impact on the implementing agency, small businesses and consumers. AHCCCS currently pursues civil remedies against those who obtain AHCCCS eligibility through fraudulent means; therefore, AHCCCS does not anticipate that adding these regulations to its recovery efforts will have more than a minimal economic impact.

In SFY 2015, the AHCCCS Member Compliance section, through prosecutions and repayment agreements, recovered \$812,124.14 in money from persons who obtained eligibility through fraudulent means. In addition, the unit saved \$840,008.24 by discontinuing the eligibility of persons who were deemed ineligible due to non-residency in Arizona, unreported income, impermissible transference of resources and other misrepresentations.

The Administration anticipates an increase of 10% to 25% above the existing recovery amounts within the next fiscal year as a result of this rulemaking, which represents a potentially positive economic impact for the implementing agency.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No changes were made between the proposed rulemaking and the final rulemaking.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

No comments were received.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The following federal law applies to the subject of this rulemaking:

42 C.F.R. Part 455 requires AHCCCS to maintain a fraud detection and investigation program to maintain the integrity of the Arizona Health Care Cost Containment System.

This rulemaking is not more stringent than, or prohibited by, federal law.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None.

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ADMINISTRATION

ARTICLE 4. ~~REPEALED~~ PENALTY FOR OBTAINING ELIGIBILITY BY FRAUD

Section

R9-22-401. ~~Repealed~~ Definitions

R9-22-402. ~~Repealed~~ Determining the Amount of the Penalty

R9-22-403. ~~Repealed~~ Mitigating and Aggravating Circumstances

R9-22-404. ~~Repealed~~ Notice of Intent

R9-22-405. ~~Repealed~~ Failure to Respond to the Notice of Intent

R9-22-406. Request for State Fair Hearing

R9-22-407. Burden of Proof

R9-22-408. Rescission of the Notice of Intent

ARTICLE 4. ~~REPEALED~~ PENALTY FOR OBTAINING ELIGIBILITY BY FRAUD

R9-22-401. ~~Repealed~~ Definitions

Definitions. The following definitions apply specifically to terms used within this Article:

“Amounts incurred by the system” include capitation payments, costs incurred by any contractor in excess of capitation, reinsurance, and other administrative, legal or investigative costs associated with a person who obtained eligibility contrary to A.R.S. §§ 36-2905.04 and/or A.R.S. § 36-2991.

“Application for eligibility” means any request for benefits administered by AHCCCS under the authority of A.R.S. Title 36, Chapter 29, including applications for presumptive eligibility submitted to hospitals as described under Article 16 of this Chapter.

“Penalty” means an amount not to exceed the amounts incurred by the system during any time period that the person would have been ineligible for benefits but for the false or fraudulent information provided on the application for eligibility. A penalty does not include, and does not need to be reduced by, the amount of any overpayments that AHCCCS may be entitled to recoup from a person who violated A.R.S. § 36-2905.04 and/or A.R.S. § 36-2991.

R9-22-402. ~~Repealed~~ Determining the Amount of the Penalty

- A. AHCCCS shall determine the amount of a penalty according to A.R.S. § 36-2905.04(B) or A.R.S. § 36-2991(B), whichever is applicable, and this Article.
- B. In addition to any penalty imposed pursuant to ARS §§ 36-2905.04 or 36-2991, and this Article, the Administration may also recoup from the person the amounts incurred by the system as a part of the notice and appeal process described in this Article.

R9-22-403. ~~Repealed~~ Mitigating and Aggravating Circumstances

- A. AHCCCS shall consider any of the following to be mitigating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.
 - 1. Degree of culpability. The degree of culpability of a person is a mitigating circumstance if the person did not intend to provide or cause to be provided false or fraudulent

information on the application for eligibility but was negligent as to the truthfulness of the information provided.

2. Prior Offenses. At the time of the submittal of the application the person:
 - a. Did not have any prior criminal convictions; and
 - b. Had not been held civilly liable for defrauding a public assistance program.
3. Financial condition. The financial condition of a person who violates A.R.S. §§ 36-2905.04 or 36-2991 is a mitigating circumstance if the imposition of a penalty without reduction will render the person incapable of obtaining necessities of life such as food, clothing, and shelter. AHCCCS may consider the resources available to the person when determining the amount of the penalty.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of a mitigating nature, if in the interest of justice; the circumstances require a reduction of the penalty.

B. AHCCCS shall consider any of the following to be aggravating circumstances when determining the amount of a penalty for obtaining eligibility by fraud.

1. Degree of culpability. The degree of culpability of a person who provides or causes to be provided false or fraudulent information on the application for eligibility is an aggravating circumstance if the person knows or had reason to know that the information provided on the application for eligibility was false or fraudulent, or the person failed to correct the false or fraudulent information prior to AHCCCS incurring a financial loss as a result of the application for eligibility.
2. Prior offenses. At any time before the submittal of the application for eligibility, the person was held criminally or civilly liable for committing any fraud, waste, or abuse against any public assistance program.
3. Financial Loss. The person's violation of A.R.S. §§ 36-2905.04 or 36-2991 caused a loss to the system equal to or exceeding \$5,000.00.
4. Other matters as justice may require. AHCCCS shall take into account other circumstances of an aggravating nature, if in the interest of justice; the circumstances require an increase of the penalty.

R9-22-404. Repealed-Notice of Intent

A. If AHCCCS imposes a penalty pursuant to this Article, AHCCCS shall hand deliver or send by certified mail, return receipt requested, or Federal Express to the person, a written Notice of Intent to impose a penalty.

B. The Notice of Intent shall include:

1. The legal and factual basis for AHCCCS' determination that there has been a violation of A.R.S §§ 36-2905.04 and/or 36-2991;
2. The penalty;
3. The amounts incurred by the system as a result of the violation of A.R.S. §§ 36-2905.04 and/or 36-2991, if AHCCCS intends to recoup those amounts through this process; and
4. The procedure for requesting a State Fair Hearing.

R9-22-405. Repealed-Failure to Respond to the Notice of Intent

If a person fails to respond to the Notice of Intent within the timeframe described in A.A.C. § R9-22-406(A), AHCCCS shall uphold the penalty and recoupment amounts described in the Notice of Intent.

R9-22-406. Request for State Fair Hearing

A. To dispute the agency action described in the Notice of Intent, the person shall file a written Request for State Fair Hearing with AHCCCS within sixty (60) days from the date of receipt of the Notice of Intent.

B. If AHCCCS receives a timely request for a State Fair Hearing from the person, AHCCCS shall mail a Notice of Hearing pursuant to the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

C. AHCCCS shall accept a written request for withdrawal of a hearing request if the written request for withdrawal is received from the person before AHCCCS mails a Notice of Hearing under the Uniform Administrative Hearing Procedures described in A.R.S. Title 41, Chapter 6, Article 10.

R9-22-407. Burden of Proof

- A. In any State Fair Hearing conducted under this Article, AHCCCS shall prove a violation of A.R.S. §§ 36-2905.04 and/or 36-2991, and any aggravating circumstances by a preponderance of the evidence.
- B. AHCCCS does not have to prove any specific intent to defraud.
- C. A person shall bear the burden of producing and proving by a preponderance of the evidence any affirmative defense or any circumstance that would justify reducing the amount of the penalty.

R9-22-408. Rescission of the Notice of Intent

AHCCCS may rescind the Notice of Intent at any time prior to the State Fair Hearing without prejudice.

ECONOMIC, SMALL BUSINESS, AND CONSUMER IMPACT STATEMENT
TITLE 9. HEALTH SERVICES
CHAPTER XX. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ADMINISTRATION

1. Identification of rulemaking.

The Arizona Health Care Cost Containment System (A.R.S. § 36-2901 et seq.) provides payment for health services for low-income Arizonans. The AHCCCS Administration and the Arizona Department of Economic Security determine the eligibility of applicants and beneficiaries in accordance with the provision of statutes and administrative rules adopted by AHCCCS. A.R.S. §§ 36-2905.04 and 36-2991 prohibit a person from providing false or fraudulent information to the state as part of an application for assistance. Furthermore, those statutes provide that any person who provides false information who is determined eligible and who would have been determined ineligible had they provided truthful information is subject to civil penalties in addition to any other penalties proscribed by law (such as the recovery of amounts actually expended by persons who fraudulently establish eligibility). A.R.S. §§ 36-2905.04(D) and (E) and 36-2991(E) state that the AHCCCS Administration shall adopt rules prescribing the procedures for the determination and collection of civil penalties and the procedures for appealing an assessment of such civil penalties. The proposed rulemaking adds R9-22-401 through R9-22-408 as new sections that establish the procedures that the AHCCCS Administration will employ to impose civil penalties against those individuals in addition to the recovery of the actual losses to the State.

a. The conduct and its frequency of occurrence that the rule is designed to change:

The rulemaking provides for the control and deterrence of fraud relating to AHCCCS eligibility. Specifically, these rules are designed to deter individuals from making false statements to obtain AHCCCS coverage for health care to which they are not otherwise entitled. During the period July 2015 - June 2016, the AHCCCS Office of the Inspector General identified 1749 cases of fraudulent eligibility.

b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

Fraudulent eligibility results in significant expenditures of taxpayer funds for individuals who are not entitled to those benefits. The Administration anticipates fraudulent eligibility will continue at a similar rate if the rule is not changed.

c. The estimated change in frequency of the targeted conduct expected from the rule change:

This rule permits the AHCCCS Administration to impose penalties, in addition to the actual losses to the system, in an amount not more than the amounts actually expended by the system. The AHCCCS Administration anticipates that the imposition of civil penalties in addition to the recovery of actual losses will act as a deterrent to fraud. Since the imposition of civil penalties is new, it is difficult to estimate the impact of deterrent effect on the number of future cases of eligibility fraud.

2. Identification of the persons who will be directly affected by, bear the costs of, or directly benefit from the rule making.

Individuals who commit eligibility fraud will bear the cost of the civil penalties. The AHCCCS Administration anticipates a marginal increase in cost associated with the appeal of some of the civil penalties, as will the Arizona Office of Administrative Hearings. By statute, any civil penalties collected are deposited in the State general fund after the return of any applicable federal share of the costs recovered. As a result, Arizona and federal taxpayers benefit from the rule making.

3. Cost benefit analysis.

a. Probable costs and benefits to the implementing agency and other agencies directly affected by the implementation and enforcement of the proposed rulemaking including the the number of new full-time employees necessary to implement and enforce the proposed rule:

i. Cost:

The AHCCCS Administration and the DES Office of Special Investigations currently employ staff who investigate eligibility fraud and seek recovery of actual losses to the system. The additional effort required by this rule making to determine and pursue civil penalties in addition to the actual losses is expected to be minimal. The impact to the

Arizona Office of Administrative Hearings is expected to be marginal because most current recovery efforts are resolved by agreement of the parties rather than through the administrative hearing process.

ii. Benefit:

The Administration expects to recover approximately \$81,000 to \$200,000 annually from civil penalties imposed on persons who obtained eligibility through fraud.

iii. Need for additional Full-time Employees:

The Administration does not anticipate the need to hire full-time employees as a result of the proposed rule changes.

b. Probable costs and benefits to political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

The Administration does not anticipate that this rulemaking will create costs or benefits for political subdivisions of the state.

c. Probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking.

None. Civil penalties for eligibility fraud are sought from individuals, not businesses.

4. General description of the probable impact on private and public employment in businesses, agencies, and political subdivisions of this state directly affected by the rulemaking.

The Administration does not anticipate any impact on private or public employment as the result of this rulemaking.

5. Statement of probable impact of the proposed rule on small businesses. The statement shall include:

a. Identification of the small businesses subject to the proposed rulemaking.

The Administration does not anticipate any impact of the proposed rule on small businesses.

b. **Administrative and other costs required for compliance with the proposed rulemaking.**

None.

c. **Description of methods prescribed in section A.R.S. § 41-1035 that the agency may use to reduce the impact on small businesses, with reasons for the agency's decision to use or not use each method:**

i. **Establishing less stringent compliance or reporting requirements in the rule for small businesses;**

This rulemaking does not impose compliance or reporting requirements on any small businesses.

ii. **Establishing less stringent schedules deadlines in the rule for compliance or reporting requirements for small businesses;**

This rulemaking does not impose compliance or reporting requirements on any small businesses. As such, it does not establish any deadlines for compliance or reporting.

iii. **Consolidate or simplify the rule's compliance or reporting requirements for small businesses;**

This rulemaking does not impose compliance or reporting requirements on any small businesses. As such, it does not establish any deadlines for compliance or reporting.

iv. **Establish performance standards for small businesses to replace design or operational standards in the rule; and**

This rulemaking does not establish performance standards for any small businesses.

v. **Exempting small businesses from any or all requirements of the rule.**

This rulemaking does not impose any requirements on any small businesses.

d. **The probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking.**

This rulemaking does not directly affect private persons or consumers other than individual who commit eligibility fraud as noted above.

6. **Statement of the probable effect on state revenues.**

The rulemaking is not expected to affect state revenues.

7. **Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using nonselected alternatives.**

The Administration did not consider other alternatives because the changes are the most cost effective and efficient method of complying with state statutes.

8. **A description of any data on which a rule is based with a detailed explanation of how the data was obtained and why the data is acceptable data.**

The Administration did not consider any data to base the rule upon.

36-2903.01. Additional powers and duties; report; definition

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons, including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:

(a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.

(b) Establish performance measures and incentives for the department.

(c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.

(d) Establish eligibility quality control reviews by the administration.

(e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

(f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.

(g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.

(h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or

the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

7. In addition to the cost sharing requirements specified in subsection D, paragraph 4 of this section:

(a) Charge monthly premiums up to the maximum amount allowed by federal law to all populations of eligible persons who may be charged.

(b) Implement this paragraph to the extent permitted under the federal deficit reduction act of 2005 and other federal laws, subject to the approval of federal waiver authority and to the extent that any changes in the cost sharing requirements under this paragraph would permit this state to receive any enhanced federal matching rate.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty percent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules that further specify the medical care and hospital services that are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993, the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety percent of its 1990 base year costs or more than one hundred ten percent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half percent or more than one hundred twelve and one-half percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five percent or more than one hundred fifteen percent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative

patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

2. For rates effective on October 1, 1994, and annually through September 30, 2011, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 percent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 percent. If charges exceed 4.7 percent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

- (a) An admission face sheet.
- (b) An itemized statement.
- (c) An admission history and physical.
- (d) A discharge summary or an interim summary if the claim is split.
- (e) An emergency record, if admission was through the emergency room.
- (f) Operative reports, if applicable.
- (g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third-party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine percent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred percent of the rate plus a fee of one percent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section 36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty percent of the hospital specific capital cost and sixty percent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for

prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(c) The administration shall distribute to hospitals any monies appropriated for graduate medical education above the amount prescribed in subdivisions (a) and (b) of this paragraph for the following purposes:

(i) For the direct costs of graduate medical education programs established or expanded on or after July 1, 2006. These programs must be approved by the administration.

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

(d) The administration shall develop, by rule, the formula by which the monies are distributed.

(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practices in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education

in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of October 1, 2011 pursuant to this subsection.

12. The administration shall adopt a diagnosis-related group based hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, 2014. The administration may make additional adjustments to the inpatient hospital rates established pursuant to this section for hospitals that are publicly operated or based on other factors, including the number of beds in the hospital, the specialty services available to patients, the geographic location and diagnosis-related group codes that are made publicly available by the hospital pursuant to section 36-437. The administration may also provide additional reimbursement for extraordinarily high cost cases that exceed a threshold above the standard payment. The administration may also establish a separate payment methodology for specific services or hospitals serving unique populations.

H. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H

or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

J. The director shall establish a special unit within the administration for the purpose of monitoring the third-party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third-party payments to be monitored pursuant to this subsection.

2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred percent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

(a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

(b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

(c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor

or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

L. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

M. Subject to title 41, chapter 4, article 4, the director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

N. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social security act if

those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system, it may adopt procedures pursuant to subsection G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

1. A monthly premium of fifteen dollars, except that the total monthly premium for an entire household shall not exceed sixty dollars.
2. A copayment of five dollars for each physician office visit.
3. A copayment of ten dollars for each urgent care visit.
4. A copayment of thirty dollars for each emergency department visit.

U. Subject to the approval of the centers for medicare and medicaid services, political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents may provide to the Arizona health care cost containment system administration monies in addition to any state general fund monies appropriated for critical access hospitals in order to qualify for additional federal monies. Any amount of federal monies received by this state pursuant to this subsection shall be distributed as supplemental payments to critical access hospitals.

V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.

36-2905.04. Eligibility by fraud; penalties; enforcement; classification

A. A person shall not provide or cause to be provided false or fraudulent information to the state as part of an application for the system under section 36-2901, paragraph 6, subdivision (a).

B. A person who violates subsection A of this section, who is determined eligible for the system and who would have been ineligible for the system if the person had provided true and correct information is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty of not to exceed the amount incurred by the system, including capitation payments, on behalf of the person. In addition, the person's eligibility may be discontinued in accordance with rules adopted by the director.

C. In addition to the requirements in state law, the medicaid fraud and abuse controls that are enacted under federal law apply to all persons eligible for the system and all contractors, noncontracting providers and subcontracted providers that provide services to persons who are eligible for the system.

D. The director shall make the determination to assess a civil penalty and is responsible for collection of the penalty. The director may adopt rules that prescribe procedures for the determination and collection of civil penalties. The director may compromise civil penalties imposed under this section in accordance with criteria established in rules.

E. The director shall adopt rules providing for the appeal of a decision by a person adversely affected by a determination made by the director under this section. The director's final decision is subject to judicial review in accordance with title 12, chapter 7, article 6.

F. Amounts paid by the state and recovered under this section shall be deposited in the state general fund, and any applicable federal share shall be returned to the United States department of health and human services.

G. If a civil penalty imposed pursuant to subsection D of this section is not paid, the state or the administration may file an action to collect the civil penalty in the superior court in Maricopa county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim is presented.

H. The department and contractors, subcontracted providers and noncontracting providers shall cooperate with the administration to prevent, discover and prosecute eligibility fraud.

I. A person who knowingly aids or abets another person pursuant to section 13-301, 13-302 or 13-303 in the commission of an offense under this section or section 13-3713 is guilty of a class 5 felony.

36-2991. Fraud; penalties; enforcement; violation; classification

A. A person shall not provide or cause to be provided false or fraudulent information on an application for eligibility pursuant to this article.

B. A person who violates subsection A of this section, who is determined eligible for services pursuant to this article and who would have been determined ineligible if the person had provided true and correct information is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty of not more than the amount incurred by the system, including capitation payments made on behalf of the person. In addition, the person's eligibility may be discontinued in accordance with rules adopted by the director.

C. In addition to the requirements of state law, any applicable fraud and abuse controls that are enacted under federal law apply to persons who are eligible for services under this article and to contractors and noncontracting providers who provide services under this article.

D. The director shall make the determination to assess a civil penalty and is responsible for collection of the penalty. The director may adopt rules that prescribe procedures for the determination and collection of civil penalties. The director may compromise civil penalties imposed under this section in accordance with criteria established in rules.

E. The director shall adopt rules providing for the appeal of a decision by a person adversely affected by a determination made by the director under this section. The director's final decision is subject to judicial review pursuant to title 12, chapter 7, article 6.

F. Amounts paid by the state and recovered under this section shall be deposited in the state general fund, and any applicable federal share shall be returned to the United States department of health and human services.

G. If a civil penalty imposed pursuant to subsection D of this section is not paid, the state may file an action to collect the civil penalty in the superior court in Maricopa county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil

action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim is presented.

H. A person who knowingly aids or abets another person pursuant to section 13-301, 13-302 or 13-303 in the commission of an offense under this section or section 13-3713 is guilty of a class 5 felony.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY (R-16-1004)

Title 6, Chapter 5, Article 52, Certification and Supervision of Family Child Care Home Providers

Amend: R6-5-5201; R6-5-5202; R6-5-5207; R6-5-5217; R6-5-5218; R6-5-5219



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: E-4

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: Chris Kleminich, Staff Attorney

DATE: September 16, 2016

SUBJECT: ARIZONA DEPARTMENT OF ECONOMIC SECURITY (R-16-1004)
Title 6, Chapter 5, Article 52, Certification and Supervision of Family Child Care Home Providers

Amend: R6-5-5201; R6-5-5202; R6-5-5207; R6-5-5217; R6-5-5218;
R6-5-5219

The Arizona Department of Economic Security (Department) is amending six sections in A.A.C. Title 6, Chapter 5, Article 52, related to family child care home providers. The rules were last amended on May 20, 1999.

The Department indicates that the rulemaking fulfills the course of action proposed in the five-year-review report approved by the Council in September 2014. Public input has revealed that the current rules unnecessarily restrict the number of organizations that are allowed to provide training in first aid and infant/child cardiopulmonary resuscitation (CPR) to family child care home providers. The rulemaking also makes technical corrections to correct typographical and citation errors.

Proposed Action

The following is a non-exhaustive summary of the Department's proposed actions:

- Section 5201: A citation is being corrected.
- Section 5202: Three technical corrections are being made.
- Section 5207: The rule currently defines an acceptable first aid and infant/child CPR training course as one that is "approved by the American Red Cross or the American Heart Association." The rule is being amended to define an acceptable training course as "a classroom or blended-learning course that conforms to the current guidelines of the American Red Cross or the American Heart Association, as confirmed in writing by the training provider."

- Section 5217: A technical correction is being made.
- Section 5218: For clarity, a sentence that was within the existing subsection (I) is being moved into the new subsection (J).
- Section 5219: Citation and grammatical corrections are being made.

Exemption or Request and Approval for Exception from the Moratorium

The Department received an exception from the moratorium on March 7, 2016.

Substantive or Procedural Concerns

None.

1. Are the rules legal, consistent with legislative intent, and within the agency’s statutory authority?

Yes. The Department cites to A.R.S. § 41-1954(A)(3) as general authority for the rules, under which the Department must “[a]dopt rules it deems necessary or desirable to further the objectives and programs of the [D]epartment.”

The Department cites to A.R.S. § 46-809 as specific authority for the rules, under which the Department must “[a]dopt rules it deems reasonable or necessary to implement child care services and to further the objectives of this article [Title 46, Chapter 7, Child Care Services, Article 1, General Provisions].”

2. Are the rules written in a manner that is clear, concise, and understandable to the general public?

Yes. The rules are generally clear, concise, and understandable.

3. Does the agency adequately address the comments on the proposed rules and any supplemental proposals?

Yes. The Department indicates that it received one written comment on the rulemaking from the Health and Safety Institute. The comment requested that the Department clarify that the rules permitted CPR training and certification using blended learning approaches in addition to the traditional classroom approach. In response, the Department modified the definition of “acceptable training” in Section 5207(C) to include both classroom and blended-learning courses.

4. Are the final rules a substantial change, considered as a whole, from the proposed rules and any supplemental proposals?

No. The Department indicates that, in addition to the modification to Section 5207(C) described above, the word “completeness” was added after “administrative” in Section 5202(R)

to correct an omission. Staff believes that the final rules are not a substantial change, when considered as a whole, from the proposed rules.

5. Does the preamble disclose a reference to any study relevant to the rules that the agency reviewed and either did or did not rely on in the agency's evaluation of or justification for the rules?

No. The Department indicates that it did not review or rely on any study for this rulemaking.

6. Are the rules more stringent than corresponding federal law and, if so, is there statutory authority that allows the agency to exceed the requirements of federal law?

No. The Department indicates that the rules are not more stringent than federal law.

7. Do the rules require a permit or license and if so, does the agency use a general permit or is any exception applicable under A.R.S. § 41-1037?

No. Section 5207 relates to the maintenance of a family child care home provider certification, not the issuance of the certification. Staff would note that by broadening the definition of "acceptable training", the Department arguably decreases the regulatory burden on those who are certified.

8. Do the rules establish a new fee or contain a fee increase?

No. The rules do not establish a new fee or contain a fee increase.

9. Conclusion

The Department requests an immediate effective date for the rules. This analyst recommends approval of the rules.



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: E-4

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: GRRC Economic Team

DATE: September 16, 2016

SUBJECT: ARIZONA DEPARTMENT OF ECONOMIC SECURITY (R-16-1004)
Title 6, Chapter 5, Article 52, Certification and Supervision of Family Child Care Home Providers

Amend: R6-5-5201; R6-5-5202; R6-5-5207; R6-5-5217; R6-5-5218;
R6-5-5219

I have reviewed the economic, small business, and consumer impact statement (hereafter referred to as EIS) and make the following comments.

GRRC Economist comments:

The Department is amending the Child Care Administration (CCA) rules and adjusting the language of its first aid and infant/child cardiopulmonary resuscitation (CPR) training requirements. The goal of the rule changes are to allow greater flexibility for child care providers to obtain training within the required 60 day period.

1. Costs and Benefits for:

a. The implementing agency:

According to the Department, the CCA has a "quality improvement contract in place that financially assists individuals who apply to become an ADES certified family child care provider." In FY 2016, contractors spent \$8,100 for CPR/First Aid (FA) training, which assisted 120 child care providers.

b. Political subdivisions:

No political subdivisions are affected by this rulemaking.

c. Businesses:

According to the Department, the amendments promote “free and fair competition that does not adversely affect public health and safety.” The amendments will allow greater flexibility of options for approximately 650 Department-certified family care providers and their backup providers who need CPR/FA certification every two years.

d. Small businesses:

The impacts are the same as those for businesses generally.

e. Consumers directly affected by the rulemaking:

No costs to consumers directly affected by the rulemaking were reported.

2. Do the probable benefits outweigh the probable costs?

Based on the information provided, the EIS indicates that the probable benefits outweigh the probable costs.

3. Analysis of methods to reduce the small business impact:

The Department indicates that the small business impact is reduced as much as possible.

4. The probable effect on state revenues:

The Department indicates that there is no anticipated impact on state revenues.

5. Analysis of any less intrusive or less costly alternative methods:

The Department reports that no less intrusive or less costly alternative methods were considered.

6. Whether an analysis was submitted to the agency regarding the rule's impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states:

The Department did not report any analysis regarding the rule’s impact on the competitiveness of businesses in this state as compared to the competitiveness of businesses in other states.

7. A description of any data on which a rule is based with an explanation of how the data was obtained and why the data is acceptable data, and the methods used by the agency to evaluate the costs and benefits in the EIS.

Not applicable.

8. Conclusion:

The submitted economic, small business and consumer impact statement contains the information required for compliance with A.R.S. §§ 41-1035, 41-1052(D)(1-3), and 41-1055. The EIS indicates that probable benefits will outweigh the probable costs, by allowing greater opportunity to obtain and provide safe CPR service in these institutions.



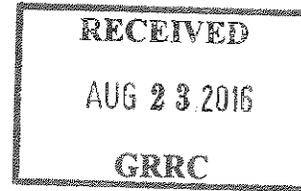
DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

Douglas A. Ducey
Governor

Timothy Jeffries
Director

August 17, 2016



Ms. Nicole A. Ong, Council Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 402
Phoenix, Arizona 85007

Re: Notice of Final Rulemaking to amend 6AAC5, Article 52, Certification and Supervision of Family Child Care Home Providers

Dear Ms. Ong:

The attached final rule package is respectfully submitted for review and approval by the Council. The following information is provided for Council's use in reviewing the rule package:

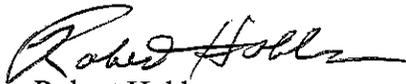
1. Close of record date: The rulemaking record was closed on June 6, 2016, following a period for public comment. This rule package is being submitted within the 120 days provided by A.R.S. § 41-1024(B). There was no oral proceeding requested and none was held.
2. General and specific statutes authorizing the rules; and definitions of terms contained in statutes or other rules: General statute: A.R.S. § 41-1954(A)(3). Specific statute: A.R.S. § 46-809. No definition is used from statute or other rules for the making of these rules.
3. Relation of the rulemaking to a Five-year-Review Report: This rulemaking is in response to a Five-year Review Report, approved by the Council on September 9, 2014.
4. New fee or fee increase: This rulemaking does not establish a new fee or increase an existing fee.
5. Effective date: The Department is requesting an immediate effective date pursuant to A.R.S. § 41-1032(A)(4) and (5).
6. Material incorporated by reference: No material is incorporated by reference in the rulemaking.
7. Certification regarding studies: I certify that the preamble accurately discloses that no study relevant to the rule was reviewed and either relied on or not relied on in the agency's evaluation of or justification for the rule.

8. JLBC Certification:
The Department was not required to make a certification to JLBC because the rule does not require any new full-time employees.

9. List of documents enclosed:
 - a. Cover letter;
 - b. Notice of Final Rulemaking including the preamble, table of contents for the rulemaking, and rule text;
 - c. Economic Impact Statement;
 - d. Current rules;
 - e. Statutes;
 - f. Copy of written comment; and
 - g. Approval from the Governor's Office.

If you have any questions about this report, please contact me at (602) 542-6555 or RHobbs@azdes.gov.

Sincerely,



Robert Hobbs
Lead Rules Analyst
(as Director's designee)

NOTICE OF FINAL RULEMAKING

TITLE 6. ECONOMIC SECURITY

**CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY
SOCIAL SERVICES**

PREAMBLE

<u>1. Articles, Parts, and Sections Affected</u>	<u>Rulemaking Action</u>
R6-5-5201	Amend
R6-5-5202	Amend
R6-5-5207	Amend
R6-5-5217	Amend
R6-5-5218	Amend
R6-5-5219	Amend

2. Citations to the agency’s statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 41-1954(A)(3)

Implementing statute: A.R.S. § 46-809

3. The effective date of the rules:

a. If the agency selected a date earlier than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the earlier date and state the reason or reasons the agency selected the earlier effective date as provided in A.R.S. § 41-1032(A)(1) through (5):

The Department requests that the rule be effective immediately on filing in the office of the Secretary of State and the time and date are affixed as provided in

A.R.S. § 41-1031, for the following reasons:

To provide a benefit to the public and a penalty is not associated with a violation of the rule. § 41-1032(A)(4); and

To adopt a rule that is less stringent than the rule that is currently in effect and that does not have an impact on the public health, safety, welfare or environment, or that does not affect the public involvement and public participation process. § 41-1032(A)(5)

b. If the agency selected a date later than the 60 day effective date as specified in A.R.S. § 41-1032(A), include the later date and state the reason or reasons the agency selected the later effective date as provided in A.R.S. § 41-1032(B):

Not applicable

4. Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the record of the proposed rulemaking:

Notice of Rulemaking Docket Opening: 22 A.A.R. 1065, May 6, 2016

Notice of Proposed Rulemaking: 22 A.A.R. 1029, May 6, 2016

5. The agency's contact person who can answer questions about the rulemaking:

Name: Rodney K. Huenemann

Address: Department of Economic Security

P.O. Box 6123, Mail Drop 1292

Phoenix, AZ 85005

or

Department of Economic Security

1789 W. Jefferson St., Mail Drop 1292

Phoenix, AZ 85007

Telephone: (602) 542-6159

Fax: (602) 542-6000

E-mail: rhuenemann@azdes.gov

6. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

This rulemaking is in response to a Five-year Review Report, approved by the Governor's Regulatory Review Council on September 9, 2014. This rulemaking will address concerns identified in a rulemaking petition that the current rule unnecessarily restricts the number of organizations that are allowed to provide training in first aid and infant/child cardiopulmonary resuscitation (CPR) to family child care home providers. The current rule defines acceptable first aid and infant/child CPR training as a course approved by the American Red Cross or the American Heart Association. The proposed rule will adjust the definition of "acceptable training" to include a classroom or blended-learning course which conforms to the current guidelines of the American Red Cross or the American Heart Association, as confirmed in writing by the training provider. Additionally, this rulemaking will make technical corrections to correct typographical errors and incorrect citations.

7. A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

The Department did not review or rely on any study relevant to the rules.

8. A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. A summary of the economic, small business, and consumer impact:

All Department certified family child care providers are small business owners who contract with Child Care Administration to care for children of Department clients. The current rule significantly limits the options of choosing first aid and CPR courses especially in the rural areas. Because of the limited availability, some providers are unable to comply with the first aid and CPR training requirement within 60 days after receiving a child care certificate. In addition, the providers, in some cases, find themselves incurring higher cost due to limited availability and not being able to wait for better options. Having more training available means less burden on the providers who will benefit from having additional opportunities to choose the training that is affordable, timely, and that fits their needs.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

There are no substantive changes between the proposed rules, published on May 6, 2016, and the final rules. In R6-5-5202(R), in the second sentence, the word “completeness” was added after “administrative” to correct an omission. In response to a public comment, the definition of “acceptable training” was changed to include a “classroom or blended-learning course” in R6-5-5207(C).

11. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

The Department received a written request on May 18, 2016, from the Health and Safety Institute, to amend the rules to permit training and certification using hybrid (blended) learning approaches in addition to the traditional classroom approach. The Department agreed with the request and changed the definition of “acceptable training” to include a classroom or blended-learning course in R6-5-5207(C).

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters are prescribed.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

These rules do not require a permit.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

The Child Care and Development Block Grant (CCDBG) Act of 1990 and 45 CFR 98 and 99 are applicable to the subject of the rule. The Department has determined that the rules are not more stringent than corresponding federal law.

c. Whether a person submitted an analysis to the agency that compares the rule’s impact of the competitiveness of business in this state to the impact on

business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and

its location in the rule:

None

14. Whether the rule was previously made, amended or repealed as an emergency rule.

If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the

agency shall state where the text was changed between the emergency and the final

rulemaking packages:

Not applicable

15. The full text of the rules follows:

TITLE 6. ECONOMIC SECURITY

**CHAPTER 5. DEPARTMENT OF ECONOMIC SECURITY
SOCIAL SERVICES**

**ARTICLE 52. CERTIFICATION AND SUPERVISION OF FAMILY CHILD CARE
HOME PROVIDERS**

Section

R6-5-5201. Definitions

R6-5-5202. Initial Application for Certification

R6-5-5207. Maintenance of Certification: General Requirements; Training

R6-5-5217. Meals and Nutrition

R6-5-5218. Health Care; Medications

R6-5-5219. Recordkeeping; Unusual incidents; Immunizations

ARTICLE 52. CERTIFICATION AND SUPERVISION OF FAMILY CHILD CARE
HOME PROVIDERS

R6-5-5201. Definitions

No change

1. No change
2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change
9. No change
10. No change
11. No change
12. No change
13. No change
14. No change
15. No change
16. No change
17. No change
18. No change

19. No change
20. No change
21. No change
22. No change
 - a. No change
 - b. No change
 - c. No change
23. No change
24. No change
25. No change
26. No change
27. No change
28. No change
29. No change
30. No change
 - a. No change
 - b. No change
31. No change
32. No change
33. No change
34. No change
35. "Neglect" has the same meaning ascribed in A.R.S. § ~~8-201(21)~~ 8-201.
36. No change

- 37. No change
- 38. No change
- 39. No change
- 40. No change
- 41. No change
 - a. No change
 - b. No change
 - c. No change
 - d. No change
 - e. No change
- 42. No change
- 43. No change
- 44. No change
- 45. No change

R6-5-5202. Initial Application for Certification

- A.** No change
- B.** No change
- C.** No change
- D.** No change
 - 1. No change
 - 2. No change
 - 3. No change

4. No change

E. No change

F. No change

1. No change

2. No change

3. No change

G. No change

H. No change

I. No change

1. No change

2. No change

3. No change

4. No change

5. No change

6. No change

7. No change

8. No change

9. No change

10. No change

11. No change

12. No change

13. No change

14. No change

- J.** No change
- K.** No change.
- L.** An applicant shall furnish proof that the applicant, the individual backup provider, and members of the applicant's household who are age 13 or younger are immune from measles, rubella, diphtheria, tetanus, ~~pertusis~~, pertussis, polio, and any other diseases for which routine immunizations are readily and safely available.
 - 1. No change
 - 2. No change
 - a. No change
 - b. No change
- M.** No change.
 - 1. No change
 - a. No change
 - b. No change
 - 2. No change
- N.** No change
 - 1. No change
 - 2. No change
 - 3. No change
 - 4. No change
 - 5. No change
 - 6. No change
- O.** No change

1. No change
2. No change
3. No change
4. No change

P. No change

Q. No change

R. The Department shall send an applicant a notice of administrative completeness or deficiency, as described in A.R.S. § 41-1074, indicating the additional information, if any, that the applicant must provide for a complete application package. The Department shall send the notice after receiving the application and before expiration of the administrative completeness review time-frame described in ~~R6-5-5204~~ R6-5-5205. If the applicant does not supply the missing information listed in the notice, the Department may close the file.

S. No change

T. No change

R6-5-5207. Maintenance of Certification: General Requirements; Training

A. No change

B. No change

C. No later than 60 days after the date of provider certification, a provider and individual backup providers shall furnish the Department with proof of acceptable first aid training and certification in infant/child cardiopulmonary resuscitation (“CPR”). As used in this Section, “acceptable training” means a classroom or blended-learning course ~~approved by~~ that conforms to the current guidelines of the American Red Cross or the American Heart

Association, as confirmed in writing by the training provider. The Department may extend the time for completing this requirement and children may remain in care during an extension, if:

1. No change

2. No change

D. No change

E. No change

1. No change

2. No change

3. No change

4. No change

5. No change

6. No change

7. No change

8. No change

9. No change

F. No change

G. No change

H. No change

I. No change

J. No change

K. No change

L. No change

- M. No change
- N. No change
- O. No change
 - 1. No change
 - 2. No change

R6-5-5217. Meals and Nutrition

- A. No change
- B. No change
- C. No change
- D. No change
- E. No change
- F. A provider shall monitor all perishable foods, including infant formulas and sack lunches.
The provider shall ensure that food is individually labeled with a child's name, dated, covered, and properly stored to prevent spoilage- at temperatures of 45°F or less.

R6-5-5218. Health Care; Medications

- A. No change
- B. No change
 - 1. No change
 - 2. No change
- C. No change
- D. No change

E. No change

F. No change

G. No change

H. No change

1. No change

2. No change

I. No change

1. No change

2. No change

3. No change

4. The dosage administered.

~~A provider shall use a sanitary medication measure for accurate dosage.~~

J. A provider shall use a sanitary medication measure for accurate dosage.

~~J.~~ **K.** No change

~~K.~~ **L.** No change

~~L.~~ **M.** No change

R6-5-5219. Recordkeeping; Unusual incidents; Immunizations

A. No change

B. No change

C. No change

D. No change

1. No change

2. No change
3. No change
4. No change
5. No change
6. No change
7. No change
8. No change

E. No change

1. No change
2. No change
3. No change
4. No change
5. No change

F. No change

1. No change
 - a. An immunization record prepared by the child's health care provider stating that child has received current, age-appropriate immunizations specified in ~~R9-6-701~~ R9-6-702, including immunizations for Diphtheria, ~~homophiles~~ Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, ~~Pertussis~~, Pertussis, Poliomyelitis, Rubella, and Tetanus;
 - b. No change
 - c. No change

2. If a child has received all current immunizations but requires further inoculations to be fully immunized, the provider shall require the parent to verify that the parent will have the child complete all immunizations in accordance with the DHS recommended schedule identified in ~~R9-6-701~~ R9-6-702. The provider shall:

a. No change

b. No change

3. No change

G. No change

Economic, Small Business and Consumer Impact Statement

Title 6. Economic Security

Chapter 5. Department of Economic Security / Social Services

Article 52. Certification and Supervision of Family Child Care Home Providers

R6-5-5207. Maintenance of Certification: General Requirements; Training

A. Economic, small business and consumer impact summary:

1. Identification of the proposed rulemaking:

Arizona Department of Economic Security (ADES or the Department), Division of Employment and Rehabilitation Services (DERS), is amending Child Care Administration (CCA) rules to adjust the language of its first aid (FA) and infant/child cardiopulmonary resuscitation (CPR) training requirement. The current rule under A.A.C. R6-5-5207(C) defines acceptable first aid and infant/child CPR training as a course approved by the American Red Cross (ARC) or the American Heart Association (AHA). The proposed rule will adjust the definition of “acceptable training” to include a classroom or blended-learning course which conforms to the current guidelines of the American Red Cross or the American Heart Association, as confirmed in writing by the training provider.

a. The conduct and its frequency of occurrence that the rule is designed to change:

All ADES certified family child care providers and their individual backup providers are required to maintain the CPR certificate at all times. In general, the certificate is good for two years from the completion date of the training. Currently, there are approximately 650 certified family child care providers. The frequency of the requirement will remain the same.

b. The harm resulting from the conduct the rule is designed to change and the likelihood it will continue to occur if the rule is not changed:

All ADES certified family child care providers are small business owners who contract with CCA to care for children of ADES clients. The current rule significantly limits the options of choosing first aid and CPR courses especially in the rural area. Because of the limited availability, some providers are unable to comply with this particular requirement within 60 days after receiving a child care certificate. In addition, the providers, in some cases, find themselves spending higher cost due to limited availability and not being able to wait for better options. Having more training available means less burden on the providers who will benefit from having further opportunities to choose the training that is affordable, timely, and that fits their needs. If the proposed rule is not accepted, the ADES certified family child care providers will continue to face this burden of having scarce resources.

c. The estimated change in frequency of the targeted conduct expected from the rule change:

There is no change in frequency of the requirement due to the rule change.

2. Brief summary of the information included in the economic, small business and consumer impact statement:

The current rule for certification and supervision of family child care home providers under A.A.C. R6-5-5207(C) defines acceptable CPR training as a course approved by the American Red Cross or the American Heart Association. Neither American Red Cross nor American Heart Association “approves” CPR courses offered by other entities; therefore, ADES certified child care providers are only allowed to take CPR courses offered by a trainer, who can issue the ARC or AHA certificates under current rules. This rule has been in existence since 1999, and it may be considered outdated. ADES Child Care Administration has received verbal and written complaints from local and national CPR trainers along with the child care providers who believe there are many other entities than ARC or AHA that are capable of delivering adequate trainings.

3. Name and address of agency employees who may be contacted to submit or request additional data on the information included in the economic, small business and consumer impact statement:

Name: Rodney K. Huenemann
Address: Department of Economic Security
P.O. Box 6123, Mail Drop 1292
Phoenix, AZ 85005
Or
Department of Economic Security
1789 W Jefferson St., Mail Drop 1292
Phoenix, AZ 85007
Telephone: (602) 542-6159
Fax: (602) 542-6000
E-mail: rhuenemann@azdes.gov

B. Economic, small business and consumer impact statement:

1. Identification of proposed rulemaking:

See paragraph (A)(1) above.

2. Identification of persons who will be directly affected by, bear the costs of or directly benefit from the proposed rulemaking:

ADES/DERS/Child Care Administration

ADES Certified Family Child Care Home/In-Home Providers and their backup providers

All CPR training entities that deliver a classroom or blended-learning course which conforms to the current guidelines of the American Red Cross or the American Heart Association

3. Analysis of costs and benefits occurring in this state:

The estimated median cost of CPR/FA/AED* training: \$90.00 per person

*Automated External Defibrillator

The estimated cost of CPR/FA/AED training for 1,000 providers: \$90,000.00
(650 Certified Providers plus 350 backup providers)

a. Probable costs and benefits to ADES and other agencies directly affected by the implementation and enforcement of the proposed rulemaking:

The current cost for CPR/FA/AED combined course by American Red Cross is listed as \$140.00 per person according to its website. The American Heart Association for the equivalent training costs anywhere from \$40.00 to \$65.00 per person depends on a trainer. The CCA has a quality improvement contract in place that financially assists individuals who apply to become an ADES certified family child care provider. For the state fiscal year 2016, the contractors have spent about \$8,100.00 toward the cost of CPR/FA training, which resulted in assisting approximately 120 child care providers.

b. Probable costs and benefits to a political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking:

There is no political subdivision of this state directly affected by the implementation and enforcement of the proposed rulemaking.

c. Probable costs and benefits to businesses directly affected by the proposed rulemaking, including any anticipated effect on the revenues or payroll expenditures of employers who are subject to the proposed rulemaking:

There are approximately 650 ADES certified family child care providers along with their individual backup providers who need a CPR/FA certificate every two years. Under current rules, only trainers who can issue the ARC or the AHA CPR/FA certificates are eligible to train ADES certified family child care providers in order for the providers to comply with the rule. By revising the rule to indicate “conforms to” in place of “approved by,” it opens up a door to many additional entities to train the child care providers. This will promote free and fair competition that does not adversely affect public health and safety.

4. General description of the probable impact on private and public employment in businesses, agencies and political subdivisions of this state directly affected by the proposed rulemaking:

The Department does not anticipate any probable impact on private and public employment in business, agencies, and political subdivisions of this state directly affected by the proposed rulemaking.

5. Statement of the probable impact of the proposed rulemaking on small businesses:

a. Identification of the small business subject to the proposed rulemaking:

All ADES certified family child care providers are small business owners. Some of the CPR/FA training entities may be small business owners.

b. Administrative and other costs required for compliance with the proposed rulemaking:

All ADES certified family child care providers are already required to pay to maintain their CPR/FA certificate under the current rule. The proposed rulemaking will positively impact those providers by making more resources available to them.

c. Description of the methods that DES may use to reduce the impact on small business:

Not applicable.

d. Probable cost and benefit to private persons and consumers who are directly affected by the proposed rulemaking:

There is no probable cost or benefit to private persons and consumers.

6. Statement of the probable effect on state revenues:

The Department does not anticipate any probable effect on state revenues.

7. Description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed rulemaking, including the monetizing of the costs and benefits for each option and providing the rationale for not using non-selected alternatives:

None.

C. Explanation of limitations of the data and the methods that were employed in the attempt to obtain the data and a characterization of the probable impacts in qualitative terms. The absence of adequate data, if explained in accordance with this subsection, shall not be grounds for a legal challenge to the sufficiency of the economic, small business and consumer impact statement:

The ADES/CCA does not collect or have exact data collection of how much money the individual provider and his/her backup provider spend on CPR/FA certification. However, the Department has received complaints from ADES certified providers, the ADES contractors, and local and national CPR trainers including the one from the Health and Safety Institute.

Amended paragraph (3) effective March 17, 1981 (Supp. 81-2). Former Section R6-5-5105 repealed, new Section R6-5-5105 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5106. Expired**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5106 repealed, new Section R6-5-5106 adopted effective September 30, 1977 (Supp. 77-5). Former Section R6-5-5106 repealed, new Section R6-5-5106 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

R6-5-5107. Expired**Historical Note**

Adopted effective July 6, 1976 (Supp. 76-4). Former Section R6-5-5107 repealed, new Section R6-5-5107 adopted effective September 30, 1977 (Supp. 77-5). Amended effective March 17, 1981 (Supp. 81-2). Former Section R6-5-5107 repealed, new Section R6-5-5107 adopted effective June 17, 1985 (Supp. 85-3). Section expired under A.R.S. § 41-1056(E) at 7 A.A.R. 5257, effective October 31, 2001 (Supp. 01-4).

ARTICLE 52. CERTIFICATION AND SUPERVISION OF FAMILY CHILD CARE HOME PROVIDERS

R6-5-5201. Definitions

The following definitions apply in this Article:

1. "Abandonment" has the meaning ascribed to "abandoned" in A.R.S. § 8-201 (1).
2. "Abuse" has the meaning ascribed in A.R.S. § 8-201 (2).
3. "Age" means years of a person's lifetime when used in reference to a number, unless the term "months" is used.
4. "Adult" means a person age 18 or older.
5. "Applicant" means a person who submits a written application to the Department to become certified as a child care provider.
6. "Backup provider" means an adult who, or an entity that, provides child care when a provider is not available.
7. "CACFP" means the Child and Adult Care Food Program.
8. "Certificate" means a document the Department issues to a provider as evidence that the provider has met the child care standards of this Article.
9. "Child" means a person younger than age 18.
10. "Child care" means the compensated care, supervision, recreation, socialization, guidance, and protection of a child who is unaccompanied by a parent.
11. "Child care personnel" means all adults residing in a home facility, an in-home provider, and any backup provider.
12. "Child care registration agreement" means a written contract between a provider and the Department; that establishes the rights and duties of the provider and the Department for provision of child care.
13. "Child care specialist" means a Department child care eligibility and/or certification staff person.
14. "CHILDS" means the Children's Information Library and Data Source, which is a comprehensive, automated system to support child welfare policies and procedures, and includes information on investigations, ongoing case management, and payments.
15. "CHILDS Central Registry" means the Child Protective Services Central Registry, a confidential, computerized database within CHILDS, which the Department maintains according to A.R.S. § 8-804.
16. "Child with special needs" means a child who needs increased supervision, modified equipment, modified activities, or a modified facility, due to any physical, mental, sensory, or emotional delay, or medical condition, and includes a child who has a physical or mental impairment that substantially limits one or more major life activities; has a record of having a physical or mental impairment that substantially limits one or more of the child's major life activities; or who is regarded as having an impairment, regardless of whether the child has the impairment.
17. "Client" means a person who applies for and meets the eligibility criteria for a child care service program administered by the Department.
18. "Compensation" means something given or received, such as money, goods, or services, as payment for child care services.
19. "Corporal punishment" means any act that is administered as a form of discipline and that either is intended to cause bodily pain, or may result in physical damage or injury.
20. "CPS" means Child Protective Services, a Department administration that operates a program to investigate allegations of child maltreatment and provide protective services.
21. "Department" means the Arizona Department of Economic Security.
22. "Developmentally appropriate" means an action that takes into account:
 - a. A child's age and family background;
 - b. The predictable changes that occur in a child's physical, emotional, social, cultural, and cognitive development; and
 - c. The individual child's pattern and timing of growth, personality, and learning style.
23. "DHS" means the Arizona Department of Health Services.
24. "Direct supervision" means within sight and sound.
25. "Exploitation" means an act of taking advantage of, or making use of a child selfishly, unethically, or unjustly for one's own advantage or profit, in a manner contrary to the best interests of the child, such as having a child panhandle, steal, or perform other illegal activities.
26. "Evening care" means child care provided at any time between 6:30 p.m. and midnight.
27. "Heating device" means an instrument designed to produce heat for a room or inside area and includes a non-electric stove, fireplace, freestanding stove, or space heater.
28. "Home facility" means a provider's residence that the Department has certified as a location where child care services may be provided.
29. "Household member" means a person who does not provide child care services and who resides in the home facility of a provider for 21 consecutive days or longer or who resides periodically throughout the year for a total of at least 21 days.
30. "Infant" means:
 - a. A child who is younger than 12 months old; and
 - b. A child who is younger than 18 months old and not walking.

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31. "In-home provider" means a provider who cares for a child in the child's home.
32. "Maltreatment" means abuse, neglect, exploitation, or abandonment of a child.
33. "Medication" means any prescribed or over-the-counter drug or medicine.
34. "Mechanical restraint" means a device to restrict a child's movement.
35. "Neglect" has the same meaning ascribed in A.R.S. § 8-201(21).
36. "Night-time care" means child care provided at any time between midnight and 6:00 a.m.
37. "Non-parent relative" means a caretaker relative who exercises responsibility for the day-to day physical care, guidance, and support of a child who physically resides with the relative and who is by affinity, consanguinity, or court decree, a grandparent, great grandparent, sibling of the whole or half-blood, stepbrother, stepsister, aunt, uncle, great aunt, great uncle, or first cousin of the child.
38. "Parent" means the biological or adoptive parent of a child, a court-appointed guardian, or a non-parent relative.
39. "Provider" means an adult who is not the parent or guardian of a child needing care, and to whom the Department has issued a certificate, and includes a backup provider who performs the provider's duties when the provider is unavailable.
40. "Physical restraint" means the use of bodily force to restrict a child's freedom of movement.
41. "Safeguard" means to use reasonable efforts and developmentally appropriate measures to eliminate the risk of harm to a child in care and ensure that a child in care will not be harmed by a particular object, substance, or activity. Safeguarding may include:
 - a. Locking up a particular substance or item;
 - b. Putting a substance or item beyond the reach of a child who is not mobile;
 - c. Erecting a barrier that prevents a child from reaching a particular place, item, or substance;
 - d. Mandating the use of a protective safety device; or
 - e. Providing direct supervision.
42. "Sanitize" means treatment by a heating or chemical process that reduces the bacterial count, including pathogens, to a safe level.
43. "Time out" means removing a child from a situation by directing the child to remain in a specific chair or place identified as the time out place, for no more than one minute for each year of a child's age, but no more than 10 minutes.
44. "Undue hardship" means significant difficulty or substantial expense concerning the operation of a provider's program. In this subsection, "significant" and "substantial" are measured relative to the level of net income the provider earns from child care services.
45. "Unusual incident" means any accident, injury, behavior problem, or other extraordinary situation involving a provider or a child in care, including suspected child maltreatment.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5202. Initial Application for Certification

- A. To become a certified child care provider, an applicant shall comply with all requirements of this Article and other applicable requirements of federal, state, or local law.
- B. An applicant shall be at least age 18.
- C. An applicant shall submit a complete, signed application form to the Department.
- D. An applicant shall designate one or more backup providers from the following list:
 1. An individual who is age 18 or older and who satisfies the requirements for backup providers outlined in this Article;
 2. A DHS-licensed child care center;
 3. A DHS-certified child care group home; or
 4. A DES-certified family child care home.
- E. An applicant shall participate in any orientation and training and shall cooperate in conducting any pre-certification interviews and inspections the Department may require.
- F. An applicant shall give the Department the names of three references who:
 1. Have known the applicant at least one year,
 2. Are unrelated by blood or marriage to the applicant, and
 3. Can furnish information regarding the applicant's character and ability to care for a child.
- G. An applicant and any designated individual backup provider shall furnish a self-statement of physical and mental health on a form provided by the Department.
- H. An applicant and each designated individual backup provider shall have the physical, mental, and emotional health necessary to perform the duties and meet the responsibilities established by this Article. If the Department has questions about the applicant's health that the applicant cannot satisfactorily answer or explain, the applicant, upon request by the Department, shall submit to a physical or psychological examination by a licensed physician, psychologist, or psychiatrist, and shall provide the Department with a professional opinion addressing the Department's questions. The applicant shall bear the cost of any professional examinations that the Department needs to determine whether the individual is qualified.
- I. The Department may require an applicant to furnish at least the following information about the applicant, the applicant's spouse, members of the applicant's household, children residing outside of the applicant's home, and the individual backup provider:
 1. Name;
 2. Current address;
 3. Telephone number;
 4. Date of birth;
 5. Social security number;
 6. Maiden name, aliases, and nicknames;
 7. Relationship to the applicant or backup provider;
 8. Marital status and marital history;
 9. Educational background;
 10. Ethnicity;
 11. Gender;
 12. Birthplace;
 13. Physical characteristics; and
 14. Citizenship status.
- J. Child care personnel shall submit the notarized criminal history certification form required by A.R.S. § 41-1964, and disclose whether they have committed any acts of child maltreatment or have been the subject of a Child Protective Service investigation.
- K. On a Department form, an applicant, all adult household members, and all individual backup providers shall provide employment histories for the five-year period immediately

preceding the application date, beginning with the individual's present or most recent job.

- L. An applicant shall furnish proof that the applicant, the individual backup provider, and members of the applicant's household who are age 13 or younger are immune from measles, rubella, diphtheria, tetanus, pertusis, polio, and any other diseases for which routine immunizations are readily and safely available.
1. The Department may waive the requirements of this subsection for a household member if the applicant will be certified as an in-home provider only and submits an affidavit attesting that household members will not be present when child care services are provided.
 2. The Department shall waive the requirements of this subsection if the applicant:
 - a. Submits an affidavit stating that household members are being raised in a religion whose teachings oppose immunization; and
 - b. Affirms, in writing, that families will be notified of the religious exemption before child care services are provided.
- M. An applicant shall submit evidence of current freedom from pulmonary tuberculosis for the applicant, all household members, and all individual backup providers. If the application is approved, this evidence shall be submitted each succeeding calendar year.
1. Evidence required under this subsection is limited to:
 - a. A report of a negative Mantoux skin test performed within three months of the date or anniversary date of initial certification.
 - b. A physician's written statement based on an examination performed within three months of the date or anniversary date of initial certification.
 2. The Department shall waive the requirements of this subsection for household members if the applicant will be certified as an in-home provider only and submits an affidavit that household members will not be present when child care services are provided.
- N. An applicant shall provide a statement of services on a Department form. The statement shall describe:
1. The home at which services will be provided, location, and hours of operation;
 2. The applicant's daily rates and fees;
 3. The ages of children the applicant will accept;
 4. The equipment, materials, daily activities, and play areas available to children in care;
 5. Any special child care skills, knowledge, or training the applicant has; and
 6. The behavior, guidance, and discipline methods the applicant uses.
- O. During an interview with the child care specialist, an applicant shall complete a Department questionnaire describing:
1. The applicant's child rearing philosophy;
 2. The home environment, including intra-family relationships and attitudes toward child care;
 3. The parenting and discipline methods employed by the applicant and the applicant's parents; and
 4. The applicant's child care training and experience.
- P. Upon Department request, an applicant, all members of the applicant's household, and all individual backup providers shall comply with any additional requirements and requests for interviews, inspections, or information necessary to determine the applicant's fitness to serve as a certified child care provider.
- Q. A complete application package consists of an applicant's completed application form and evidence that the applicant, all

members of the applicant's household, and all individual backup providers have met all requirements and submitted all information and documentation listed in this Section.

- R. The Department shall send an applicant a notice of administrative completeness or deficiency, as described in A.R.S. § 41-1074, indicating the additional information, if any, that the applicant must provide for a complete application package. The Department shall send the notice after receiving the application and before expiration of the administrative review time-frame described in R6-5-5204. If the applicant does not supply the missing information listed in the notice, the Department may close the file.
- S. An applicant whose file is closed may reapply for certification.
- T. After an applicant submits a complete application for initial certification, the Department shall inspect the applicant's home to determine whether the home meets the regulations of this Article.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5203. Initial Certification: The Home Facility

A provider's home facility shall meet the requirements of this Section.

1. A provider shall maintain the indoor and outdoor premises of the home facility in a safe and sanitary condition, free from hazards and vermin, and in good repair. A mobile home shall have skirting to ensure that a child in care cannot go beneath the mobile home.
2. Any area to be occupied by a child in care shall have heat, light, ventilation, and screening. The provider shall maintain the home facility between 68° and 85° F.
3. A provider shall vent and safeguard all heating devices to protect each child from burns and harmful fumes.
4. A provider shall safeguard all potentially dangerous objects from children, including:
 - a. Household and automotive tools;
 - b. Sharp objects, such as knives, glass objects, and pieces of metal;
 - c. Fireplace tools, butane lighters and igniters, and matches;
 - d. Machinery;
 - e. Electrical boxes;
 - f. Electrical outlets;
 - g. Electrical wires; and
 - h. Chemicals, cleaners, and toxic substances.
5. A provider shall store firearms and ammunition separately from one another, under lock and key or combination lock.
6. A home facility shall have adequate space and equipment to accommodate each child in care, and other household members who are in the home facility at the same time as children in care. In this subsection, "adequate" means sufficient space and equipment to:
 - a. Permit all persons in the dwelling to have safe freedom of movement;
 - b. Permit children in care to be seated together for meals and snacks; and
 - c. Permit all children in care to be engaged in developmentally appropriate activities at the same time and in a room where the provider can keep all children within sight.
7. A provider shall keep outside play areas clean and safe and shall fence the play area if there are conditions that

may pose a danger to any child playing outside. The fence shall be at least 4 feet high and free of hazards, including splinters and protruding nails or wires. The fence shall have only self-closing, self-latching, lockable gates.

8. A home facility shall have the following equipment:
 - a. A charged, readily accessible, operable, multi-purpose (ABC class) fire extinguisher that the applicant knows how to operate;
 - b. At least one UL-approved, working smoke detector, properly mounted on each level of the dwelling;
 - c. At least two usable outdoor exits;
 - d. A posted written plan or diagram for emergency evacuation;
 - e. A working telephone or other two-way communication device acceptable to the Department; and
 - f. An easily accessible life-saving device if the home facility has a pool or other body of water more than 12 inches deep. A "life-saving device" means a ring buoy with at least 25 feet of 1/2-inch rope attached or a shepherd's crook.
9. If a home facility has a swimming pool or other body of water more than 12 inches deep, the pool or body of water shall be enclosed by a permanent fence that separates it from all other outdoor areas and from doors and windows into the home facility. The fence shall be at least 5 feet high and shall have only self-closing, self-latching, lockable gates. Open spaces between upright or parallel posts and poles on fences and gates shall be no more than 4 inches apart. When the pool or body of water is not in use, the provider shall lock the gates.
10. A provider shall enclose spas and hot tubs with fencing as described in subsection (9), or with a hard, locked cover that prevents access and can support at least 100 pounds.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Amended effective March 5, 1979 (Supp. 79-2). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5204. Initial Certification: Department Responsibilities

- A. Before issuing a certificate, the Department shall:
 1. Conduct at least one face-to-face interview with an applicant;
 2. Contact any other person necessary to determine an applicant's fitness to be a certified provider;
 3. Ensure that an applicant and all individual backup providers have complied with and satisfy the requirements of R6-5-5202;
 4. Inspect the home where an applicant will provide child care, unless it is the child's own home, and ensure that it meets the requirements of R6-5-5203;
 5. Conduct a CHILDS Central Registry check for:
 - a. An applicant;
 - b. The applicant's household members;
 - c. The applicant's emancipated children who live outside the applicant's home, if any; and
 - d. Any individual backup provider.
 6. Find that an applicant has the intent and ability to provide child care that is safe, developmentally appropriate, and in compliance with the requirements of this Article.
- B. The Department shall objectively determine whether to certify an applicant based on the applicant's entire application package, and the information the Department has acquired during the course of the application process.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5205. Certification Time-frames

For the purpose of A.R.S. § 41-1073, the Department established the following certification time-frames:

1. Administrative completeness review time-frame: 60 days,
2. Substantive review time-frame: 30 days, and
3. Overall time-frame: 90 days.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5205 renumbered to R6-5-5206 and new Section adopted by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5206. Certificates; Issuance; Non-transferability

- A. A certificate is valid for three years from the date of issuance. The Department may revoke a certificate before expiration as provided in this Article and by law.
- B. A certificate is not transferable and is valid only for the provider and location identified on the certificate.
- C. A provider shall post the certificate in a conspicuous location in the home facility.
- D. A certificate is the property of the state of Arizona. Upon revocation or voluntary closure, a provider shall surrender the certificate issued to the provider to the Department within seven days.
- E. The Department shall designate on the certificate issued to the provider the total number of children to be allowed in child care at any one time. The total shall not exceed the limits set in R6-5-5220.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Amended effective February 24, 1977 (Supp. 77-1). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5206 renumbered to R6-5-5207; new Section R6-5-5206 renumbered from R6-5-5205 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5207. Maintenance of Certification: General Requirements; Training

- A. Child care personnel and all individual backup providers shall be fingerprinted and pay all required fingerprint fees within the time prescribed in A.R.S. § 41-1964.
- B. A provider and all individual backup providers shall maintain the physical, mental, and emotional health necessary to fulfill all legal requirements for child care providers.
- C. No later than 60 days after the date of provider certification, a provider and individual backup providers shall furnish the Department with proof of acceptable first aid training and certification in infant/child cardiopulmonary resuscitation ("CPR"). As used in this Section, "acceptable training" means a course approved by the American Red Cross or the American Heart Association. The Department may extend the time for completing this requirement and children may remain in care during an extension, if:
 1. The class was not available within the 60-day time period; or
 2. The provider, individual backup provider, or a dependent was ill, and the provider or backup provider was unable to attend a scheduled class due to the illness.

- D. A provider and individual backup providers shall maintain current training and certification in first aid and infant/child CPR through acceptable training courses.
- E. A certified provider shall attend at least six hours of training each calendar year in any of the following subjects:
1. The Department's child care program, policies, and procedures;
 2. Child health and safety, including recognition, control, and prevention of illness and disease;
 3. Child growth and development;
 4. Child abuse prevention, detection, and reporting;
 5. Positive guidance and discipline;
 6. Child nutrition;
 7. Communication with families; family involvement;
 8. Developmentally appropriate practices; and
 9. Other similar subjects designed to improve the provider's ability to provide child care.
- F. A provider shall maintain a record of all training, and annually furnish the Department with proof of attendance.
- G. A provider shall maintain a safe and clean home facility, including furnishings, equipment, supplies, materials, utensils, toys, and grounds, that meets the standards in this Article.
- H. At all times, a provider shall allow the Department access to all parts of the home facility. The Department shall make at least two onsite visits each year to each home facility and in-home provider. At least one visit shall be unannounced.
- I. A provider shall allow a parent or a designated representative access to the home facility at all times when the parent's child is present, and shall give parents and designated representatives written notice explaining this right.
- J. A provider shall directly supervise a visitor to the home facility while the visitor is in an area with a child in care.
- K. A provider shall not expose a child in care to tobacco products or smoke.
- L. A provider shall not care for a child while under the influence of alcoholic beverages, medication, or any other substance, that may or does impair the provider's ability to care for a child.
- M. A provider shall not consume alcoholic beverages while caring for a child.
- N. A provider shall not refuse to provide care to any child on the basis of color, sex, religion, disability, or national origin.
- O. If a provider is notified that a child or household member has a communicable disease, the provider shall ensure that a child who lacks written evidence of immunity to the communicable disease is not permitted to be present in the home facility until:
1. A parent provides written evidence of the child's immunity to the disease; or
 2. A local health department notifies the provider that the child may return to the home facility
- B. A provider shall demonstrate the continued physical, mental, and emotional health necessary to perform the duties and fulfill the responsibilities in this Article.
- C. Before recertification, a provider and designated individual backup provider shall furnish a self statement of physical and mental health and freedom from communicable diseases on a form furnished by the Department.
- D. The Department shall renew a certificate only after a provider demonstrates the intent and ability to provide child care that is safe, developmentally appropriate, and in compliance with the requirements of this Article.
- E. Unless the Department, in its sole discretion, accepts a provider's written assurance of future compliance with the requirements of this subsection, the Department shall deny recertification or take other enforcement action when the provider does not accept Department-referred children on three separate occasions unless the refusal is for:
1. Illness, accident, or incapacity of the provider;
 2. Illness, accident, or incapacity of any household member, if the existing condition will pose a risk to children in care, or limit the provider's ability to provide child care in accordance with the law;
 3. The provider is not equipped or trained to provide care to the referred child, and the provider cannot acquire the equipment or training without undue hardship;
 4. The provider has no available slots;
 5. The situations listed in R6-5-5222 and a backup provider is unavailable;
 6. A child has not been immunized, and the parent or guardian is unwilling to obtain appropriate immunization, in accordance with R6-5-5219(F); or
 7. The home facility is in temporary disrepair or under construction.
- F. The Department may obtain any supplemental information needed to determine continuing fitness to serve as a certified child care provider.
- G. A provider, all household members, and an individual backup provider shall cooperate with the Department in providing all information required for recertification.
- H. The Department shall determine whether to recertify a provider based on the provider's original application package, all previous monitoring reports, and all additional information the Department receives during the recertification process.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5208 renumbered to R6-5-5209; new Section R6-5-5208 renumbered from R6-5-5207 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5209. Program and Equipment

R6-5-5208. Recertification Requirements

- A. Before recertifying a provider, the Department shall interview the provider at the location where child care will be provided. The Department Representative may interview an in-home provider at the in-home provider's residence. The interview shall include a discussion and review of the provider's experiences in the provision of child care services during the current certification period.

- A. A provider shall offer a program that is developmentally appropriate for, and meets the needs of each child in care. The daily program and activity schedule shall include a balance of the following:
1. Indoor and outdoor activities;
 2. Activities that encourage movement and quiet time;
 3. Activities that encourage a child's creativity;
 4. Individual and group activities;
 5. Small and large muscle development activities; and
 6. Activities that include social interaction, problem solving, and negotiating skills.
- B. A provider shall incorporate into the program each child's daily routine activities, such as diapering, toileting, eating,

dressing, resting, and sleeping, in accordance with the developmental needs of each child.

- C. A provider shall develop a flexible, developmentally appropriate program that the provider can adjust to accommodate unanticipated events such as the illness of a child or changes in the weather.
- D. A provider shall have play equipment and materials sufficient to meet the program requirements described in subsections (A) through (C), and to ensure that all children in care can be occupied in developmentally appropriate play at the same time.
- E. A provider who cares for a child who is younger than age 2 shall have a variety of developmentally appropriate play equipment and supplies available for the child, such as:
 1. Touch boards;
 2. Soft puppets;
 3. Soft or plastic blocks;
 4. Simple musical instruments;
 5. Push-pull toys for beginning walkers;
 6. Picture and texture books;
 7. Developmentally appropriate art materials, including crayons, paints, finger paints, watercolors, and paper;
 8. Simple, 2-3 piece puzzles and peg boards; and
 9. Large beads to string or snap.
- F. A provider who cares for a child age 2 or older shall have a variety of developmentally appropriate play equipment and supplies available for the child, such as:
 1. Art supplies;
 2. Blocks and block accessories;
 3. Books and posters;
 4. Dramatic play areas with toys and dress-up clothes;
 5. Large muscle equipment;
 6. Manipulative toys;
 7. Science materials; and
 8. Musical instruments.
- G. A provider shall have a bed, cot, mat, crib, or playpen for each child in care who requires a daily nap or rest period. Each infant in care shall have a safe crib, port-a-crib, bassinet, or playpen.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5209 renumbered to R6-5-5210; new Section R6-5-5209 renumbered from R6-5-5208 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5210. Safety; Supervision

- A. When a provider is unavailable to care for a child for a reason described in R6-5-5222(B), the provider may use only the backup provider designated under R6-5-5202 or R6-5-5222(E).
- B. A provider shall give parents and guardians written notice of the provider's backup care plan.
- C. A provider shall not engage in activities that interfere with the ability to supervise and care for children, including other employment, and volunteer or recreational activities. An in-home provider shall not perform housekeeping duties unrelated to the care of the child.
- D. A provider shall directly supervise each child who is awake.
- E. A provider shall have unobstructed access to and shall be able to hear each child who is sleeping.
- F. A provider shall not permit a child in care to use a spa or hot tub.
- G. A provider shall have written permission from a parent or guardian before allowing a child to engage in water play. In this subsection, "water play" means any activity in which water is likely to get into a child's ears.
- H. A provider shall directly supervise any child who is in a pool area.
- I. A provider shall accompany a child who is using a public or semi-public swimming place.
- J. A provider shall have written permission from a child's parent or designated representative to bathe or shower the child, or to allow the child to bathe or shower independently.
- K. A provider shall not permit a child younger than age 6 to bathe or shower unsupervised.
- L. A provider shall report suspected child abuse or neglect to CPS or the local law enforcement department as required by A.R.S. § 13-3620.
- M. A provider shall use developmentally appropriate precautions to separate a child in care from hazardous areas, including locked doors and safe portable folding gates.
- N. A provider shall release a child only to the child's parent or to an adult who has been designated in writing by the parent.
- O. A provider shall not allow a person addicted to or under the influence of illegal drugs or alcohol in the home facility while children in care are present.
- P. A provider shall not permit a person who is abusive to children, or who uses unacceptable disciplinary methods as described in R6-5-5212, into the home facility when children in care are present.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Amended effective March 5, 1979 (Supp. 79-2). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5210 renumbered to R6-5-5211; new Section R6-5-5210 renumbered from R6-5-5209 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5211. Sanitation

- A. A provider and each child in care shall wash their hands with soap and running water after playing with animals or using the toilet, and before and after handling, serving, or eating food. If a child cannot reach a sink with running water, due to the child's age or some limiting condition, the provider shall clean that child's hands with an individual, clean, washcloth.
- B. A provider shall wash, in hot soapy water, and sanitize, all utensils used for eating, drinking, and food preparation.
- C. A provider shall have a garbage can with a close-fitting lid.
- D. A provider shall dispose of garbage in the home facility at least once a day.
- E. A provider shall empty and sanitize wading pools measuring 12 inches deep or less, after each use.
- F. A provider shall maintain, in a sanitary condition, a swimming pool or other area or container, which is more than 12 inches deep and used for water play.
- G. A provider shall frequently check the diaper of each child in care and shall immediately change a soiled diaper.
- H. A provider shall have sanitary arrangements for diaper changing and disposal of soiled diapers, including the following:
 1. The diaper changing area shall not be in an area where food is prepared or consumed;
 2. The diapering surface shall be cleaned, sanitized, and dried after each diaper change;
 3. Following bulk stool disposal into a toilet, soiled cloth diapers shall not be rinsed, but shall be bagged in plastic, individually labeled with child's name, stored in a covered container out of reach of children, and returned to the child's parent each day; and

4. Soiled disposable diapers shall be discarded in a tightly covered, lined container out of reach of children.
- I. Before and after each diaper change, a provider shall wash hands with soap and running water in a sink not used for food preparation.
- J. A provider shall sanitize a bathtub before bathing each child in care.

Historical Note

Adopted effective July 6, 1976 (Supp. 76-4). Section repealed, new Section adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5211 renumbered to R6-5-5212; new Section R6-5-5211 renumbered from R6-5-5210 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5212. Discipline

- A. A certified provider and all individual backup providers shall sign a written agreement to abide by the Department's policy on developmentally appropriate discipline.
- B. Only a provider may discipline a child in care;
- C. A provider may physically restrain a child whose behavior is uncontrolled, only when the physical restraint:
1. Is necessary to prevent harm to the child or others;
 2. Occurs simultaneously with the uncontrolled behavior;
 3. Does not impair the child's breathing; and
 4. Cannot harm the child.
- A provider shall use the minimum amount of restraint necessary to bring the child's behavior under control.
- D. A provider shall not use the following disciplinary measures:
1. Corporal punishment, including shaking, biting, hitting, or putting anything in a child's mouth;
 2. Placing a child in isolation or in a closet, laundry room, garage, shed, basement, or attic;
 3. Locking a child out of the home facility;
 4. Placing a child in any area where the provider cannot directly supervise the child;
 5. Methods detrimental to the health or emotional needs of a child;
 6. Administering medications;
 7. Mechanical restraints of any kind;
 8. Techniques intended to humiliate or frighten a child;
 9. Discipline associated with eating, sleeping, or toileting; or
 10. Abusive or profane language.
- E. As a disciplinary measure, a provider may place a child in time out. During the time out period, the provider shall keep the child in full view. Time out shall not be used for children less than age 3.
- F. A provider shall maintain consistent, reasonable rules that define acceptable behavior for a child in care.
- G. A provider shall use discipline only to teach acceptable behavior and to promote self-discipline, not for punishment or retribution.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5212 renumbered to R6-5-5213; new Section R6-5-5212 renumbered from R6-5-5211 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5213. Evening And Nighttime Care

- A. A provider who offers evening or nighttime care shall remain awake until each child in care is asleep.
- B. A provider who offers nighttime care shall have a safe and sturdy crib for each infant, and a safe and sturdy bed or cot with mattress for each child. Crib bars or slats shall be no more

than 2 3/8 inches apart, and the crib mattress shall fit snugly into the crib frame so that no space remains between the mattress and frame.

- C. A provider may allow siblings to share a bed only if the provider has received written parental permission.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5213 renumbered to R6-5-5214; new Section R6-5-5213 renumbered from R6-5-5212 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5214. Children Younger than Age 2

A provider who cares for a child younger than age 2 shall comply with the following requirements:

1. A provider shall frequently hold a child and give each infant and toddler physical contact and attention throughout the day.
2. A provider shall respond promptly to a child's distress signals and need for comfort.
3. A provider shall get written permission from a parent or guardian to give a child a bedtime or nap-time bottle. If the provider receives permission, the provider shall use only water in the bottles, unless otherwise directed by the child's physician.
4. A provider shall not confine a child in a crib, high chair, swing, or playpen, for more than one consecutive waking hour.
5. A provider shall not feed cereal by bottle, except with the written instruction of a physician.
6. A provider shall hold an infant younger than age 1 for any bottle feeding, and shall not prop bottles with a child in care.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5214 renumbered to R6-5-5215; new Section R6-5-5214 renumbered from R6-5-5213 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5215. Children with Special Needs

- A. When enrolling a child with special needs, a provider shall comply with the requirements of this Section:
1. A provider shall consult with parents to establish a mutually agreed upon plan regarding services for a child with special needs;
 2. A provider shall have the physical ability and appropriate training to provide the care required by a child with special needs;
 3. A provider shall use best efforts to integrate a child with special needs into the daily activities of the home facility in a manner that is the least restrictive, and that meets the child's individual needs;
 4. If a provider regularly cares for a child with special needs older than age 3 who requires diapering, the home facility shall have a diaper changing area that permits the child to have privacy. Proper sanitation shall be maintained as described in R6-5-5211.
- B. A provider shall make reasonable accommodations in the home facility, equipment, and materials for a child with special needs.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5215 renumbered to R6-5-5216; new Section R6-5-5215 renumbered from R6-5-5214 and amended by final rulemaking at 5 A.A.R. 1983, effective

May 20, 1999 (Supp. 99-2).

R6-5-5216. Transportation

- A. A provider shall obtain prior written permission from a child's parent before transporting a child in a privately owned vehicle or on public transportation.
- B. A provider shall ensure that a child in care is transported in a private vehicle by a person who has:
 1. A valid Arizona driver's license;
 2. Automobile insurance that meets the financial responsibility requirement of Arizona law; and
 3. No convictions for driving while intoxicated within three years before the date of transportation.
- C. A provider shall transport a child only in a mechanically safe vehicle. "Mechanically safe" means a vehicle with:
 1. Functioning brakes, signal lights, and headlights;
 2. Tires with tread; and
 3. Structural integrity.
- D. A provider shall not transport a child on a motorcycle or in a vehicle that is not constructed for the purpose of transporting people, such as a truck bed, camper, or any trailered attachment to a motor vehicle.
- E. A provider shall transport a child in a separate car seat, seat belt, or child-restraint device in compliance with A.R.S. § 28-907.
- F. A provider shall never leave a child unattended in a vehicle.
- G. A provider shall maintain first-aid supplies in a privately owned vehicle used to transport children in care.
- H. A provider shall carry a child's emergency-information card when transporting a child in care.
- I. A provider shall sign a form that states that the provider will abide by R6-5-5216.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5216 renumbered to R6-5-5217; new Section R6-5-5216 renumbered from R6-5-5215 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5217. Meals and Nutrition

- A. A provider shall serve a child in care wholesome and nutritious foods and beverages. In this Section, "wholesome and nutritious" means foods and beverages consistent with the requirements of 7 CFR 226.20 (January 1, 1998), which is incorporated by reference and available for inspection at the Department's Authority Library, 1789 West Jefferson, Phoenix, Arizona 85007 and in the office of the Secretary of State at 1700 West Washington, Phoenix, Arizona. The incorporated material contains no later amendments or editions.
- B. A provider shall supplement meals and snacks supplied by a parent when the supplied food does not provide a child with a wholesome and nutritious diet.
- C. A provider shall make available to a child in care meals and snacks that satisfy the child's appetite and dietary needs.
- D. A provider shall consult with a parent to identify, in writing, any special dietary needs or instructions for a child in care.
- E. A provider shall give a child any necessary assistance in feeding and shall teach self-feeding skills, but shall not force a child to eat.
- F. A provider shall monitor all perishable foods, including infant formulas and sack lunches. The provider shall ensure that food is individually labeled with a child's name, dated, covered, and properly stored to prevent spoilage, at temperatures of 45°F or less.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former

Section R6-5-5217 renumbered to R6-5-5218; new Section R6-5-5217 renumbered from R6-5-5216 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5218. Health Care; Medications

- A. When a provider enrolls a child for care, the provider shall make written arrangements with the child's parent for emergency medical care of the child.
- B. If a child becomes ill while in care, a provider shall:
 1. Make the child comfortable and keep the child in full view; and
 2. Notify the parent or other designated person that the child is ill and must be immediately removed from care.
- C. A provider shall notify the parent of other children in care when a child in care contracts an infectious illness.
- D. A provider shall not provide care while knowingly infected with or presenting symptoms of an infectious disease.
- E. If a child exhibits symptoms of an infectious disease, the child may return to care when fever free and symptom free, or with written permission from the child's medical practitioner that returning will not endanger the health of the child or other children in care.
- F. A provider shall not admit a child in need of professional medical attention to the home facility and shall direct the parent to obtain medical attention for the child.
- G. Only a provider shall administer medication with signed written instructions for administering the medication from the child's parent.
- H. A provider shall not administer:
 1. Medication that is date expired or in something other than its original container; or
 2. Prescription medication that does not bear the date of issue, the child's name, the amount and frequency of dosage, and the doctor's name.
- I. A provider shall maintain a written log of all medications administered. The log shall include:
 1. The name of the child receiving the medication;
 2. The name of the medication;
 3. The date and time of administration; and
 4. The dosage administered.
 A provider shall use a sanitary medication measure for accurate dosage.
- J. A provider shall keep all medication in a locked storage container, and refrigerate if necessary.
- K. A provider shall have first-aid supplies available at the home facility, which shall be administered only by the provider.
- L. A provider is responsible for obtaining only emergency medical treatment for a child in care.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5218 renumbered to R6-5-5219; new Section R6-5-5218 renumbered from R6-5-5217 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5219. Recordkeeping; Unusual incidents; Immunizations

- A. A provider shall maintain a daily attendance log on a Department-approved form and shall require that each child be signed in and out on the log by the parent or other individual designated in writing by the parent.
- B. On a form approved by the Department, a provider shall promptly log all accidents, injuries, behavior problems, or other unusual incidents at the home facility, including any suspected child abuse or neglect.

- C. A provider shall immediately report all unusual incidents to a parent or guardian of the child involved and shall report the incidents to the Department within 24 hours of the time of occurrence.
- D. A provider shall maintain records in accordance with the requirements of the provider's child care registration agreement. The provider shall make the following records readily available for inspection by the Department and shall keep them separate from household and other personal records:
1. Information listed in subsection (E);
 2. Immunization records identified in subsection (F) and R6-5-5202 (L);
 3. Documentary evidence of freedom from communicable tuberculosis as required by R6-5-5202 (M);
 4. The provider's certification, re-certification, and monitoring records;
 5. Health records of child care personnel;
 6. The provider's training records;
 7. Unusual incident reports; and
 8. Daily logs of attendance, accidents, injuries, medications administered, behavior problems, or other unusual incidents.
- E. A provider shall maintain at least the following information for each child in care:
1. The child's name, home address, telephone number, gender, and date of birth;
 2. The name, home and business addresses, and telephone numbers of the child's parent;
 3. The name, address and telephone number of the child's physician or health care provider and hospital;
 4. Authorization and instructions for emergency medical care when the parent cannot be located; and
 5. Written authorization to release a child to any individual other than the parent and the name, home and work addresses, and telephone numbers of that individual.
- F. A provider shall maintain an immunization record or exemption affidavit for each child in care.
1. Documentation required under this subsection is limited to:
 - a. An immunization record prepared by the child's health care provider stating that child has received current, age-appropriate immunizations specified in R9-6-701, including Immunizations for Diphtheria, homophiles influenza type b, Hepatitis B, Measles, Mumps, Pertusis, Poliomyelitis, Rubella, and Tetanus;
 - b. An affidavit signed by the child's health care provider stating that the child has a medical condition that causes the required immunizations to endanger the child's health; or
 - c. An affidavit signed by the child's parent stating that the child is being raised in a religion whose teachings oppose immunization.
 2. If a child has received all current immunizations but requires further inoculations to be fully immunized, the provider shall require the parent to verify that the parent will have the child complete all immunizations in accordance with the DHS recommended schedule identified in R9-6-701. The provider shall:
 - a. Require the parent to produce documented records from the child's health care provider of the immunizations as they are completed; and
 - b. Maintain the records as required by subsection (F)(1).
 3. The provider shall not permit a child in care to remain enrolled for more than 15 days if the parent does not pro-

vide proof of current, age-appropriate immunizations, a statement of timely completion of further inoculations, or exemption from immunization.

- G. Children exempted from immunizations for religious or medical reasons shall be excluded from the home facility if there is an outbreak of an immunizable disease at the home facility.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5219 renumbered to R6-5-52020; new Section R6-5-5219 renumbered from R6-5-5218 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5220. Provider/Child Ratios

- A. The Department may certify a provider in a home facility to care for a maximum of four children at a time, from birth through age 12, for compensation. A provider in a home facility may care for a maximum of six children at a time, from birth through age 12, or a child age 13 or older who is a child with special needs, when all of the following conditions are met:
1. No more than four children in care are for compensation; and
 2. No more than two of the children in care are younger than age 1, unless a sibling group.
- B. The Department may certify an in-home provider to provide the following care:
1. An in-home provider may care for a sibling group of no more than six children.
 2. An in-home provider shall care only for the children who live in that home.
 3. An in-home provider may bring the in-home provider's own children to the in-home location with the written permission of the client, and so long as the total number of children at the in-home location does not exceed six children.
- C. The Department may further limit the ratios allowed in subsections (A) and (B) to protect the well-being of children in care. The Department may impose additional restrictions when:
1. There are more than two children residing in the home facility who are counted in the ratio;
 2. The Department determines that the home facility and the furnishings are inadequate to accommodate four children at a time for compensation, as provided in Section R6-5-5203(6);
 3. The Department has determined that a provider is physically unable to care for four children at a time; for compensation or
 4. A provider requests certification for fewer than four children at a time for compensation.
- D. For the sole purpose of establishing and monitoring ratios, the Department shall not count any child who is age 13 or older, except as provided in subsection (A) for a child with special needs.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5220 renumbered to R6-5-5221; new Section R6-5-5220 renumbered from R6-5-5219 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5221. Change Reporting Requirements

At least 15 days before the effective date of any scheduled change, or within 24 hours after an unscheduled change, which significantly affects the provision of child care services, a provider shall furnish

the Department with written notice of the change. Significant changes include, but are not limited to:

1. Home remodeling;
2. Home repair;
3. Pool installation;
4. Relocating to a new residence;
5. Change in household composition;
6. Telephone number change;
7. Change of backup provider;
8. Voluntarily relinquishing the certificate; and
9. Any other change in the home facility or the provider's personal circumstances that affect the provider's ability to provide stable child care services.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5221 renumbered to R6-5-5222; new Section R6-5-5221 renumbered from R6-5-5220 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5222. Use of A Backup Provider

- A. A provider shall maintain a backup provider, and shall keep clients and the Department apprised of the backup provider's identity and location.
- B. A provider may use a backup provider only in the following circumstances:
 1. When the provider is ill;
 2. When the provider is attending to an emergency related to the provision of child care;
 3. When the provider has an emergency involving the provider or the provider's dependent family members;
 4. When the provider needs to attend a non-emergency appointment for the provider or the provider's dependent family members, and the provider cannot schedule the appointment outside of normal child care hours;
 5. When the provider is attending classes to meet training requirements listed in this Article; or
 6. When the provider is taking a vacation.
- C. At the time of enrollment of a child in care, a provider shall advise the parent of the possible use of a backup provider.
- D. A provider shall notify the Department within 24 hours of the onset of the use of a backup provider.
- E. When a provider designates a new backup provider, the provider shall ensure that the backup provider meets the requirements for backup providers in R6-5-5202.
- F. A provider shall execute a backup provider agreement form furnished by the Department, which identifies the backup provider and contains assurances that the backup provider will be used in accordance with the requirement of this Section.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5222 renumbered to R6-5-5223; new Section R6-5-5222 renumbered from R6-5-5221 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5223. Claims For Payment

- A. A provider shall submit claims for payment in the manner prescribed in the child care registration agreement with the Department.
- B. A provider shall make all financial arrangements with a backup provider. The Department shall not make direct payments to the backup provider.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5223 renumbered to R6-5-5224; new Sec-

tion R6-5-5223 renumbered from R6-5-5222 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5224. Complaints; Investigations

- A. Any person may register, with the Department, a written or verbal complaint about a provider or the operation of a home facility. Upon receipt of a complaint, or in response to the observations of Department staff, the Department shall investigate the allegations made and any matters related to certification and compliance with the child care registration agreement.
- B. A provider who is the subject of a complaint shall cooperate with the Department in conducting an investigation. The provider shall allow a Department representative to inspect the home facility and all records, and to interview any child care personnel, or household member.
- C. The Department shall maintain a file on all complaints against a provider and shall make information on valid complaints available to parents and to the general public upon request and as permitted by law.
- D. Following an investigation, the Department shall take appropriate administrative action as described in this Article.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5224 renumbered to R6-5-5225; new Section R6-5-5224 renumbered from R6-5-5223 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5225. Probation

- A. The Department may place a provider on probation when a Department representative observes a problem or the Department receives and validates a complaint in an area of noncompliance that does not endanger a child in care.
- B. The Department shall set a term of probation that does not exceed 30 days.
- C. The Department may suspend a provider's child care certificate if the same infraction that resulted in probation is repeated during a provider's current certification period and the Department determines that the provider has not demonstrated either the intent or ability to comply with the requirements of this Article.
- D. The Department shall not authorize any new child for payment to a provider who is on probation. Children already in that provider's care may remain authorized.
- E. Probationary status is not appealable.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5225 renumbered to R6-5-5226; new Section R6-5-5225 renumbered from R6-5-5224 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5226. Certification, Denial, Suspension, and Revocation

- A. The Department may deny, suspend, or revoke certification when:
 1. An applicant or provider violates or fails to comply with any statute or rule applicable to the provision of Child Care Services.
 2. An applicant or provider has a certificate or license to operate a child care home or facility denied, revoked, or suspended in any state or jurisdiction.
 3. An applicant or provider fails to disclose requested information or provides false or misleading information to the Department.

4. A provider's contract with the Department to furnish child care services expires or is terminated.
 5. Child care personnel fail or refuse to comply with or meet the requirements of A.R.S. § 41-1964.
 6. A provider fails or refuses to correct or repeats a violation that resulted in probation or suspension.
 7. The Department, through its CPS hotline, receives a report of alleged child maltreatment by an applicant, provider, or household member who is under investigation by CPS or a law enforcement agency or is being reviewed in a civil, criminal, or administrative hearing.
 8. An applicant or provider fails or refuses to cooperate with the Department in providing information required by these rules or any information necessary to determine compliance with these rules.
 9. An applicant, provider, or household member engages in any activity or circumstance that may threaten or adversely affect the health, safety, or welfare of children, including inadequate supervision or failure to protect from actual or potential harm.
 10. An applicant or provider is unable or unwilling to meet the physical, emotional, social, educational, or psychological needs of children.
 11. The Department, through its CPS hotline, receives a report of alleged child maltreatment in a home facility that is under investigation by CPS or a law enforcement agency or is being reviewed in a civil, criminal, or administrative proceeding.
 12. An applicant, provider, or household member is the subject of a substantiated or undetermined report of child maltreatment in any state or jurisdiction. Substantiated child maltreatment includes, but is not limited to, a probable cause finding by CPS or a law enforcement agency.
 13. CPS or a law enforcement agency substantiates a report of child maltreatment in a home facility.
- B.** In determining whether to take disciplinary action against a provider, or to grant or renew a certificate, the Department may evaluate the provider's history from other certification periods, both in Arizona and in other jurisdictions, and shall consider multiple violations of statutes or rules applicable to the provision of child care services as evidence that the applicant or provider is unable or unwilling to meet the needs of children.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Former Section R6-5-5226 repealed; new Section renumbered from R6-5-5225 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5227. Adverse Action; Notice Effective Date

- A.** When the Department denies, suspends, or revokes certification, it shall mail a written, dated notice of the adverse action to the applicant or the provider at the applicant's or provider's last known address.
- B.** A notice of adverse action shall specify:
 1. The adverse action taken and date the action will be effective;
 2. The reasons supporting the adverse action; and
 3. The procedures by which the applicant or provider may contest the action taken and the time period in which to do so.
- C.** Except as provided in subsection (D), a revocation, suspension, or denial of recertification is effective 20 calendar days from the date on the notice or letter advising the provider of the adverse action.

- D.** A suspension, revocation, or denial of recertification is effective on the date of the notice or letter advising the person of the adverse action if:
 1. The adverse action is based on the failure of child care personnel to comply with or meet the requirements of A.R.S. § 41-1964; or
 2. The Department bases the adverse action on a determination that the health, safety, or welfare of a child in care is in jeopardy.
- E.** The Department shall stop payment authorization for all subsidized children in care on the effective date of a suspension, revocation, or denial of recertification.
- F.** The Department shall not authorize the referral of additional children to a provider after mailing a notice of adverse action to the provider's last known address.

Historical Note

Adopted effective May 11, 1994 (Supp. 94-2). Amended effective June 4, 1998 (Supp. 98-2). Former Section R6-5-5227 renumbered to R6-5-5228 and new Section adopted by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

R6-5-5228. Appeals

- A.** An applicant or provider may appeal the following Department decisions:
 1. Denial of certification or re-certification;
 2. Suspension of a certificate; and
 3. Revocation of a certificate.
- B.** A person who wishes to appeal an adverse action shall file a written request for a hearing with the Department within 15 calendar days of the date on the notice or letter advising the provider of the adverse action.
- C.** The Department shall conduct a hearing as prescribed in 6 A.A.C. 5, Article 75. Decisions based on failure to clear a fingerprint check or criminal history check are not appealable under this Article.
- D.** Matters relating to contractual agreements with the Department, including payment rates and amounts, are not appealable under this Article.
- E.** When an adverse action based on R6-5-5226(A)(7) is appealed under this Article, allegations of child maltreatment are not at issue and shall not be adjudicated in an administrative proceeding conducted under subsection (C).

Historical Note

New Section R6-5-5228 renumbered from R6-5-5227 and amended by final rulemaking at 5 A.A.R. 1983, effective May 20, 1999 (Supp. 99-2).

ARTICLE 53. REPEALED

Former Article 53 consisting of Sections R6-5-5301 through R6-5-5305 repealed effective April 9, 1981.

ARTICLE 54. REPEALED

Former Article 54 consisting of Sections R6-5-5401 through R6-5-5411 repealed effective November 8, 1982.

ARTICLE 55. CHILD PROTECTIVE SERVICES**R6-5-5501. Definitions**

The definitions in A.R.S. §§ 8-531, 8-201, and 8-801, and the following definitions apply in this Article:

1. "Abandonment" has the same meaning ascribed to "abandoned" in A.R.S. § 8-201(1).
2. "Abuse" means the same as A.R.S. § 8-201(2).
3. "Aggravating factor" means a specific circumstance that increases the risk of harm to a child and may result in a shorter investigation response time.

41-1954. Powers and duties

A. In addition to the powers and duties of the agencies listed in section 41-1953, subsection E, the department shall:

1. Administer the following services:

(a) Employment services, including manpower programs and work training, field operations, technical services, unemployment compensation, community work and training and other related functions in furtherance of programs under the social security act, as amended, the Wagner-Peyser act, as amended, the federal unemployment tax act, as amended, 33 United States Code, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(b) Individual and family services, which shall include a section on aging, services to children, youth and adults and other related functions in furtherance of social service programs under the social security act, as amended, title IV, except parts B and E, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services, the older Americans act, as amended, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(c) Income maintenance services, including categorical assistance programs, special services unit, child support collection services, establishment of paternity services, maintenance and operation of a state case registry of child support orders, a state directory of new hires, a support payment clearinghouse and other related functions in furtherance of programs under the social security act, title IV, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services, as amended, and other related federal acts and titles.

(d) Rehabilitation services, including vocational rehabilitation services and sections for the blind and visually impaired, communication disorders, correctional rehabilitation and other related functions in furtherance of programs under the vocational rehabilitation act, as amended, the Randolph-Sheppard act, as amended, and other related federal acts and titles.

(e) Administrative services, including the coordination of program evaluation and research, interagency program coordination and in-service training, planning, grants, development and management, information, legislative liaison, budget, licensing and other related functions.

(f) Manpower planning, including a state manpower planning council for the purposes of the federal-state-local cooperative manpower planning system and other related functions in furtherance of programs under the comprehensive employment and training act of 1973, as amended, and other related federal acts and titles.

(g) Economic opportunity services, including the furtherance of programs prescribed under the economic opportunity act of 1967, as amended, and other related federal acts and titles.

(h) Intellectual disability and other developmental disability programs, with emphasis on referral and purchase of services. The program shall include educational, rehabilitation, treatment and training services and other related functions in furtherance of programs under the developmental disabilities services and facilities construction act, Public Law 91-517, and other related federal acts and titles.

(i) Nonmedical home and community based services and functions, including department designated case management, housekeeping services, chore services, home health aid, personal care, visiting nurse services, adult day care or adult day health, respite sitter care, attendant care, home delivered meals and other related services and functions.

2. Provide a coordinated system of initial intake, screening, evaluation and referral of persons served by the department.

3. Adopt rules it deems necessary or desirable to further the objectives and programs of the department.

4. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

5. Employ and determine the conditions of employment and prescribe the duties and powers of administrative, professional, technical, secretarial, clerical and other persons subject to chapter 4, article 4 and, as applicable, article 5 of this title as may be necessary in the performance of its duties, contract for the services of outside advisors, consultants and aides as may be reasonably necessary and reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business.

6. Make contracts and incur obligations within the general scope of its activities and operations subject to the availability of funds.

7. Contract with or assist other departments, agencies and institutions of the state, local and federal governments in the furtherance of its purposes, objectives and programs.

8. Be designated as the single state agency for the purposes of administering and in furtherance of each federally supported state plan.

9. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.

10. Provide information and advice on request by local, state and federal agencies and by private citizens, business enterprises and community organizations on matters within the scope of its duties subject to the departmental rules on the confidentiality of information.

11. Establish and maintain separate financial accounts as required by federal law or regulations.

12. Advise and make recommendations to the governor and the legislature on all matters concerning its objectives.

13. Have an official seal that shall be judicially noticed.

14. Annually estimate the current year's population of each county, city and town in this state, using the periodic census conducted by the United States department of commerce, or its successor agency, as the basis for such estimates and deliver such estimates to the economic estimates commission before December 15.

15. Estimate the population of any newly annexed areas of a political subdivision as of July 1 of the fiscal year in which the annexation occurs and deliver such estimates as promptly as is feasible after the annexation occurs to the economic estimates commission.

16. Establish and maintain a statewide program of services for persons who are both hearing impaired and visually impaired and coordinate appropriate services with other agencies and organizations to avoid duplication of these services and to increase efficiency. The department of economic security shall enter into agreements for the utilization of the personnel and facilities of the department of economic security, the department of health services and other appropriate agencies and organizations in providing these services.

17. Establish and charge fees for deposit in the department of economic security prelayoff assistance services fund to employers who voluntarily participate in the services of the department that provide job service and retraining for persons who have been or are about to be laid off from employment. The department shall charge only those fees necessary to cover the costs of administering the job service and retraining services.

18. Establish a focal point for addressing the issue of hunger in Arizona and provide coordination and assistance to public and private nonprofit organizations that aid hungry persons and families throughout this state. Specifically such activities shall include:

(a) Collecting and disseminating information regarding the location and availability of surplus food for distribution to needy persons, the availability of surplus food for donation to charity food bank organizations, and the needs of charity food bank organizations for surplus food.

(b) Coordinating the activities of federal, state, local and private nonprofit organizations that provide food assistance to the hungry.

(c) Accepting and disbursing federal monies, and any state monies appropriated by the legislature, to private nonprofit organizations in support of the collection, receipt, handling, storage and distribution of donated or surplus food items.

(d) Providing technical assistance to private nonprofit organizations that provide or intend to provide services to the hungry.

(e) Developing a state plan on hunger that, at a minimum, identifies the magnitude of the hunger problem in this state, the characteristics of the population in need, the availability and location of charity food banks and the potential sources of surplus food, assesses the effectiveness of the donated food collection and distribution network and other efforts to alleviate the hunger problem, and recommends goals and strategies to improve the status of the hungry. The state plan on hunger shall be incorporated into the department's state comprehensive plan prepared pursuant to section 41-1956.

(f) Establishing a special purpose advisory council on hunger pursuant to section 41-1981.

19. Establish an office to address the issue of homelessness and to provide coordination and assistance to public and private nonprofit organizations that prevent homelessness or aid homeless individuals and families throughout this state. These activities shall include:

(a) Promoting and participating in planning for the prevention of homelessness and the development of services to homeless persons.

(b) Identifying and developing strategies for resolving barriers in state agency service delivery systems that inhibit the provision and coordination of appropriate services to homeless persons and persons in danger of being homeless.

(c) Assisting in the coordination of the activities of federal, state and local governments and the private sector that prevent homelessness or provide assistance to homeless people.

(d) Assisting in obtaining and increasing funding from all appropriate sources to prevent homelessness or assist in alleviating homelessness.

(e) Serving as a clearinghouse on information regarding funding and services available to assist homeless persons and persons in danger of being homeless.

(f) Developing an annual state comprehensive homeless assistance plan to prevent and alleviate homelessness.

(g) Submitting an annual report to the governor, the president of the senate and the speaker of the house of representatives on the status of homelessness and efforts to prevent and alleviate homelessness.

20. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.

21. Exchange information, including case specific information, and cooperate with the department of child safety for the administration of the department of child safety's programs.

B. If the department of economic security has responsibility for the care, custody or control of a child or is paying the cost of care for a child, it may serve as representative payee to receive and administer social security and United States department of veterans affairs benefits and other benefits payable to such child. Notwithstanding any law to the contrary, the department of economic security:

1. Shall deposit, pursuant to sections 35-146 and 35-147, such monies as it receives to be retained separate and apart from the state general fund on the books of the department of administration.

2. May use such monies to defray the cost of care and services expended by the department of economic security for the benefit, welfare and best interests of the child and invest any of the monies that the director determines are not necessary for immediate use.

3. Shall maintain separate records to account for the receipt, investment and disposition of funds received for each child.

4. On termination of the department of economic security's responsibility for the child, shall release any funds remaining to the child's credit in accordance with the requirements of the funding source or in the absence of such requirements shall release the remaining funds to:

(a) The child, if the child is at least eighteen years of age or is emancipated.

(b) The person responsible for the child if the child is a minor and not emancipated.

C. Subsection B of this section does not pertain to benefits payable to or for the benefit of a child receiving services under title 36.

D. Volunteers reimbursed for expenses pursuant to subsection A, paragraph 5 of this section are not eligible for workers' compensation under title 23, chapter 6.

E. In implementing the temporary assistance for needy families program pursuant to Public Law 104-193, the department shall provide for cash assistance to two parent families if both parents are able to work only on documented participation by both parents in work activities described in title 46, chapter 2, article 5, except that payments may be made to families who do not meet the participation requirements if:

1. It is determined on an individual case basis that they have emergency needs.

2. The family is determined to be eligible for diversion from long-term cash assistance pursuant to title 46, chapter 2, article 5.

F. The department shall provide for cash assistance under temporary assistance for needy families pursuant to Public Law 104-193 to two parent families for no longer than six months if both parents are able to work, except that additional assistance may be provided on an individual case basis to families with extraordinary circumstances. The department shall establish by rule the criteria to be used to determine eligibility for additional cash assistance.

G. The department shall adopt the following discount medical payment system for persons who the department determines are eligible and who are receiving rehabilitation services pursuant to subsection A, paragraph 1, subdivision (c) of this section:

1. For inpatient hospital admissions and outpatient hospital services the department shall reimburse a hospital according to the rates established by the Arizona health care cost containment system administration pursuant to section 36-2903.01, subsection G.

2. The department's liability for a hospital claim under this subsection is subject to availability of funds.

3. A hospital bill is considered received for purposes of paragraph 5 of this subsection on initial receipt of the legible, error-free claim form by the department if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

4. The department shall require that the hospital pursue other third-party payors before submitting a claim to the department. Payment received by a hospital from the department pursuant to this subsection is considered payment by the department of the department's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third party payors or in situations covered by title 33, chapter 7, article 3.

5. For inpatient hospital admissions and outpatient hospital services rendered on and after October 1, 1997, if the department receives the claim directly from the hospital, the department shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the department shall pay ninety-nine per cent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the department shall pay one hundred per cent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the department shall pay one hundred per cent of the rate plus a fee of one per cent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. For medical services other than those for which a rate has been established pursuant to section 36-2903.01, subsection G, the department shall pay according to the Arizona health care cost containment system capped fee-for-service schedule adopted pursuant to section 36-2904, subsection K or any other established fee schedule the department determines reasonable.

H. The department shall not pay claims for services pursuant to this section that are submitted more than nine months after the date of service for which the payment is claimed.

I. To assist in the location of persons or assets for the purpose of establishing paternity, establishing, modifying or enforcing child support obligations and other related functions, the department has access, including automated access if the records are maintained in an automated database, to records of state and local government agencies, including:

1. Vital statistics, including records of marriage, birth and divorce.

2. State and local tax and revenue records, including information on residence address, employer, income and assets.

3. Records concerning real and titled personal property.

4. Records of occupational and professional licenses.

5. Records concerning the ownership and control of corporations, partnerships and other business entities.

6. Employment security records.

7. Records of agencies administering public assistance programs.

8. Records of the motor vehicle division of the department of transportation.

9. Records of the state department of corrections.

10. Any system used by a state agency to locate a person for motor vehicle or law enforcement purposes, including access to information contained in the Arizona criminal justice information system.

J. Notwithstanding subsection I of this section, the department or its agents shall not seek or obtain information on the assets of an individual unless paternity is presumed pursuant to section 25-814 or established.

K. Access to records of the department of revenue pursuant to subsection I of this section shall be provided in accordance with section 42-2003.

L. The department also has access to certain records held by private entities with respect to child support obligors or obligees, or individuals against whom such an obligation is sought. The information shall be obtained as follows:

1. In response to a child support subpoena issued by the department pursuant to section 25-520, the names and addresses of these persons and the names and addresses of the employers of these persons, as appearing in customer records of public utilities and cable television companies.

2. Information on these persons held by financial institutions.

M. Pursuant to department rules, the department may compromise or settle any support debt owed to the department if the director or an authorized agent determines that it is in the best interest of the state and after considering each of the following factors:

1. The obligor's financial resources.

2. The cost of further enforcement action.

3. The likelihood of recovering the full amount of the debt.

N. Notwithstanding any law to the contrary, a state or local governmental agency or private entity is not subject to civil liability for the disclosure of information made in good faith to the department pursuant to this section.

46-809. Rules

The department shall adopt rules it deems reasonable or necessary to implement child care services and to further the objectives of this article. Rules adopted by the department shall include:

1. Criteria for making child care assistance eligibility determinations.

2. Criteria for certifying child care home and in-home providers.

3. Criteria for operating child care resource and referral services and for suspending and terminating referrals to participating child care providers pursuant to section 41-1967.

F-1

ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY (F-16-0608)

Title 18, Chapter 14, Articles 1, Water Quality Protection Fees; Article 2, Public Water System
Design Review Fees



**GOVERNOR'S REGULATORY REVIEW COUNCIL
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

MEETING DATE: October 4, 2016

AGENDA ITEM: F-1

TO: Members of the Governor's Regulatory Review Council ("Council")
FROM: Marcus McGillivray, Legal Intern
DATE : September 16, 2016
SUBJECT: ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY (F-16-0608)
Title 18, Chapter 14, Article 1, Water Quality Protection Fees; Article 2, Public
Water System Design Review Fees

COMMENTS ON THE FIVE-YEAR-REVIEW REPORT

Purpose of the Department and Number of Rules in the Report

This five-year-review report from the Arizona Department of Environmental Quality (Department) covers 16 rules in A.A.C. Title 18, Chapter 14. Articles 1-2, related to water quality protection fees and water system design review fees.

Article 1, related to water quality protection fees, contains twelve rules that lists various fees for APPs (Aquifer Protection Permits), Reclaimed Water Permits, AZPDES (Arizona Pollutant Discharge Elimination System), dry well permits, reclaimed water permits, and water protection service fees. The rules also expand on the implementation and collection of those fees, and the requirements and methods by which a bill can be reconsidered or appealed.

Article 2, related to the fees associated the Department's mandatory review and approval of public water system designs, contains three rules regarding fees which must be paid for these design reviews and approvals. These rules were last amended prior to July 29th, 2010.

Proposed Action

The Department plans significant rule amendments by December 2018:

1. R18-14-103: The Department wishes to abolish the initial fee requirement.
2. R18-14-106: The Department wishes to amend this rule as the invoice review process may contradict the appeal process set forth in 18 A.A.C. 1, Article 2.

3. R18-14-108: The Department wishes to amend this rule to set the fees proportionately to the amount of work completed by the Department.
4. R18-14-109: The Department wishes to change this fee to reflect the Department's level of effort regarding the water quality protection services.
5. R18-14-111: The Department wishes to amend this rule to allow expedited subdivision review.
6. R18-14-112: The Department proposes to appeal this rule after it amends rules in 18 A.A.C.

Analysis of the Department's report pursuant to criteria in A.R.S. § 41-1056 and R1-6-301:

1. Has the Department certified that it is in compliance with A.R.S. § 41-1091?

Yes, the cover letter has certified compliance with A.R.S. § 41-1091 and has provided contact information for the Department's representative.

2. Has the Department analyzed the rules' effectiveness in achieving their objectives?

Yes. The objectives of these rules are to establish hourly, initial, maximum, flat, and application fees related to APPs, AZPDES, dry wells, water quality protection services, and public water system design reviews. The Department indicates that the rules are effective in achieving their objectives.

3. Has the Department received any written criticisms of the rules during the last five years, including any written analysis questioning whether the rules are based on valid scientific or reliable principles or methods?

Yes. The Department received written criticism regarding R18-14-109. The criticism, received from an engineering firm on behalf of a potential client, said that the flat fee for the Multi-Sector General Permit Certificate of No Exposure is costly as an initial fee. The Department states that this particular fee is collected for a five-year duration while most other fees are collected annually, and that is what makes it seem costly. The Department has proposed a rulemaking for December 2018.

4. Has the Department analyzed whether the rules are authorized by statute?

Yes. ADEQ has both general and specific statutory authority to issue these rules, permits, and fees. A.R.S. § 49-104(B)(11) and (B)(13)(c), authorizes the department to make reasonable rules related to water supply and sewage disposal in subdivisions, and require documentation and fees for water system designs. A.R.S. § 49-203(A)(8) authorizes the Department to assess and collect fees related to water quality services and permits such as but not limited to, APPs and AZPDES. A.R.S. § 49-332 establishes authority to regulate the registration of dry wells that are or have been used for disposal and to charge fees associated with the registration. A.R.S. § 49-241.02 Authorizes the director to establish various fees and collection methods for those fees for Aquifer Protection Permits, Individual, or Wide Area Permits and modification to those permits. A.R.S. § 49-255.01(J) establishes the authority for implementing fees regarding AZPDES.

5. **Has the Department analyzed the rules' consistency with other rules and statutes?**

Yes. The Department indicates that the rules are consistent with state statutes and rules, and that there are no corresponding federal programs that apply to Article One or Two.

6. **Has the Department analyzed the current enforcement status of the rules?**

Yes. The Department enforces these rules by assessing and collecting fees for various water related permits, water quality protection services, and public water system design reviews. However, R18-14-101 and R18-14-201 are definitions, and are not enforced themselves, although they are used as a tool to enforce the other rules of these articles. Moreover, R18-14-107 does not need to be enforced because it simply stipulates that stakeholders may be subjected to fees issued by other counties.

7. **Has the Department analyzed whether the rules are clear, concise, and understandable?**

Yes. The rules are clear, concise, and understandable.

8. **Has the Department analyzed whether:**

a. **The rules are more stringent than corresponding federal law?**

No. There is no corresponding federal law.

b. **There is statutory authority to exceed the requirements of federal law?**

Not applicable.

9. **For rules adopted after July 29, 2010, has the Department analyzed whether:**

The rules were adopted after July 29, 2010

a. **The rules require issuance of a regulatory permit, license or Department authorization?**

Not applicable. Although these rules are regarding permits, they solely authorize and set forth various fees. The Department's authority to issue permits is found elsewhere.

b. **It is in compliance with the general permit requirements of A.R.S. § 41-1037 or explained why it believes an exception applies?**

Not applicable.

10. Has the Department indicated whether it completed the course of action identified in the previous five-year-review report?

No previous proposed course of action. The Department, under the authority of House Bill 2767, proposed to raise the fees for APPs and their annual registrations, dry well registrations, and establish fees for the AZPDES program. The rules were amended in July 2011 to reflect these courses of action.

11. Has the Department included a proposed course of action?

The Department proposes to amend six of the rules. The Department is projecting that these rulemakings will be made by December 2018.

Conclusion

This report meets the requirements of A.R.S. § 41-1056 and R1-6-301. This analyst recommends approval of the report.



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: F-1

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: GRRC Economic Team

DATE : September 16, 2016

SUBJECT: **ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY (F-16-0608)**
Title 18, Chapter 14, Article 1, Water Quality Protection Fees; Article 2, Public Water System Design Review Fees

I reviewed the five-year-review report's economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments.

1. Economic Impact Comparison

The economic, small business, and consumer impact statement (EIS) from the most recent rulemaking was available for all of the rules contained in the five-year-review report. The rules in Article 1 address the definitions and other provisions related to the water quality protection fees. Rules that received criticism included R18-14-108 and R18-14-109. Article 2 addresses the public water system design review fees.

Fees were last increased in 2011 for the Article 1 rules and in 2008 for the Article 2 rules. The Department indicates that the impact of the rules on the state's economy, small business and consumers has not changed since the effective date.

Under Section 113, the Department prepares an annual accounting of the water quality fee fund (WQFF) revenue and expenditure for the prior fiscal year. The Department has reported the following information:

Fiscal Year	Total Revenues	Total Expenditures	Number of FTEs on WQFF
FY 2012	\$7,861,400	\$6,232,800	53.1
FY 2013	\$6,474,900	\$5,196,600	95.2
FY 2014	\$7,811,400	\$6,535,100	92.1
FY 2015	\$6,892,300	\$5,789,200	57.32.

The Department also reports revenues on public water system design review fees:

Fiscal Year	Total Revenues
FY 2012	\$326,100
FY 2013	\$305,200
FY 2014	\$276,100
FY 2015	\$312,500

2. Has the agency determined that the rules impose the least burden and costs to persons regulated by the rules?

The Department reports that they have determined that the rules impose the least burden and costs to regulated persons, including paperwork and other compliance costs, while still achieving the underlying regulatory and statutory objective.

3. Was an analysis submitted to the agency under A.R.S. § 41-1056(A)(7)?

No analysis was submitted to the agency by another person that compares the rules' impact on this state's business competitiveness to the impact on businesses in other states.

4. Conclusion

After review, staff concludes that the report complies with A.R.S. § 41-1056 and recommends approval.



Douglas A. Ducey
Governor

ARIZONA DEPARTMENT OF ENVIRONMENTAL QUALITY



Misael Cabrera
Director

April 7, 2016

Ms. Nicole A. Ong, Chair
Governor's Regulatory Review Council
100 N. 15th Avenue, Suite 402
Phoenix, AZ 85007

Re: Title 18, Chapter 14, Articles 1 and 2

Dear Ms. Ong:

The Arizona Department of Environmental Quality (ADEQ) has reviewed Title 18, Chapter 14, Articles 1 and 2 pursuant to A.R.S. § 41-1056 and the Governor's Regulatory Review Council's five-year review schedule. Enclosed is a report of ADEQ's findings, proposed courses of action and reasons, and justifications. As ADEQ reviews and establishes its rulemaking priorities, it proposes to revise certain rules as agency priorities allow, as detailed in this Report.

I certify that this agency is in compliance with A.R.S. § 41-1091.

You may contact Wendy LeStarge with questions on the report at (602) 771-4836 or e-mail at w11@azdeq.gov.

Sincerely,

Misael Cabrera
Director

Enclosures: Five-Year Review Report

FIVE-YEAR REVIEW REPORT
TITLE 18. ENVIRONMENTAL QUALITY
CHAPTER 14. DEPARTMENT OF ENVIRONMENTAL QUALITY
PERMITS AND COMPLIANCE FEES
ARTICLE 1. WATER QUALITY PROTECTION FEES
ARTICLE 2. PUBLIC WATER SYSTEM DESIGN REVIEW FEES

ARTICLE 1. WATER QUALITY PROTECTION FEES

I. Information That Is Identical For Rules (unless noted differently in the Section-by-Section Analysis of Rules)

1. Authorization of rules by existing statutes:

A.R.S. §§ 49-104(B)(11), (B)(13)(c), 49-203(A)(8), 49-241.02, 49-255.01(J), and 49-332

2. Objective of the rules:

Article 1 establishes fees for the Aquifer Protection Permit (APP) program, Arizona Pollutant Discharge Elimination System (AZPDES) program, reclaimed water permits, and other water quality protection services.

4. Consistency of the rules with state and federal statutes and rules:

These rules are consistent with state statutes and rules. ADEQ uses the following statutes and rules to determine that the rules are consistent: A.R.S. §§ 49-104(B)(11), (B)(13)(c), 49-203(A)(8), 49-241.02, 49-242, 49-255.01(J), and 49-332; 18 A.A.C. Chapter 9, Articles 1-4, 6-7, and 9-10; and R18-1-501. No corresponding federal programs apply to Article 1.

5. Status of Agency enforcement policy regarding the rule:

ADEQ assesses the fees established in these rules when conducting reviews of an APP, AZPDES, or reclaimed water individual or general permit, or other water quality protection services.

6. Analysis of clarity, conciseness, and understandability:

ADEQ believes that the rules are clear, concise, and understandable.

7. Written criticisms of the rules received within the last five years:

ADEQ has not received any written criticisms on the rules within the past five years, unless stated otherwise in the Section-By-Section Analysis.

8. Current Economic, small business, and consumer impact of the rules as compared to EIS at last rule adoption:

ADEQ amended most of 18 A.A.C. 14, Article 1 in 2011 and described probable economic impacts in qualitative and quantitative terms in the economic impact statement. At that time, ADEQ believed that most applicants would experience an increase in their permitting fees as ADEQ implemented a fee structure: 1) sufficient to support the water quality permitting program in the absence of the General Fund, and 2) representative of the actual cost of providing the service, from development through issuance and managing the permit once in effect. ADEQ believes that the impact of the Article 1 rules on the state's economy, small business and consumers has not changed since the effective date.

Under R18-14-113, ADEQ prepares an annual accounting of the water quality fee fund revenue and expenditure for the prior fiscal year. ADEQ has reported the following information:

- Fiscal Year 2012: Total revenues - \$7,861,400; Total expenditures - \$6,232,800; Number of FTEs on WQFF – 53.1
- Fiscal Year 2013: Total revenues - \$6,474,900; Total expenditures - \$5,196,600; Number of FTEs on WQFF – 95.2
- Fiscal Year 2014: Total revenues - \$7,811,400; Total expenditures - \$6,535,100; Number of FTEs on WQFF – 92.1
- Fiscal Year 2015: Total revenues - \$6,892,300; Total expenditures - \$5,789,200; Number of FTEs on WQFF – 57.32.

9. Any analysis submitted to ADEQ by another person that compares the rules' impact on Arizona's business competitiveness to the impact on businesses in other states:

ADEQ has not received any analysis submitted by another person that compares the rules' impact on Arizona's business competitiveness to the impact on businesses in other states.

10. Completion of previous proposed courses of action:

On April 5, 2011, Council approved ADEQ's Notice of Final Rulemaking on the Article 1 rules and approved the Five Year Review Report on the previous version of these rules at the same meeting.

11. A determination that the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

ADEQ believes that these rules impose the least burden and costs to regulated persons, including paperwork and other compliance costs, while still achieving the underlying regulatory and statutory objective.

12. Stringency Compared to Corresponding Federal Law:

No corresponding federal programs apply to Article 1.

13. Compliance with A.R.S. § 41-1037:

These rules were amended after July 29, 2010. The rules comply with A.R.S. § 41-1037 as they govern the procedures and establish the amounts of fees for individual permit applications, and flat fee rates for general permits or other types of water quality protection services that are substantially similar in nature, where such permits are authorized by the underlying permit rules.

14. Proposed course of action:

No amendments are proposed, unless noted specifically in the Section-by-Section Analysis.

II. Section-by-Section Analysis of Rules

R18-14-101. Definitions

2. Objective of the rules:

The definition section defines important terms used in Article 1, so that the rules are understandable to the general public.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively defines important terms used in the rules.

5. Status of Agency enforcement policy regarding the rule:

Definitions are not enforceable but are used in enforcement of the rules.

R18-14-102. Hourly Rate and Maximum Fees for Water Quality Protection Services

2. Objective of the rules:

This rule establishes an hourly rate fee for reviews of individual APPs, amendments to APPs, clean closure of a facility with an APP, AZPDES individual and individual reclaimed water permits. The hourly rate applies unless a flat fee is prescribed elsewhere.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively provides the information necessary to determine hourly and maximum fees.

5. Status of Agency enforcement policy regarding the rule:

ADEQ assesses the fees established in this rule when conducting reviews of an APP, AZPDES or reclaimed water individual permit, or other water quality protection services.

R18-14-103. Initial Fees

2. Objective of the rules:

This rule establishes initial fees to be paid at the time a person submits a request for a water quality protection service to ADEQ. This rule specifies that up-front fees must be paid before ADEQ can begin to process an application associated with specific water quality permits subject to the hourly rate. ADEQ may set lower initial fees.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively informs applicants that certain permits require initial fees before ADEQ can begin to process an application.

5. Status of Agency enforcement policy regarding the rule:

ADEQ assesses the initial fee before processing an application associated with specific water quality permits subject to the hourly rate.

14. Proposed course of action:

ADEQ evaluated its rules in accordance with Executive Order 2015-01, Paragraph 5. In its evaluation submitted to the Office of the Governor, ADEQ proposed to repeal this rule as limiting flexibility of payment and efficiency of processing. ADEQ proposes to amend this rule in order to repeal the initial fee requirement but retain the language in subsection (C). As ADEQ reviews and establishes its rulemaking priorities, and pending the status of the rule moratorium, ADEQ anticipates submitting a rulemaking to the Council by December 2018. Additionally, ADEQ must ensure that a future rulemaking complies with the qualification on fee increases in A.R.S. §§ 49-241.02(A), 49-255.01(J), and 49-332(A).

R18-14-104. Annual Fees for Water Quality Protection Services Subject to Hourly Rate Fee

2. Objective of the rules:

This rule establishes the annual registration fees for individual APPs, and annual fees for individual AZPDES permits, approved pretreatment programs, and individual reclaimed water permits.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively establishes the amount of an annual fee, depending on the type of permit and relative to the size of the permitted facility.

R18-14-105. Fee Assessment and Collection

2. Objective of the rules:

This rule explains that ADEQ charges for the hours or portions of hours that ADEQ staff spend to review a request for water quality protection services, and the hours spent by a supervisor or unit manager if requested by the applicant.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively establishes criteria for periodic and final billing.

5. Status of Agency enforcement policy regarding the rule:

ADEQ follows these procedures when assessing and collecting fees from an applicant for an application associated with specific water quality permits subject to the hourly rate.

R18-14-106. Reconsideration of a Bill; Appeal Process

2. Objective of the rules:

This rule establishes the requirements for reconsideration of a bill and provides the specifics on an appeal process. The request must be submitted to ADEQ by the due date for payment printed on the bill or within 35 days of the date for the invoice, whichever is greater.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively establishes and explains the process for requesting ADEQ's reconsideration of fees.

14. Proposed course of action:

ADEQ evaluated its rules in accordance with Executive Order 2015-01, Paragraph 5. In its evaluation submitted to the Office of the Governor, ADEQ proposed to amend this rule as the invoice review process may contradict with the appeal process in 18 A.A.C. 1, Article 2. As ADEQ reviews and establishes its rulemaking priorities, and pending the status of the rule moratorium, ADEQ anticipates submitting a rulemaking to the Council by December 2018. Additionally, ADEQ must ensure that a future rulemaking complies with the qualification on fee increases in A.R.S. §§ 49-241.02(A), 49-255.01(J), and 49-332(A).

R18-14-107. Effect on County Fees

2. Objective of the rules:

This rule establishes that county and other local governments may set fees independent of these rules for water quality protection services delegated by ADEQ.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively establishes and informs that ADEQ's water quality fee rules do not affect the authority of county or other local governments to charge fees for implementing water quality protection programs delegated by ADEQ.

5. Status of Agency enforcement policy regarding the rule:

This rule does not require enforcement as it explains that ADEQ's water quality fee rules do not affect the authority of county or other local governments to charge fees for implementing water quality protection programs delegated by ADEQ.

8. Current Economic, small business, and consumer impact of the rules as compared to EIS at last rule adoption:

ADEQ amended this rule in 2001 and described probable economic impacts in qualitative and quantitative terms in the economic impact statement. The economic impact is that the rule does not affect the authority of county or other local governments to charge fees for implementing water quality protection programs delegated by ADEQ. ADEQ believes that the impact of the Article 1 rules on the state's economy, small business and consumers has not changed since the effective date.

R18-14-108. APP Water Quality Protection Services Flat Fees

2. Objective of the rules:

This rule establishes flat fees related to APP general permits as well as other water quality protection services requiring a flat fee.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively provides the mechanisms necessary to determine hourly and flat fee rates.

7. Written criticisms of the rules received within the last five years:

ADEQ has not received any written criticisms, but has received comments regarding that fees based on design flow for the 4.01 General Permit in Table 5 are disproportionate for the amount of review in certain situations. The situation is when a small amount of sewer pipe is installed, as part of an overall larger project; the sewer pipe is for a large design flow that accounts for the overall future project, but at the time, ADEQ is reviewing for only a small amount of sewer pipe being installed.

Before the 2011 rule amendments, the fees for a 4.01 General Permit were based on the number of connections in the sewer line. This fee formula did not account for ADEQ's level of review on very large projects. The existing fee structure allows ADEQ to cover its review costs for these large projects. ADEQ would like to amend the rule to account for review for large capacity design flow in a small installation project.

14. Proposed course of action:

ADEQ wants to examine fee amounts in the rulemaking process to ensure that fees continue to represent ADEQ's level of effort. As ADEQ reviews and establishes its rulemaking priorities, and pending the status of the rule moratorium, ADEQ anticipates submitting a rulemaking to the Council by December 2018. Additionally, ADEQ must ensure that a future rulemaking complies with the qualification on fee increases in A.R.S. §§ 49-241.02(A), 49-255.01(J), and 49-332(A).

R18-14-109. AZPDES Water Quality Protection Services Flat Fees

2. Objective of the rules:

This rule establishes fees related to AZPDES General Permits, and the annual report for land applicators of biosolids.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively provides the mechanisms necessary to determine hourly and flat fee rates.

7. Written criticisms of the rules received within the last five years:

ADEQ received a written criticisms that the fee for the Multi-Sector General Permit Certificate of No Exposure is costly as an initial fee.

Most of the flat fees for AZPDES water quality protection services were created on a formula that distributes the fee amount equally over the five year term of the AZPDES permit. The Multi-Sector General Permit Certificate of No Exposure is an exception to this fee formula; the entire amount for the water quality protection service is due at the time of application in one initial payment. A Certificate of No Exposure is for a five-year term. ADEQ is willing to consider restructuring this fee, possibly in a manner similar to other AZPDES flat fees of an equal fee amount for initial and annual fees.

14. Proposed course of action:

ADEQ wants to examine fee amounts and fee schedules in the rulemaking process to ensure that fees continue to represent ADEQ's level of effort. As ADEQ reviews and establishes its rulemaking priorities, and pending the status of the rule moratorium, ADEQ anticipates submitting a rulemaking to the Council by December 2018. Additionally, ADEQ must ensure that a future rulemaking complies with the qualification on fee increases in A.R.S. §§ 49-241.02(A), 49-255.01(J), and 49-332(A).

R18-14-110. Reclaimed Water Flat Fees

2. Objective of the rules:

This rule establishes separate flat fees for the reclaimed water general permits.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively provides the mechanisms necessary to determine hourly and flat fee rates.

R18-14-111. Other Flat Fees

2. Objective of the rules:

This rule identifies fees for other water quality protection services that are not directly related to an APP or AZPDES permit, such as dry wells registrations, transfer of dry well registration, and subdivision approvals.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively provides the mechanisms necessary to determine hourly and flat fee rates.

14. Proposed course of action:

ADEQ evaluated its rules in accordance with Executive Order 2015-01, Paragraph 5. In its evaluation submitted to the Office of the Governor, ADEQ proposed to amend this rule to allow for expedited subdivision review. As ADEQ reviews and establishes its rulemaking priorities, and pending the status of the rule moratorium, ADEQ anticipates submitting a rulemaking to the Council by December 2018. Additionally, ADEQ must ensure that a future rulemaking complies with the qualification on fee increases in A.R.S. §§ 49-241.02(A), 49-255.01(J), and 49-332(A).

R18-14-112. Implementation

2. Objective of the rules:

This rule implemented the new fees to apply to water quality protection services on the effective date of the rules.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively provides the mechanisms necessary to determine hourly and flat fee rates.

14. Proposed course of action:

ADEQ evaluated its rules in accordance with Executive Order 2015-01, Paragraph 5. In its evaluation submitted to the Office of the Governor, ADEQ proposed to repeal this rule as the implementation was no longer required. ADEQ proposes to repeal this rule after it amends the AZPDES rules in 18 A.A.C. 9, Article 9 in order to specify payment requirement language for AZPDES permits. As ADEQ reviews and establishes its rulemaking priorities, and pending the status of the rule moratorium, ADEQ anticipates submitting a rulemaking to the Council by December 2018. Additionally, ADEQ must ensure that a future rulemaking complies with the qualification on fee increases in A.R.S. §§ 49-241.02(A), 49-255.01(J), and 49-332(A).

R18-14-113. Annual Report

2. Objective of the rules:

This rule explains that ADEQ will publish an annual accounting of WQFF revenue and expenditure activity for the prior fiscal year.

3. Effectiveness of the rule in achieving the objectives:

The rule effectively provides the mechanisms necessary to determine hourly and flat fee rates.

ARTICLE 2. PUBLIC WATER SYSTEM DESIGN REVIEW FEES

I. Information That Is Identical For All Rules in Title 18, Chapter 14, Article 2 (unless stated otherwise in the Section-by-Section Analysis)

1. Authorization of rules by existing statutes:

A.R.S. § 49-353(A)(2)

2. Objective of the rules:

ADEQ must review and approve the design of a public water system under A.R.S. § 49-353, which also requires that ADEQ charge fees to cover its costs. Article 2 establishes the fees for various design review services for a public water system.

4. Analysis of consistency with state and federal statutes and rules:

These rules are consistent with state statutes and rules. ADEQ uses the following statutes and rules to determine that the rules are consistent: A.R.S. § 49-353 and 18 A.A.C. 5, Article 5 (Minimum Design Criteria). No corresponding federal programs apply to Article 2.

5. Status of Agency enforcement policy regarding the rules:

ADEQ enforces these rules by assessing fees for conducting design review services for a public water system, required under A.R.S. § 49-353 and 18 A.A.C. 5, Article 5 (Minimum Design Criteria).

6. Analysis of clarity, conciseness, and understandability:

ADEQ believes that the rules are clear, concise, and understandable.

7. Written criticisms of the rules received within the last five years:

ADEQ has not received any written comments on the rules within the past five years.

8. Current Economic, small business, and consumer impact of the rules as compared to EIS at last rule adoption:

ADEQ described probable economic impacts in qualitative and quantitative terms in the economic impact statement prepared when it created these rules in 2008. ADEQ believes that the qualitative assessments of the economic impacts to the rules were accurate and any costs have been minor. ADEQ believes that the Article 2 rules impact on the state's economy, small business and consumers has not changed since the rules became effective on December 6, 2008.

ADEQ reports revenues of public water system design review as part of the annual accounting under R18-14-113. ADEQ has reported the following information:

- Fiscal Year 2012: Total revenues - \$326,100
- Fiscal Year 2013: Total revenues - \$305,200
- Fiscal Year 2014: Total revenues - \$276,100
- Fiscal Year 2015: Total revenues - \$312,500.

9. Any analysis submitted to ADEQ by another person that compares the rules impact on Arizona's business competitiveness to the impact on businesses in other states:

ADEQ has not received any analysis submitted by another person that compares the rules impact on Arizona's business competitiveness to the impact on businesses in other states.

10. Completion of previous proposed courses of action:

ADEQ did not propose any amendments in the previous Five-Year Review Report, approved by Council on April 5, 2011.

11. A determination that the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs, necessary to achieve the underlying regulatory objective.

ADEQ believes that these rules impose the least burden and costs to regulated persons, including paperwork and other compliance costs, necessary to achieve the underlying regulatory and statutory objective.

12. Stringency Compared to Corresponding Federal Law:

No corresponding federal programs apply to Article 2.

13. Compliance with A.R.S. § 41-1037:

These rules were amended before July 29, 2010. The rules in Article 2 govern the procedures and establish the amounts for ADEQ to assess flat fees for design review services for public water systems.

II. Section by Section Analysis of Rules

R18-14-201. Definitions

2. Objective of the rules:

The definition section defines important terms used in Article 2, so that the rules are understandable to the general public.

3. Analysis of effectiveness of the rules in achieving the objective:

The rule effectively defines important terms used in the rules.

5. Status of Agency enforcement policy regarding the rule:

Definitions are not enforceable, but are used for implementing the rules.

14. Proposed course of action:

No amendments are proposed.

R18-14-202. Flat Rate Fees

2. Objective of the rules:

This rule establishes criteria to determine fees based on flat rates for design review services for public water systems.

3. Analysis of effectiveness of the rules in achieving the objectives:

The rule effectively provides the mechanisms necessary to determine flat fee rates.

14. Proposed course of action:

ADEQ evaluated its rules in accordance with Executive Order 2015-01, Paragraph 5. In its evaluation submitted to the Office of the Governor, ADEQ proposed to amend this rule so that the fees are based on design flow similar to the sewer fees. As ADEQ reviews and establishes its rulemaking priorities, and pending the status of the rule moratorium, ADEQ anticipates submitting a rulemaking to the Council by December 2018.

Table 1. Design Review Service Fees

2. Objective of the Table:

This table specifies the actual amounts and types of fees associated with design review services.

3. Analysis of effectiveness of the Table in achieving the objectives:

The table effectively establishes a clear and concise fee schedule.

14. Proposed course of action:

No amendments are proposed

TITLE 18. ENVIRONMENTAL QUALITY
CHAPTER 14. DEPARTMENT OF ENVIRONMENTAL QUALITY
PERMIT AND COMPLIANCE FEES

ARTICLE 1. WATER QUALITY PROTECTION FEES

Article 1, consisting of Sections R18-14-101 through R18-14-108, adopted effective November 15, 1996 (Supp. 96-4).

Section

- R18-14-101. Definitions
- R18-14-102. Hourly Rate and Maximum Fees for Water Quality Protection Services
 - Table 1. Repealed
- R18-14-103. Initial Fees
- R18-14-104. Annual Fees for Water Quality Protection Services Subject to Hourly Rate Fee
 - Schedule A. Repealed
 - Schedule B. Repealed
 - Schedule C. Repealed
 - Schedule D. Repealed
- R18-14-105. Fee Assessment and Collection
- R18-14-106. Reconsideration of a Bill; Appeal Process
- R18-14-107. Effect on County Fees
- R18-14-108. APP Water Quality Protection Services Flat Fees
- R18-14-109. AZPDES Water Quality Protection Services Flat Fees
- R18-14-110. Reclaimed Water Flat Fees
- R18-14-111. Other Flat Fees
- R18-14-112. Implementation
- R18-14-113. Annual Report

ARTICLE 2. PUBLIC WATER SYSTEM
DESIGN REVIEW FEES

Article 2, consisting of Sections R18-14-201 through R18-14-202 and Table 1, made by final rulemaking at 14 A.A.R. 4102, effective December 6, 2008 (Supp. 08-4).

Section

- R18-14-201. Definitions
- R18-14-202. Flat Rate Fees
 - Table 1. Design Review Service Fees

ARTICLE 1. WATER QUALITY PROTECTION FEES**R18-14-101. Definitions**

In addition to the definitions in A.R.S. §§ 49-201, 49-241.02, 49-255, 49-331, and A.A.C. R18-9-101, A.A.C. R18-9-701, and A.A.C. R18-9-A901, the following terms apply to this Article:

1. "APP" means an Aquifer Protection Permit.
2. "Complex modification" means:
 - a. A revision of an individual Aquifer Protection Permit for a facility within a mining sector as defined in A.R.S. § 49-241.02(F)(1); and
 - b. A revision of an individual Aquifer Protection Permit for a facility within a non-mining sector due to any of the following:
 - i. An expansion of an existing pollutant management area requiring a new or relocated point of compliance;
 - ii. A new subsurface disposal including injection or recharge, or new wetlands construction;
 - iii. Submission of data indicating contamination, or identification of a discharging facility or pollutants not included in previous applications that requires reevaluation of BADCT; or
 - iv. Closure of a facility that cannot meet the clean closure requirements of A.R.S. § 49-252 and requires post-closure care, monitoring, or remediation.
3. "Courtesy review" means a design review service that the Department performs within 30 days from the date of receiving the submittals, of the 60 percent completion specifications, design report, and construction drawings for a sewage collection system.
4. "Priority review" means a design review service for an APP Type 4 permit application that the Department completes using not more than 50 percent of the total review time-frame for the applicable Type 4 permit application as specified in 18 A.A.C. 1, Table 10.
5. "Request" means a written application, notice, letter, or memorandum submitted by an applicant to the Department for water quality protection services. The Department considers a request made on the date it is received by the Department.
6. "Review hours" means the hours or portions of hours that the Department's staff spends on a request for a water quality protection service. Review hours include the time spent by the project manager and technical review team members, and if requested by the applicant, the supervisor or unit manager.
7. "Review-related costs" means any of the following costs applicable to a specific request for water quality protection service:
 - a. Presiding officer services for public hearings on a permitting decision,
 - b. Court reporter services for public hearings on a permitting decision,
 - c. Facility rentals for public hearings on a permitting decision,
 - d. Charges for laboratory analyses performed during the review, and
 - e. Other reasonable and necessary review-related expenses documented in writing by the Department and agreed to by an applicant.
8. "Standard modification" means an amendment to an individual Aquifer Protection Permit that is not a complex modification.
9. "Water quality protection service" means:
 - a. Reviewing a request for an APP determination of applicability;
 - b. Issuing, renewing, amending, transferring, or denying an aquifer protection permit, an AZPDES permit, or a reclaimed water permit;
 - c. Reviewing supplemental information required by a permit condition, including closure for an APP;
 - d. Performing an APP clean closure plan review;
 - e. Issuing or denying a Certificate of Approval for Sanitary Facilities for a Subdivision;
 - f. Registering or transferring registration of a dry well;
 - g. Conducting a site visit;
 - h. Reviewing proprietary and other reviewed products under A.A.C. R18-9-A309(E);
 - i. Reviewing, processing, and managing documentation related to an AZPDES general permit, including a notice of intent, notice of termination, certificate of no exposure, and waiver;
 - j. Registering and reporting land application of biosolids; or
 - k. Pretreatment program review, inspection, or audit.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4).
 Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

and (3) and A.A.C. R18-9-B906(B), unless a flat fee is otherwise designated in this Article.

R18-14-102. Hourly Rate and Maximum Fees for Water Quality Protection Services

A. The Department shall assess and collect an hourly rate fee for a water quality protection service, except for minor permit amendments specified under A.A.C. R18-9-A211(C)(1), (2)

B. Hourly rate fees. The Department shall calculate the fee using an hourly rate of \$122, multiplied by the number of review hours to provide a water quality protection service, plus any applicable review-related costs, up to the maximum fee specified in subsection (C). The Department shall not charge an applicant for the first 60 minutes of Department pre-application consultation time costs for the project manager.

C. Maximum fees for a water quality protection service assessed at an hourly rate are as follows:

Table 1. Maximum Fees

Program Area	Permit Type	Maximum Fee
APP	Individual or area-wide	\$200,000
APP	Complex modification to individual or area-wide	\$150,000
APP	Clean closure of facility	\$50,000
APP	Standard modification to individual or area-wide (per modification up to the maximum fee, and modification can be reassigned under A.A.C. R18-1-516): <ul style="list-style-type: none"> ▪ Maximum fee (cumulative per submittal) \$150,000 ▪ Modification under A.A.C. R18-9-A211(C)(1) through (3) No fee ▪ Modification under A.A.C. R18-9-A211(C)(4) through (6) \$5,000 ▪ Modification under A.A.C. R18-9-A211(C)(7), (D)(2)(b) through (i), and (k) through (l) \$15,000 ▪ Modification under A.A.C. R18-9-A211(D)(2)(a) and (j) \$25,000 ▪ Modification under A.A.C. R18-9-A211(B) that is not classified as complex modification under R18-14-101(2) \$25,000 	
APP	For an APP issued before July 1, 2011, the fee for a submittal required by a compliance schedule is assessed per submittal and cumulative up to the maximum fee. The applicable maximum fee for all compliance schedule submissions shall be according to one of the three maximum fee categories listed below. The maximum fee is for the lifetime of the APP unless a new compliance schedule is established in the APP due to a modification that is classified as both a significant amendment under A.A.C. R18-9-A211(B) and a complex modification under R18-14-101(2) <ul style="list-style-type: none"> ▪ For a permit with a compliance schedule where one or more submissions require a permit modification that requires a determination or reevaluation of BADCT, the fee is assessed as described above for each standard modification, with a maximum fee for the permit's entire compliance schedule of: \$150,000 ▪ For a permit with a compliance schedule where one or more submissions require a permit modification, but no determination or reevaluation of BADCT is required, the fee is assessed as described above for each standard modification, with a maximum fee for the permit's entire compliance schedule of: \$100,000 ▪ For a permit with a compliance schedule requiring one or more submissions that require ADEQ review but do not require a permit modification, the maximum fee for the permit's entire compliance schedule is: \$100,000 	
APP	For an APP issued on or after July 1, 2011, the fee for a submittal required by a compliance schedule is assessed per submittal and cumulative up to the maximum fee for the lifetime of the APP	\$100,000
APP	Determination of applicability	\$15,000
APP	Reviewing proprietary and other reviewed products under A.A.C. R18-9-A309(E)	\$15,000
AZPDES	Individual permit for municipal separate storm sewer system	\$40,000
AZPDES	Individual permit for wastewater treatment plant (based on gallons of discharge per day) <ul style="list-style-type: none"> ▪ 3,000 to 99,999 \$15,000 ▪ 100,000 to 999,999 \$20,000 	

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Program Area	Permit Type	Maximum Fee
	<ul style="list-style-type: none"> ▪ 1,000,000 to 9,999,999 ▪ 10,000,000 or more 	<p>\$30,000</p> <p>\$50,000</p>
AZPDES	Individual permit for a facility or activity that is not a wastewater treatment plant or a municipal separate storm sewer	\$30,000
AZPDES	Amendment to an individual permit	\$12,500
AZPDES	Approval of a new or revised pretreatment program under AZPDES	\$10,000
AZPDES	Consolidated individual permit for multiple AZPDES individual permits, as allowed under A.A.C. R18-9-B901(C)	Aggregate of the applicable maximum fees
Reclaimed	Reclaimed water individual permit	\$32,000

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

Table 1. Repealed

Historical Note

New Table adopted by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Table 1 repealed by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-103. Initial Fees

- A. A person shall submit the applicable fee at the time a request for a water quality protection service is submitted to the Department.
- B. For each water quality protection service subject to an hourly rate fee established under R18-14-102:
 - 1. An applicant shall submit a \$2,000 initial fee at the time a request is submitted to the Department for review.
 - 2. If requested by an applicant, the Department may set a lower initial fee when the Department estimates a review fee that is less than the applicable initial fee.
- C. The Department shall not review a request for a water quality protection service if the applicant or permittee has not paid any fee due under this Article, unless the applicant or permittee has an outstanding water quality protection service bill that is under appeal pursuant to R18-14-106.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-104. Annual Fees for Water Quality Protection Services Subject to Hourly Rate Fee

- A. Annual Registration Fees. The annual registration fee required under A.R.S. § 49-242 is in Table 2:

Table 2. APP Annual Registration Fees

Discharge or Influent per Day under the Individual APP or Notice of Disposal (in Gallons)	Annual Registration Fee	Annual Registration Fee if New Facility Under New APP Not Yet Constructed
3,000 to 9,999	\$500	\$250
10,000 to 99,999	\$1,000	\$250
100,000 to 999,999	\$2,500	\$500
1,000,000 to 9,999,999	\$6,000	\$625
10,000,000 or more	\$8,500	\$750

- B. The Department shall assess an annual fee for an AZPDES-related water quality protection service subject to an hourly rate fee as listed in Table 3:

Table 3. AZPDES Annual Fees

Permit Type	Annual Fee	Annual Fee if New Facility Under New AZPDES Not Yet Constructed
Municipal separate storm sewer system	\$10,000	N/A
Wastewater treatment plant (based on gallons of discharge per day): <ul style="list-style-type: none"> ▪ Less than 99,999 ▪ 100,000 to 999,999 ▪ 1,000,000 to 9,999,999 ▪ 10,000,000 or more 	<p>\$250</p> <p>\$500</p> <p>\$2,500</p> <p>\$4,000</p>	<p>\$250</p> <p>\$500</p> <p>\$625</p> <p>\$750</p>
Facility or activity that is not a wastewater treatment plant or municipal separate storm sewer and designated in the permit as either:		

Major	\$2,500	\$625
Minor	\$500	\$500
Pretreatment program	\$3,000	N/A
Consolidated individual permit for multiple AZPDES individual permits, as allowed under A.A.C. R18-9-B901(C)	Aggregate of the applicable annual fees of each individual permit	Aggregate of the applicable annual fees of each individual permit

C. The Department shall assess an annual fee of \$500 for an individual reclaimed water permit.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

Schedule A. Repealed

Historical Note

Schedule A adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

Schedule B. Repealed

Historical Note

Schedule B adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

Schedule C. Repealed

Historical Note

Schedule C adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

Schedule D. Repealed

Historical Note

Schedule D adopted effective November 15, 1996 (Supp. 96-4). Schedule repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

R18-14-105. Fee Assessment and Collection

- A. Billing. The Department shall bill an applicant for water quality protection services subject to an hourly rate no more than monthly, but at least quarterly. The following information shall be included in each bill:
 - 1. The dates of the billing period;
 - 2. The date and number of review hours itemized by employee name, position type and specifically describing:
 - a. Each water quality protection service performed,
 - b. Each facility involved and program component, and
 - c. The hourly rate for each water quality protection service performed;
 - 3. A description and amount of each review-related cost incurred for the project;
 - 4. The total fees paid to date, the total fees due for the billing period, the date when the fees are due, which shall be at least 35 days after the date on the bill, and the maximum fee for the project.
- B. Final bill. After the Department makes a final determination whether to grant or deny a request for water quality protection services subject to an hourly rate fee, or when an applicant withdraws or closes the request, the Department shall prepare a final itemized bill of its review.
 - 1. If the total fee exceeds the amount of the initial fee plus all invoicing, the Department shall issue a final itemized bill for the cost of the water quality protection services up to the applicable maximum fee established under R18-14-102.

- 2. If the total fee is less than the initial fee and all paid invoicing charges, the Department shall refund the difference to the applicant.
- 3. Fees for water quality protection services shall be paid in U.S. dollars by cash, check, cashier's check, money order, or any other method acceptable to the Department.
- 4. The Department shall not release the final permit or approval until the final itemized bill is paid in full.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-106. Reconsideration of a Bill; Appeal Process

- A. A person may seek review of a bill by filing a written request for reconsideration with the Director.
 - 1. The request shall specify, in detail, why the bill is in dispute and shall include any supporting documentation.
 - 2. The written request for reconsideration shall be delivered to the Director in person, by mail, or by facsimile on or before the payment due date or within 35 days of the invoice print date, whichever is greater.
- B. The Director shall make a final decision on the request for reconsideration of the bill and mail a final written decision to the person within 20 working days after the date the Director receives the written request.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

R18-14-107. Effect on County Fees

Nothing in this Chapter affects the authority of county or other local governments to charge fees for implementing delegated Department water quality protection programs in accordance with statutory authority.

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Amended by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1).

R18-14-108. APP Water Quality Protection Services Flat Fees

- A. The Department shall assess a flat fee for an APP water quality protection service listed in this Section.
- B. Type 1 General Permits. No fee is required, except as stated in A.A.C. R18-9-A304(A)(2).
- C. Fees for Type 2 and Type 3 General Permits and related water quality protection services are listed in Table 4. For purposes of this Section, "complex" is defined in A.A.C. R18-1-501(9). "Standard" means any permit that does not meet the definition of complex.

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Table 4. Type 2 and 3 General Permit Fees

Permit Description	Permit Fee	Renewal Fee
Standard Type 2	\$1,500	\$500
Complex Type 2	\$3,000	\$1,000
Standard Type 3	\$4,500	\$1,500
Complex Type 3	\$7,500	\$2,500
Amendment to Notice of Intent	Same as applicable renewal fee	N/A
Transfer of permit authorization	\$50	N/A
If a site contains more than one facility covered by the same Type 2 or Type 3 General Permit and each facility is substantially similar in design, construction, and operation, the first facility is paid at the full applicable fee, and each additional facility is:	Half the applicable fee	Half the applicable fee

D. Fees for Type 4 General Permits and related water quality protection services are listed in Table 5.

Table 5. Type 4 General Permit Fees

Water Quality Protection Service	Description	Permit Fee
4.01 General Permit: Sewage Collection Systems	<p>Under each Notice of Intent to Discharge, the fee is assessed on a per-component basis for the components listed below and is assessed cumulatively up to the maximum fee:</p> <ul style="list-style-type: none"> ▪ Maximum fee ▪ Force mains with design flow less than or equal to 10,000 gpd ▪ Each additional increment of 50,000 gpd or less of force mains ▪ Gravity sewer with design flow less than or equal to 10,000 gpd ▪ Each additional increment of 50,000 gpd or less of gravity sewer ▪ Each sewer lift station ▪ Each depressed sewer ▪ Realignment of existing sewer for a contiguous project that is less than 300 linear feet with no change in design flow or pipe size 	<p>\$25,000</p> <p>\$1,000</p> <p>\$1,000</p> <p>\$1,000</p> <p>\$1,000</p> <p>\$1,000</p> <p>\$1,000</p> <p>\$500</p>
4.01 General Permit courtesy review	If an applicant requests courtesy review, the Department shall approve or deny the request. When determining whether to approve a courtesy review request, the Department shall consider the complexity of the project and the Department's current work load	One-third applicable fee upon submittal, then balance of fee if Notice of Intent to Discharge is submitted with final documentation within 180 days of first submittal
4.23 General Permit: 3,000 to less than 24,000 Gallons per day Design Flow	<ul style="list-style-type: none"> ▪ Onsite wastewater treatment facility with up to: <ul style="list-style-type: none"> • Three treatment technologies and disposal methods consisting of technologies or designs that are covered under other Type 4 general permits; and • Two onsite wastewater treatment facilities ▪ Maximum fee (cumulative) ▪ Each additional onsite wastewater treatment facility on same Notice of Intent to Discharge up to maximum fee ▪ Each additional treatment technology or disposal method consisting of technologies or designs that are covered under other Type 4 general permits on same Notice of Intent to Discharge up to maximum fee 	<p>\$3,600</p> <p>\$7,500</p> <p>\$1,200</p> <p>\$500</p>
4.23 General Permit annual report	Annual report required under A.A.C. R18-9-E323(G)	\$200
Type 4 General Permits (4.02 through 4.22)	<ul style="list-style-type: none"> ▪ Maximum fee ▪ First Type 4 general permit ▪ Each additional Type 4 general permit on same Notice of Intent to Discharge 	<p>\$3,700</p> <p>\$1,200</p> <p>\$500</p>
Alternative Design under A.A.C. R18-9-A312(G)	<p>A request for an alternative design, installation, or operational feature, per alternative design:</p> <ul style="list-style-type: none"> ▪ Type 4.01 general permit ▪ All other Type 4 general permits 	<p>\$750</p> <p>\$250</p>

Water Quality Protection Service	Description	Permit Fee
Interceptor under A.A.C. R18-9-A315	A design requiring an interceptor (per interceptor)	\$100
Transfer	Transfer of discharge authorization	\$50
Priority Review	If an applicant requests priority review, the Department shall approve or deny the request. When determining whether to approve a priority review request, the Department shall consider the complexity of the project and the Department's current work load.	Double the Applicable Fee (including any applicable maximum fee)

Historical Note

Adopted effective November 15, 1996 (Supp. 96-4). Section repealed by final rulemaking at 7 A.A.R. 564, effective January 2, 2001 (Supp. 01-1). New Section made by exempt rulemaking at 16 A.A.R. 851, effective July 1, 2010 (Supp. 10-2). Amended by exempt rulemaking at 16 A.A.R. 1505, effective July 1, 2010 (Supp. 10-3). Amended by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-109. AZPDES Water Quality Protection Services Flat Fees

- A. The Department shall assess a flat fee for an AZPDES water quality protection service, as described in Table 6.
- B. In addition to the requirements in A.A.C. R18-9-A907(B), a draft permit will state the category and fee assigned to the permit and the factors for establishing the fee, according to Table 6. Any person may comment on the fee category assignment as part of the public comment period described in A.A.C. R18-9-A908.
- C. Annual Fee. The Department shall bill an annual fee to permittees who have not filed a notice of termination for an applicable general permit.

Table 6. AZPDES Water Quality Protection Services Flat Fees

Category	Factors for Establishing Fees	Initial Fee	Annual Fee
Municipal Separate Storm Sewer System General Permit	The fee is based on the population of the permitted area:		
	▪ Less than or equal to 10,000	\$2,500	\$2,500
	▪ Greater than 10,000 but less than or equal to 100,000	\$5,000	\$5,000
	▪ Greater than 100,000	\$7,500	\$7,500
	The fee for a non-traditional municipal separate storm sewer system, such as a hospital, college or military facility	\$5,000	\$5,000
Construction General Permit	The fee is based on the amount of acreage identified in the Notice of Intent:		
	▪ Less than or equal to 1 acre	\$250	\$250
	▪ Greater than 1 acre but less than or equal to 50 acres	\$350	\$350
	▪ Greater than 50 acres	\$500	\$500
	Pollution prevention plan review	\$1,000	N/A
	▪ Each additional submittal due to deficiency	\$500	N/A
	Waiver	\$750	N/A
	If more than one person must apply for general permit coverage of the same facility or discharge activity, each person pays:	Fee applicable to the amount of acreage each person controls	Fee applicable to the amount of acreage each person controls
Multi-Sector General Permit	The fee is based on the amount of acreage identified in the Notice of Intent:		
	▪ Less than or equal to 1 acre	\$350	\$350
	▪ Greater than 1 acre but less than or equal to 40 acres	\$500	\$500
	▪ Greater than 40 acres	\$1,000	\$1,000
	Pollution prevention plan review	\$1,000	N/A
	▪ Each additional submittal due to deficiency	\$500	N/A
	Certificate of No Exposure	\$1,250	N/A
	If more than one person must apply for general permit coverage of the same facility or discharge activity, each person pays:	Fee applicable to the amount of acreage each person controls	Fee applicable to the amount of acreage each person controls

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Category	Factors for Establishing Fees	Initial Fee	Annual Fee
General Permits for Non-Stormwater Discharges	The fee is based on the Department’s total anticipated staff hours (including permit development, customer service, review of the notice of intent, and annual data review and inspections) divided by the total number of potential permittees over a five-year period:		
	▪ Level 1A	\$250	\$250
	• Staff hours: 1,500		
	• Number of potential permittees: 750		
	▪ Level 1B	\$500	\$500
	• Staff hours: 1,500		
	• Number of potential permittees: 375		
	▪ Level 2	\$1,250	\$1,250
	• Staff hours: 1,000		
	• Number of potential permittees: 100		
▪ Level 3	\$1,500	\$1,500	
• Staff hours: 1,300			
• Number of potential permittees: 100			
▪ Level 4A	\$2,000	\$2,000	
• Staff hours: 1,600			
• Number of potential permittees: 100			
▪ Level 4B	\$2,500	\$2,500	
• Staff hours: 1,900			
• Number of potential permittees: 100			
	Pollution prevention plan review	\$1,000	N/A
	▪ Each additional submittal due to deficiency	\$500	N/A
Emergency Discharge General Permit	Authorization for emergency discharge	\$10,000	N/A
Transfer	Authorization for permit transfer as allowed under A.A.C. R18-9-B905	\$50	N/A
Biosolids Land Applicators	Initial registration	\$500	N/A
	Registration amendment	\$250	N/A
	Annual report based on amount of dry metric tons applied		
	▪ Less than or equal to 7,500 dry metric tons	N/A	\$2,500
	▪ Greater than 7,500 dry metric tons but less than or equal to 15,000 dry metric tons	N/A	\$3,000
	▪ Greater than 15,000 dry metric tons	N/A	\$4,500

Historical Note

New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-110. Reclaimed Water Flat Fees

The Department shall assess a flat fee for a reclaimed water quality protection service as listed in Table 7. For purposes of this Section, “complex” is defined in A.A.C. R18-1-501(9). “Standard” means any permit that does not meet the definition of complex.

Table 7. Reclaimed Water General Permit Fees

Permit Description	Permit Fee	Renewal Fee
Standard Type 2	\$600	\$450
Complex Type 2	\$750	\$575
Standard Type 3	\$1,500	\$1,250
Complex Type 3	\$2,000	\$1,500
Amendment to Notice of Intent	Same as applicable renewal fee	N/A
Transfer of permit authorization	\$50	N/A

Historical Note

New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-111. Other Flat Fees

Flat fees. The Department shall assess a flat fee for the following water quality protection services:

1. Dry well registration, \$100 per dry well;
2. Dry well transfer of registration, \$50 per transfer;
3. Certificate of Approval for Sanitary Facilities for Subdivisions.
 - a. Subdivision with public sewerage system: \$800 for every increment of 150 lots or less;
 - b. Subdivision with individual sewerage system:
 - i. \$500 for less than 10 lots;
 - ii. \$1,000 for greater than 10 lots but less than 50 lots;
 - iii. \$1,000 for each additional increment of 50 lots or less.
 - c. If water from a central system is not provided to the lot, the fee is one and one-half the applicable fee stated in subsection (3)(a) or (b).
 - d. Condominium subdivision: \$1,000 for every increment of 150 units or less.

Historical Note

New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-112. Implementation

The fees in this Article apply on July 1, 2011. For fees related to the AZPDES program:

1. A person shall submit the applicable fee when requesting a water quality protection service as specified in an AZPDES General Permit or in 18 A.A.C. 9, Article 9; and
2. A person is responsible for paying the annual fee for an AZPDES general permit, even if the person filed for coverage before the effective date of these rules.

Historical Note

New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

R18-14-113. Annual Report

By December 1 of each year, the Department shall publish an accounting of Water Quality Fee Fund revenue and expenditure activity for the prior fiscal year.

Historical Note

New Section made by final rulemaking at 17 A.A.R. 568, effective July 1, 2011 (Supp. 11-2).

**ARTICLE 2. PUBLIC WATER SYSTEM
DESIGN REVIEW FEES**

R18-14-201. Definitions

In addition to the definitions in A.A.C. R18-1-501, and 18 A.A.C. 4, the following terms apply to this Article:

“Design review” means the process for reviewing an application for an Approval to Construct as prescribed in A.A.C. R18-5-505(B).

“Design review service” means all activities related to processing an application for an Approval to Construct, including reviewing, approving, or denying an application, conducting a pre-application meeting or site visit, or other activity required to review an Approval to Construct application.

“Distribution system” has the same meaning prescribed in A.A.C. R18-5-101.

“Priority Review” means a design review service where a license application is reviewed using not more than 50% of the total review time-frame for an Approval to Construct license application.

“Public water system” has the same meaning prescribed in A.R.S. § 49-352(B).

“Licensing time-frame” means a period of time described and defined in A.R.S. Title 41, Chapter 6, Article 7.1, and 18 A.A.C. 1, Article 5.

“Water treatment plant” has the same meaning prescribed in A.A.C. R18-5-101.

Historical Note

Section made by final rulemaking at 14 A.A.R. 4102, effective December 6, 2008 (Supp. 08-4).

R18-14-202. Flat Rate Fees

- A. The Department shall assess and collect a flat rate fee for design review services for public water systems.
- B. Design criteria for public water systems are specified in 18 A.A.C. 4 and 18 A.A.C. 5.
- C. An applicant shall submit public water system design review fees with an application for an Approval to Construct, as specified in 18 A.A.C. 5, Article 5.
- D. The flat rate fees for a design review service:
 1. Are established in Table 1, are assessed on a per-unit basis where applicable, and are cumulative unless otherwise specified in this Article;
 2. Shall be paid by cash, check, cashier’s check, money order, or any other method acceptable to the Department; and
 3. Shall be paid in full before the Department issues approval of an application.
- E. The Department shall refund 50 percent of the application fee paid by an applicant if, during the administrative completeness review time-frame period, the applicant:
 1. Fails to respond in a reasonably timely manner, as set forth in A.A.C. R18-1-507, to a notice of administrative deficiencies requesting additional information under A.A.C. R18-1-503, and the Department denies the application; or
 2. Withdraws the application.
- F. If an application is denied under A.A.C. R18-1-507 after the end of the administrative completeness review time-frame, the Department shall retain the flat fee paid by the applicant.
- G. If an applicant requests priority review, the Department shall approve or deny the request. When determining whether to approve a priority review request, the Department shall consider the complexity of the project and the Department’s current work load. If priority review is approved by the Department, the applicant shall pay the priority review fee specified in Table 1.
- H. State agencies are exempt from all fees imposed under this Article pursuant to A.R.S. § 49-353(A)(2)(b).

Historical Note

Section made by final rulemaking at 14 A.A.R. 4102, effective December 6, 2008 (Supp. 08-4).

Table 1. Design Review Service Fees

Public Water System Design Review Application Types	Fees^{1, 2}
Approval to Construct Public Water Supply Distribution System:	
• 150 or fewer service connections	\$900
• 151 to 300 service connections	\$1,400
• 301 to 450 service connections	\$1,900
• 451 to 600 service connections	\$2,400
• 601 to 750 service connections	\$2,900
• Each additional 150 service connections	Add \$500
Water Treatment Plants and Blending Plans (including new source approval if applicable):	
• < 0.1 mgd	\$1,500
• ≥ 0.1 mgd and < 1 mgd	\$2,000
• ≥ 1 mgd and < 5 mgd	\$3,000
• ≥ 5 mgd	\$5,000
Well (including new source approval if applicable)	\$1,250
Storage Tank	\$800
Booster Pump	\$800
Main Line Extension	\$250
Chlorinators/Disinfection Devices	\$250
Extension of Time to Construct ³	50% of the application fee, not to exceed \$500
Priority Review Fee ⁴	Double the Standard Fee

- 1 Fees are calculated on a per-unit basis; i.e., a separate fee is assessed for each separate storage tank, booster pump, disinfection device, or main line extension.
- 2 Fees for each application type are cumulative; an applicant must pay the total of all pertinent fees.
- 3 Extensions of time to construct are issued pursuant to A.A.C. R18-5-505(E); the Section states that an Approval to Construct becomes void if construction is not commenced or completed within a specified time period, unless the Department grants an extension of time.
- 4 Priority Review Projects require Department authorization prior to filing.

Historical Note

Table 1, Design Review Service Fees, made by final rulemaking at 14 A.A.R. 4102, effective December 6, 2008 (Supp. 08-4).

49-104. Powers and duties of the department and director

A. The department shall:

1. Formulate policies, plans and programs to implement this title to protect the environment.
2. Stimulate and encourage all local, state, regional and federal governmental agencies and all private persons and enterprises that have similar and related objectives and purposes, cooperate with those agencies, persons and enterprises and correlate department plans, programs and operations with those of the agencies, persons and enterprises.
3. Conduct research on its own initiative or at the request of the governor, the legislature or state or local agencies pertaining to any department objectives.
4. Provide information and advice on request of any local, state or federal agencies and private persons and business enterprises on matters within the scope of the department.
5. Consult with and make recommendations to the governor and the legislature on all matters concerning department objectives.
6. Promote and coordinate the management of air resources to assure their protection, enhancement and balanced utilization consistent with the environmental policy of this state.
7. Promote and coordinate the protection and enhancement of the quality of water resources consistent with the environmental policy of this state.
8. Encourage industrial, commercial, residential and community development that maximizes environmental benefits and minimizes the effects of less desirable environmental conditions.
9. Assure the preservation and enhancement of natural beauty and man-made scenic qualities.
10. Provide for the prevention and abatement of all water and air pollution including that related to particulates, gases, dust, vapors, noise, radiation, odor, nutrients and heated liquids in accordance with article 3 of this chapter and chapters 2 and 3 of this title.
11. Promote and recommend methods for the recovery, recycling and reuse or, if recycling is not possible, the disposal of solid wastes consistent with sound health, scenic and environmental quality policies. Beginning in 2014, the department shall report annually on its revenues and expenditures relating to the solid and hazardous waste programs overseen or administered by the department.
12. Prevent pollution through the regulation of the storage, handling and transportation of solids, liquids and gases that may cause or contribute to pollution.
13. Promote the restoration and reclamation of degraded or despoiled areas and natural resources.
14. Assist the department of health services in recruiting and training state, local and district health department personnel.
15. Participate in the state civil defense program and develop the necessary organization and facilities to meet wartime or other disasters.
16. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope

of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.

17. Unless specifically authorized by the legislature, ensure that state laws, rules, standards, permits, variances and orders are adopted and construed to be consistent with and no more stringent than the corresponding federal law that addresses the same subject matter. This provision shall not be construed to adversely affect standards adopted by an Indian tribe under federal law.

B. The department, through the director, shall:

1. Contract for the services of outside advisers, consultants and aides reasonably necessary or desirable to enable the department to adequately perform its duties.
2. Contract and incur obligations reasonably necessary or desirable within the general scope of department activities and operations to enable the department to adequately perform its duties.
3. Utilize any medium of communication, publication and exhibition when disseminating information, advertising and publicity in any field of its purposes, objectives or duties.
4. Adopt procedural rules that are necessary to implement the authority granted under this title, but that are not inconsistent with other provisions of this title.
5. Contract with other agencies, including laboratories, in furthering any department program.
6. Use monies, facilities or services to provide matching contributions under federal or other programs that further the objectives and programs of the department.
7. Accept gifts, grants, matching monies or direct payments from public or private agencies or private persons and enterprises for department services and publications and to conduct programs that are consistent with the general purposes and objectives of this chapter. Monies received pursuant to this paragraph shall be deposited in the department fund corresponding to the service, publication or program provided.
8. Provide for the examination of any premises if the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed on the premises. The director shall give the owner or operator the opportunity for its representative to accompany the director on an examination of those premises. Within forty-five days after the date of the examination, the department shall provide to the owner or operator a copy of any report produced as a result of any examination of the premises.
9. Supervise sanitary engineering facilities and projects in this state, authority for which is vested in the department, and own or lease land on which sanitary engineering facilities are located, and operate the facilities, if the director determines that owning, leasing or operating is necessary for the public health, safety or welfare.

10. Adopt and enforce rules relating to approving design documents for constructing, improving and operating sanitary engineering and other facilities for disposing of solid, liquid or gaseous deleterious matter.
11. Define and prescribe reasonably necessary rules regarding the water supply, sewage disposal and garbage collection and disposal for subdivisions. The rules shall:
 - (a) Provide for minimum sanitary facilities to be installed in the subdivision and may require that water systems plan for future needs and be of adequate size and capacity to deliver specified minimum quantities of drinking water and to treat all sewage.
 - (b) Provide that the design documents showing or describing the water supply, sewage disposal and garbage collection facilities be submitted with a fee to the department for review and that no lots in any subdivision be offered for sale before compliance with the standards and rules has been demonstrated by approval of the design documents by the department.
12. Prescribe reasonably necessary measures to prevent pollution of water used in public or semipublic swimming pools and bathing places and to prevent deleterious conditions at such places. The rules shall prescribe minimum standards for the design of and for sanitary conditions at any public or semipublic swimming pool or bathing place and provide for abatement as public nuisances of premises and facilities that do not comply with the minimum standards. The rules shall be developed in cooperation with the director of the department of health services and shall be consistent with the rules adopted by the director of the department of health services pursuant to section 36-136, subsection H, paragraph 10.
13. Prescribe reasonable rules regarding sewage collection, treatment, disposal and reclamation systems to prevent the transmission of sewage borne or insect borne diseases. The rules shall:
 - (a) Prescribe minimum standards for the design of sewage collection systems and treatment, disposal and reclamation systems and for operating the systems.
 - (b) Provide for inspecting the premises, systems and installations and for abating as a public nuisance any collection system, process, treatment plant, disposal system or reclamation system that does not comply with the minimum standards.
 - (c) Require that design documents for all sewage collection systems, sewage collection system extensions, treatment plants, processes, devices, equipment, disposal systems, on-site wastewater treatment facilities and reclamation systems be submitted with a fee for review to the department and may require that the design documents anticipate and provide for future sewage treatment needs.
 - (d) Require that construction, reconstruction, installation or initiation of any sewage collection system, sewage collection system extension, treatment plant, process, device, equipment, disposal system, on-site wastewater treatment facility or reclamation system conform with applicable requirements.

14. Prescribe reasonably necessary rules regarding excreta storage, handling, treatment, transportation and disposal. The rules shall:
 - (a) Prescribe minimum standards for human excreta storage, handling, treatment, transportation and disposal and shall provide for inspection of premises, processes and vehicles and for abating as public nuisances any premises, processes or vehicles that do not comply with the minimum standards.
 - (b) Provide that vehicles transporting human excreta from privies, septic tanks, cesspools and other treatment processes shall be licensed by the department subject to compliance with the rules. The department may require payment of a fee as a condition of licensure. After July 20, 2011, the department shall establish by rule a fee as a condition of licensure, including a maximum fee. As part of the rule making process, there must be public notice and comment and a review of the rule by the joint legislative budget committee. After September 30, 2013, the department shall not increase that fee by rule without specific statutory authority for the increase. The fees shall be deposited, pursuant to sections 35-146 and 35-147, in the solid waste fee fund established by section 49-881.
 15. Perform the responsibilities of implementing and maintaining a data automation management system to support the reporting requirements of title III of the superfund amendments and reauthorization act of 1986 (P.L. 99-499) and article 2 of this chapter.
 16. Approve remediation levels pursuant to article 4 of this chapter.
 17. Establish or revise fees by rule pursuant to the authority granted under title 44, chapter 9, article 8 and chapters 4 and 5 of this title for the department to adequately perform its duties. All fees shall be fairly assessed and impose the least burden and cost to the parties subject to the fees. In establishing or revising fees, the department shall base the fees on:
 - (a) The direct and indirect costs of the department's relevant duties, including employee salaries and benefits, professional and outside services, equipment, in-state travel and other necessary operational expenses directly related to issuing licenses as defined in title 41, chapter 6 and enforcing the requirements of the applicable regulatory program.
 - (b) The availability of other funds for the duties performed.
 - (c) The impact of the fees on the parties subject to the fees.
 - (d) The fees charged for similar duties performed by the department, other agencies and the private sector.
- C. The department may:
1. Charge fees to cover the costs of all permits and inspections it performs to ensure compliance with rules adopted under section 49-203, except that state agencies are exempt from paying the fees. Monies collected pursuant to this subsection shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.
 2. Contract with private consultants for the purposes of assisting the department in reviewing applications for licenses, permits or other authorizations to determine whether an applicant meets the criteria for issuance of the license, permit or other authorization. If the department contracts with a consultant under this paragraph, an applicant may request that the department

expedite the application review by requesting that the department use the services of the consultant and by agreeing to pay the department the costs of the consultant's services. Notwithstanding any other law, monies paid by applicants for expedited reviews pursuant to this paragraph are appropriated to the department for use in paying consultants for services.

D. The director may:

1. If the director has reasonable cause to believe that a violation of any environmental law or rule exists or is being committed, inspect any person or property in transit through this state and any vehicle in which the person or property is being transported and detain or disinfect the person, property or vehicle as reasonably necessary to protect the environment if a violation exists.
2. Authorize in writing any qualified officer or employee in the department to perform any act that the director is authorized or required to do by law.

49-203. Powers and duties of the director and department

A. The director shall:

1. Adopt, by rule, water quality standards in the form and subject to the considerations prescribed by article 2 of this chapter.
2. Adopt, by rule, a permit program that is consistent with but no more stringent than the requirements of the clean water act for the point source discharge of any pollutant or combination of pollutants into navigable waters. The program and the rules shall be sufficient to enable this state to administer the permit program identified in section 402(b) of the clean water act including the sewage sludge requirements of section 405 of the clean water act and as prescribed by article 3.1 of this chapter.
3. Adopt, by rule, a program to control nonpoint source discharges of any pollutant or combination of pollutants into navigable waters.
4. Adopt, by rule, an aquifer protection permit program to control discharges of any pollutant or combination of pollutants that are reaching or may with a reasonable probability reach an aquifer. The permit program shall be as prescribed by article 3 of this chapter.
5. Adopt, by rule, the permit program for underground injection control described in the safe drinking water act.
6. Adopt, by rule, technical standards for conveyances of reclaimed water and a permit program for the direct reuse of reclaimed water.
7. Adopt, by rule or as permit conditions, such discharge limitations, best management practice standards, new source performance standards, toxic and pretreatment standards and such other standards and conditions as are reasonable and necessary to carry out the permit programs and regulatory duties described in paragraphs 2 through 5 of this subsection.
8. Assess and collect fees to revoke, issue, deny, modify or suspend permits issued pursuant to this chapter and to process permit applications. The director may also assess and collect costs reasonably necessary if the director must conduct sampling or monitoring relating to a facility because the owner or operator of the facility has refused or failed to do so on order by the director. The director shall set fees that are reasonably related to the

department's costs of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this chapter. Monies collected from aquifer protection permit fees and from Arizona pollutant discharge elimination system permit fees shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210. Monies from other permit fees shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund unless otherwise provided by law. Monies paid by an applicant for review by consultants for the department pursuant to section 49-241.02, subsection D, shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.

9. Adopt, modify, repeal and enforce other rules that are reasonably necessary to carry out the director's functions under this chapter.
 10. Require monitoring at an appropriate point of compliance for any organic or inorganic pollutant listed under section 49-243, subsection I if the director has reason to suspect the presence of the pollutant in a discharge.
 11. Adopt rules establishing what constitutes a significant increase or adverse alteration in the characteristics or volume of pollutants discharged for purposes of determining what constitutes a major modification to an existing facility under the definition of new facility pursuant to section 49-201. Before the adoption of these rules, the director shall determine whether a change at a particular facility results in a significant increase or adverse alteration in the characteristics or volume of pollutants discharged on a case by case basis, taking into account site conditions and operational factors.
- B. The director may:
1. On presentation of credentials, enter into, on or through any public or private property from which a discharge has occurred, is occurring or may occur or on which any disposal, land application of sludge or treatment regulated by this chapter has occurred, is occurring or may be occurring and any public or private property where records relating to a discharge or records that are otherwise required to be maintained as prescribed by this chapter are kept, as is reasonably necessary to ensure compliance with this chapter. The director or a department employee may take samples, inspect and copy records required to be maintained pursuant to this chapter, inspect equipment, activities, facilities and monitoring equipment or methods of monitoring, take photographs and take other action reasonably necessary to determine the application of, or compliance with, this chapter. The owner or managing agent of the property shall be afforded the opportunity to accompany the director or department employee during inspections and investigations, but prior notice of entry to the owner or managing agent is not required if reasonable grounds exist to believe that such notice would frustrate the enforcement of this chapter. If the director or department employee obtains any samples before leaving the premises, the director or department employee shall give the owner or managing agent a receipt describing the samples obtained and a portion of each sample equal in volume or weight to the portion retained. If an analysis is made of samples, or monitoring and testing are performed, a copy of the results shall be furnished promptly to the owner or managing agent.

2. Require any person who has discharged, is discharging or may discharge into the waters of the state under article 3 or 3.1 of this chapter and any person who is subject to pretreatment standards and requirements or sewage sludge use or disposal requirements under article 3.1 of this chapter to collect samples, to establish and maintain records, including photographs, and to install, use and maintain sampling and monitoring equipment to determine the absence or presence and nature of the discharge or indirect discharge or sewage sludge use or disposal.
 3. Administer state or federal grants, including grants to political subdivisions of this state, for the construction and installation of publicly and privately owned pollutant treatment works and pollutant control devices and establish grant application priorities.
 4. Develop, implement and administer a water quality planning process, including a ranking system for applicant eligibility, wherein appropriated state monies and available federal monies are awarded to political subdivisions of this state to support or assist regional water quality planning programs and activities.
 5. Enter into contracts and agreements with the federal government to implement federal environmental statutes and programs.
 6. Enter into intergovernmental agreements pursuant to title 11, chapter 7, article 3 if the agreement is necessary to more effectively administer the powers and duties described in this chapter.
 7. Participate in, conduct and contract for studies, investigations, research and demonstrations relating to the causes, minimization, prevention, correction, abatement, mitigation, elimination, control and remedy of discharges and collect and disseminate information relating to discharges.
 8. File bonds or other security as required by a court in any enforcement actions under article 4 of this chapter.
- C. Subject to section 38-503 and other applicable statutes and rules, the department may contract with a private consultant for the purposes of assisting the department in reviewing aquifer protection permit applications and on-site wastewater treatment facilities to determine whether a facility meets the criteria and requirements of this chapter and the rules adopted by the director. Except as provided in section 49-241.02, subsection D, the department shall not use a private consultant if the fee charged for that service would be greater than the fee the department would charge to provide that service. The department shall pay the consultant for the services rendered by the consultant from fees paid by the applicant or facility to the department pursuant to subsection A, paragraph 8 of this section.
- D. The director shall integrate all of the programs authorized in this section and such other programs affording water quality protection that are administered by the department for purposes of administration and enforcement and shall avoid duplication and dual permitting to the maximum extent practicable.

49-241.02. Payment for aquifer protection permit fees; definitions

- A. Only for a one-time rule making after July 29, 2010, the director shall establish by rule fees for aquifer protection permits, including maximum fees and fees for individual or area-wide permits, complex and standard modifications to permits and clean closure of a nonpermitted facility. After the one-time rule making, the director shall not increase those fees by rule without specific statutory authority for the increase. Monies collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.
- B. Each permit action application submitted by the applicant is subject to a maximum fee.
- C. Notwithstanding any other provision in this section, an applicant may request that the department waive the applicable maximum fee for processing an application for a permit action. On requesting the waiver, the applicant agrees to pay the total direct costs incurred by the department in processing the application and the department may process the application for a permit action.
- D. If the department contracts with a consultant under section 49-203, an applicant may request that the department expedite the application review by requesting that the department use the services of the consultant and agreeing to pay to the department the costs of the consultant's services regardless of the other provisions of this section.
- E. The department shall review the revenues derived from and expenses incurred for processing permit action applications through June 30, 2014 to determine the adequacy of the maximum fees, and by August 31, 2014, the department shall issue a report to the legislature on its findings.
- F. For the purposes of this section:
 - 1. "Complex modification" means, for purposes of the mining sector, any of the following:
 - (a) Any new tailing impoundment, leach pad or stockpile, or process solution impoundment or conveyance required to have an individual permit under this article, unless this new facility is within an approved passive containment capture zone under section 49-243, subsection G, paragraph 1.
 - (b) The expansion of the footprint of any tailing impoundment, leach pad or stockpile, or process solution impoundment or conveyance permitted under this article if the expanded facility is not located within a passive containment capture zone under section 49-243, subsection G, paragraph 1, and the expansion either:
 - (i) Requires expansion of the pollutant management area and a new or relocated point of compliance.
 - (ii) Extends over a geologic unit of higher hydraulic conductivity than the original facility, unless the original facility is lined and the same liner is extended to cover the entire expansion area.
 - (c) A new or expanded waste rock pile is not considered to be a discharging facility under section 49-241, subsection B and may be categorized as a complex modification for purposes of this section only if the department determines all of the following:
 - (i) The new or expanded waste rock pile otherwise qualifies as a discharging facility and is not exempted under section 49-250.

- (ii) The new or expanded waste rock pile is located outside of a passive containment capture zone under section 49-243, subsection G, paragraph 1.
 - (iii) The new or expanded waste rock pile either requires expansion of the pollutant management area and a new or relocated point of compliance or it extends over a geologic unit of higher hydraulic conductivity than the original facility.
- 2. "Maximum fee" means the maximum amount the director establishes by rule for services for a permit action.
- 3. "Permit action" means:
 - (a) Issuance of an individual or area-wide aquifer protection permit to operate or to close.
 - (b) Issuance of a complex modification of an individual or area-wide aquifer protection permit.
 - (c) Issuance of a clean closure approval.
 - (d) Issuance of a standard modification of an individual or area-wide aquifer protection permit.
 - (e) Denial of any application.
 - (f) Processing any permit action application request that the applicant withdraws.
- G. The department shall adopt a rule to define "complex modification" for other nonmining aquifer protection permit sectors.

49-255.01. Arizona pollutant discharge elimination system program; rules and standards; affirmative defense; fees; general permit; exemption from termination

- A. A person shall not discharge except under either of the following conditions:
 - 1. In conformance with a permit that is issued or authorized under this article.
 - 2. Pursuant to a permit that is issued or authorized by the United States environmental protection agency until a permit that is issued or authorized under this article takes effect.
- B. The director shall adopt rules to establish an AZPDES permit program consistent with the requirements of sections 402(b) and 402(p) of the clean water act. This program shall include requirements to ensure compliance with section 307 and requirements for the control of discharges consistent with sections 318 and 405(a) of the clean water act. The director shall not adopt any requirement that is more stringent than or conflicts with any requirement of the clean water act. The director may adopt federal rules pursuant to section 41-1028 or may adopt rules to reflect local environmental conditions to the extent that the rules are consistent with and no more stringent than the clean water act and this article.
- C. The rules adopted by the director shall provide for:
 - 1. Issuing, authorizing, denying, modifying, suspending or revoking individual or general permits.
 - 2. Establishment of permit conditions, discharge limitations and standards of performance as prescribed by section 49-203, subsection A, paragraph 7, including case by case effluent limitations that are developed in a manner consistent with 40 Code of Federal Regulations section 125.3(c).

3. Modifications and variances as allowed by the clean water act.
 4. Other provisions necessary for maintaining state program authority under section 402(b) of the clean water act.
- D. This article does not affect the validity of any existing rules that are adopted by the director and that are equivalent to and consistent with the national pollutant discharge elimination system program authorized under section 402 of the clean water act until new rules for AZPDES discharges are adopted pursuant to this article.
- E. An upset constitutes an affirmative defense to any administrative, civil or criminal enforcement action brought for noncompliance with technology-based permit discharge limitations if the permittee complies with all of the following:
1. The permittee demonstrates through properly signed contemporaneous operating logs or other relevant evidence that:
 - (a) An upset occurred and that the permittee can identify the specific cause of the upset.
 - (b) The permitted facility was being properly operated at the time of the upset.
 - (c) If the upset causes the discharge to exceed any discharge limitation in the permit, the permittee submitted notice to the department within twenty-four hours of the upset.
 - (d) The permittee has taken appropriate remedial measures including all reasonable steps to minimize or prevent any discharge or sewage sludge use or disposal that is in violation of the permit and that has a reasonable likelihood of adversely affecting human health or the environment.
 2. In any administrative, civil or criminal enforcement action, the permittee shall prove, by a preponderance of the evidence, the occurrence of an upset condition.
- F. Compliance with a permit issued pursuant to this article shall be deemed compliance with both of the following:
1. All requirements in this article or rules adopted pursuant to this article relating to state implementation of sections 301, 302, 306 and 307 of the clean water act, except for any standard that is imposed under section 307 of the clean water act for a toxic pollutant that is injurious to human health.
 2. Limitations for pollutants in navigable waters adopted pursuant to sections 49-221 and 49-222, if the discharge of the pollutant is specifically limited in a permit issued pursuant to this article or the pollutant was specifically identified as present or potentially present in facility discharges during the application process for the permit.
- G. Notwithstanding section 49-203, subsection D, permits that are issued under this article shall not be combined with permits issued under article 3 of this chapter.
- H. The decision of the director to issue or modify a permit takes effect on issuance if there were no changes requested in comments that were submitted on the draft permit unless a later effective date is specified in the decision. In all other cases, the decision of the director to issue, deny, modify, suspend or revoke a permit takes effect thirty days after the decision is served on the permit applicant, unless either of the following applies:
1. Within the thirty day period, an appeal is filed with the water quality appeals board pursuant to section 49-323.

2. A later effective date is specified in the decision.
- I. In addition to other reservations of rights provided by this chapter, nothing in this article shall impair or affect rights or the exercise of rights to water claimed, recognized, permitted, certificated, adjudicated or decreed pursuant to state or other law.
- J. Only for a one-time rule making after July 29, 2010, the director shall establish by rule fees, including maximum fees, for processing, issuing and denying an application for a permit pursuant to this section. After the one-time rule making, the director shall not increase those fees by rule without specific statutory authority for the increase. Monies collected pursuant to this section shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210.
- K. Any permit conditions concerning threatened or endangered species shall be limited to those required by the endangered species act.
- L. When developing a general permit for discharges of storm water from construction activity, the director shall provide for reduced control measures at sites that retain storm water in a manner that eliminates discharges from the site, except for the occurrence of an extreme event. Reduced control measures shall be available if all of the following conditions are met:
 1. The nearest downstream receiving water is ephemeral and the construction site is a sufficient distance from a water warranting additional protection as described in the general permit.
 2. The construction activity occurs on a site designed so that all storm water generated by disturbed areas of the site exclusive of public rights-of-way is directed to one or more retention basins that are designed to retain the runoff from an extreme event. For the purposes of this subsection, "extreme event" means a rainfall event that meets or exceeds the local one hundred-year, two-hour storm event as calculated by an Arizona registered professional engineer using industry practices.
 3. The owner or operator complies with good housekeeping measures included in the general permit.
 4. The owner or operator maintains the capacity of the retention basins.
 5. Construction conforms to the standards prescribed by this section.
- M. If the director commences proceedings for the renewal of a general permit issued pursuant to this article, the existing general permit shall not expire and coverage may continue to be obtained by new dischargers until the proceedings have resulted in a final determination by the director. If the proceedings result in a decision not to renew the general permit, the existing general permit shall continue in effect until the last day for filing for review of the decision of the director not to renew the permit or until any later date that is fixed by court order.
- N. This program is exempt from section 41-3102.

49-332. Registration

- A. A person who owns an existing dry well that is or has been used for disposal shall register the well on a registration form provided by the director. This form shall be accompanied by a registration fee established by the director by rule in

a one-time rule making after the effective date of this amendment to this section. After the one-time rule making, the director shall not increase that fee by rule without specific statutory authority for the increase. Monies collected by the department shall be deposited, pursuant to sections 35-146 and 35-147, in the water quality fee fund established by section 49-210. The registration form shall include information that the director determines is necessary to meet the purpose of this article.

- B. The director shall assign a registration number to each dry well registered pursuant to this section and shall maintain a permanent record of the information contained on the registration form and the registration number.
- C. An owner who brings a dry well into operation after August 13, 1986 shall register the well on a registration form provided by the director and shall pay the registration fee established by the director by rule within thirty days of beginning operations.
- D. A person who installs a dry well shall notify the owner of the registration requirements of subsection C of this section.
- E. This article shall not be construed to legalize any dry well that exists on August 13, 1986 and that is not in compliance with this chapter and chapter 5 of this title.

49-353. Duties of director; rules; prohibited lead use

- A. The director shall:
 - 1. Exercise general supervision over all matters related to water quality control of public water systems throughout this state.
 - 2. Prescribe rules regarding the production, treatment, distribution and testing of potable water by public water systems, except that such rules shall not apply to irrigation, industrial or similar systems where the water is used for nonpotable purposes. The rules shall comply with at least the following:
 - (a) The requirements established by the United States environmental protection agency for state primary enforcement responsibility of the safe drinking water act, including the requirements of 40 Code of Federal Regulations parts 141 and 142.
 - (b) Require that the plans and specifications for all public water systems, including water treatment plants, distribution systems, distribution system extensions, water treatment methods and devices and all appurtenances and devices for sale to be used in water supplies and public water systems be submitted with a fee for review to the department. The department, in establishing fees authorized by this section, shall comply with title 41, chapter 6. The department shall not set a fee at more than the department's cost of providing the service for which the fee is charged. State agencies are exempt from all fees imposed pursuant to this section. Monies collected from the fees shall be deposited in the water quality fee fund established by section 49-210. The director may require that plans and specifications for public water systems include programs to meet future needs for drinking water and to supply specified minimum quantities of drinking water. The director shall:

- (i) Require that a new public water system demonstrate that the system possesses adequate managerial and financial capacity to operate in compliance with this article and the rules adopted pursuant to this article.
- (ii) Accept adequate findings of other public authorities regarding the adequate managerial and financial capacity of a public water system to operate in compliance with this article and the rules adopted pursuant to this article.
- (c) Provide that no public water system, including a water treatment plant, distribution system, distribution system extension, water treatment method or device, appurtenance and device used in water supplies or public water systems be constructed, reconstructed, installed or initiated before compliance with the standards and rules has been demonstrated by approval of the plans and specifications by the department. The rules shall prescribe minimum standards for the bacteriological, physical and chemical quality of water distributed through public water systems. The director of environmental quality may consult with the director of the department of health services in developing these standards.
- (d) Provide for a simplified administrative procedure for approving structural revisions, additions, extensions or modifications to existing small public water systems for potable water serving a population of three thousand three hundred or fewer persons.
- (e) Exempt from the plan review requirements of this paragraph, including any requirements for approval to construct or approval of construction, any structural revisions, additions, extensions or modifications to public water systems which are in compliance with the department's rules applicable to those systems or which are making satisfactory progress towards compliance under a schedule approved by the department if either of the following conditions is satisfied:
 - (i) The revision, addition, extension or modification has a project cost of twelve thousand five hundred dollars or less.
 - (ii) The revision, addition, extension or modification is made to a water line which is not for a subdivision requiring plat approval by a city, town or county, and has a project cost of more than twelve thousand five hundred dollars but less than fifty thousand dollars, the design of which is sealed by a professional engineer registered in this state and the construction of which is reviewed for conformance with the design by a professional engineer.
- (f) Require a notice of compliance with the conditions for exemption upon the completion of any revisions, additions, extensions or modifications completed in accordance with subdivision (e) of this paragraph.
- (g) Provide for the submission of samples at stated intervals.
- (h) Provide for inspection and certification of such water supplies.
- (i) Provide for the abatement as public nuisances of any premises, equipment, process or device, or public water system that does not comply with the minimum standards and rules.

- (j) Provide for records regarding water quality to be kept by owners and operators of the public water systems and that reports regarding water quality be filed with the department.
 - (k) Provide for appropriate actions to be taken if a water supply does not meet the standards established by the department.
 - (l) Require a public water system to implement a specified program to control contamination from backflow, backsiphonage or cross connection. All such programs shall be consistent with title 41, chapter 16.
 - (m) Require that public water systems identify and provide notice to persons that may be affected by lead contamination of their drinking water where such contamination results from either or both of the following:
 - (i) The lead content in the construction materials of the public water distribution system.
 - (ii) Corrosivity of the water supply sufficient to cause leaching of lead.
 - (n) Provide for relief from water testing and monitoring requirements for public water systems qualifying under the federal safe drinking water act (P.L. 93-523; 88 Stat. 1660; P.L. 95-190; 91 Stat. 1393; P.L. 104-182; 110 Stat. 1613), as amended in 1996.
3. Develop and implement strategies to assist public water systems in acquiring and maintaining the technical, managerial and financial capacity to operate in compliance with this article and the rules adopted pursuant to this article. Assistance may be provided based on the needs of the water system.
- B. Pipes and pipe fittings having a lead content in excess of eight per cent and solders and flux having a lead content in excess of two-tenths of one per cent shall not be used in the installation or repair of public water systems or of any plumbing in residential or nonresidential facilities providing water for human consumption which are connected to public water systems. This subsection shall not apply to leaded joints necessary for the repair of cast iron pipes.
- C. Notwithstanding subsection A, paragraph 2, subdivision (c) of this section, a public water system may construct, reconstruct, install, extend or initiate a water supply system, water treatment plant, distribution system, water treatment method or device, or appurtenance that is used in water supply or in a public water system when the system is out of compliance with standards and rules adopted pursuant to this article only if the construction is necessary to correct the system's noncompliance.
- D. The provisions of this section and the rules adopted pursuant to this section apply to public water systems as described by section 49-352, subsection B.

ARIZONA DEPARTMENT OF INSURANCE (F-16-0804)

Title 20, Chapter 6, Article 1, Hearing Procedures and Rulemaking Petitions; Article 2, Transaction of Insurance; Article 3, Financial Provisions and Procedures; Article 18, Prepaid Dental Plan Organizations; Article 20, Captive Insurers; Article 23, Threshold Rate Review – Individual Health Insurance



**GOVERNOR'S REGULATORY REVIEW COUNCIL
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

MEETING DATE: October 4, 2016

AGENDA ITEM: F-2

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: Shama Thathi, Staff Attorney

DATE : September 16, 2016

SUBJECT: ARIZONA DEPARTMENT OF INSURANCE (F-16-0804)
Title 20, Chapter 6, Article 1, Hearing Procedures and Rulemaking Petitions;
Article 2, Transaction of Insurance; Article 3, Financial Provisions and Procedures;
Article 18, Prepaid Dental Plan Organizations; Article 20, Captive Insurers;
Article 23, Threshold Rate Review – Individual Health Insurance

COMMENTS ON THE FIVE-YEAR-REVIEW REPORT

Purpose of the Agency and Number of Rules in the Report

The purpose of the Arizona Department of Insurance (Department) is to administer the state's insurance laws, protect the citizens of the state who purchase insurance, provide a better response to the needs of persons who purchase insurance, stimulate the insurance market by encouraging competition, protect the public from unregulated insurers and represent insurance consumers' interests. Laws 2010, Ch. 13 § 3.

The rules, as written, became effective at various times between 1992 and 2012.

This five-year-review report covers 44 rules and one table in A.A.C. Title 20, Chapter 6 (Chapter 6). The Department has chosen not to review four additional rules, R20-6-111, R20-6-112, R20-6-206, and R20-6-308, and has allowed them to expire.

Article Contents

Article 1 contains seven rules addressing hearing procedures and rulemaking petitions.

Article 2 contains sixteen rules addressing transactions of insurance, including advertising, surplus lines broker requirements, local or regional retaliatory tax information, unfair gender discrimination, group coverage discontinuance, life insurance solicitation,

readability of policies, unfair discrimination on the basis of blindness, forms for replacement of life insurance, life and disability policy language, and coordination of benefits.

Article 3 contains two rules and one exhibit addressing financial provisions and procedures, including requests for termination of certificate of authority and life and disability reinsurance agreements.

Article 18 contains thirteen rules addressing prepaid dental plan organization, including applications for certificate of authority, officers, required reporting, basic dental services provided, the service delivery system, designation of services areas, contract requirements, dental advertising records, quality improvement, confidentiality of records, and assignment of members and providers.

Article 20 contains one rule addressing fees and costs paid by captive insurers.

Article 23 contains five rules addressing rates charged by health insurers for individual health insurance, including disclosure and timing of submission of preliminary justification, response to unreasonable determination, and document requirements for threshold rate increase.

Proposed Action

Although the Department has identified specific amendments that would make the rules more effective and clear, it does not anticipate this rulemaking will take immediate priority. The specific actions are outlined throughout this memorandum.

Exemption or Request and Approval for Exception from the Moratorium

The Department does not have any immediate plans to request for an exception from the moratorium.

Substantive or Procedural Concerns

None.

Analysis of the agency's report pursuant to criteria in A.R.S. § 41-1056 and R1-6-301:

1. Has the agency certified that it is in compliance with A.R.S. § 41-1091?

Yes. The Department has certified its compliance with A.R.S. § 41-1091.

2. Has the agency analyzed the rules' effectiveness in achieving their objectives?

Yes. The Department indicates that most of the rules are effective in achieving their objectives, with the following exceptions:

- Article 1 contains many rules that are duplicative of the Uniform Administrative Hearing Procedures Act.
- R20-6-102 and R20-6-103 should address parties who wish to appear before the Director and present in a public comment hearing.
- R20-6-160 allows a person to Petition for a Rulemaking. The rule is duplicative of A.R.S. § 41-1033 and should be updated to eliminate any redundancy.
- R20-6-201 should address the significant changes in health insurer advertising methods and venues, resulting from the evolution of social media.
- R20-6-204 should be revised to replace the requirement for an original or certified certificate of compliance with a copy of the certificate. In addition, subsections (E)(5) and (G)(1) should be revised to only require the submission of an annual statement if it has not been filed electronically with the National Association of National Insurance Commissioners.
- R20-6-1805 should be modified to accurately reflect the Department’s current practices.

3. Has the agency received any written criticisms of the rules during the last five years, including any written analysis questioning whether the rules are based on valid scientific or reliable principles or methods?

Yes. The Department indicates that it received one written comment from an insurer, Metropolitan Life Insurance Company (MetLife). The insurer argued that the phrases “tax, license, or other obligation imposed” in R20-6-205(A)(9) and “tax obligation paid” in A.R.S. § 20-230 should be interpreted to mean that an addition to the rate of tax should be based on the tax liabilities incurred from, rather than the cash-basis payments made to, political subdivisions by domestic insurers in other states. However, R20-6-205(D) specifies the calculation to be the quotient of the local or regional taxes reported as paid divided by the premiums taxed under the premium taxing statute of the other state or foreign country.

Although the Department does not agree with the interpretation suggested by MetLife, it adjusted its procedures for establishing the addition to the rate of tax to get a fairer, more predictable outcome for insurers subject to the tax. Also, the Department made a change to the corresponding statute so that the insurers whose home state does not levy a tax on Arizona domestics are not subject to retaliation.

4. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Department cites applicable statutory authority for the rules reviewed. Pursuant to A.R.S. § 20-143(A), “[t]he director may make reasonable rules necessary for effectuating any provision of this title [Title 20, Insurance].” Furthermore, under A.R.S. § 20-142, the director has the authority to enforce Title 20 and has powers expressly conferred by or reasonably implied by Title 20. The Department has also cited specific statutory authority in the report.

5. Has the agency analyzed the rules’ consistency with other rules and statutes?

Yes. The Department indicates that most of the rules are consistent with other rules and statutes, with the following exceptions:

- Article 1 needs to be made consistent with A.R.S. Title 41, Articles 3 and 10, and correct terminology and incorrect references.
- R20-6-101 should be amended to delete definitions such as “contested case” and “hearing officer” and instead include references to the Uniform Administrative Hearing Procedures Act where applicable. Further, new definitions establishing procedures for conducting mandated public comment hearings should be added.
- R20-6-160 contains provisions that are duplicative of A.R.S. § 41-1033. Those provisions should be deleted and only sections which augment the statute should be retained.
- R20-6-207 should be revised to incorporate the new requirements in the Affordable Care Act that prohibit gender classification as a criteria in major medical health insurance policies.
- R20-6-209 and R20-6-214 should be reorganized for consistency with the other rules in the Article.
- R20-6-1802(C), (D), and (F) should be deleted because the provisions are duplicative of statute or impose undue burden on the applicant.
- R20-6-1808(E)(7)(e) should be amended to replace the reference from BODEX to the Council on Dental Education and Licensure, American Dental Association.
- R20-6-2002 contains incorrect statutory references.
- R20-6-2301 should be modified to update or add new definitions to reflect changes in the federal rules. Specifically, a definition for “Plan” should be added, and definitions for “Product” and “Rate increase” should be updated.

6. Has the agency analyzed the current enforcement status of the rules?

Yes. The Department indicates that it enforces the rules to the extent that they are consistent with federal or state rules and statutes.

7. Has the agency analyzed whether the rules are clear, concise, and understandable?

Yes. The Department has identified the following changes that would make the rules more clear, concise, and understandable:

- R20-6-106 should provide clarification as for its application to contested cases only.
- R20-6-160 should be amended to delete definitions that are defined in R20-6-101. This amendment will avoid confusion.
- R20-6-209, R20-6-210 and R20-6-211 should be amended to alphabetize the definitions.
- R20-6-212 contains an outdated reference to the National Association of Insurance Commissioners’ Life Insurance and Annuities Replacement Model Regulation.
- R20-6-1801 should be amended to replace the word “Chapter” with “Article” to reflect that the definitions only apply to Article 18.
- R20-6-2302 should contain language in subsection (A) to include plans within a product.
- R20-6-2305 should be amended to include actuarial values and to add three more submission requirements to reflect the impacts of geographic factors and variations, the

impact of changes within a single risk pool to all products or plans within the risk pool, and the impact of reinsurance and risk adjustment payments and changes.

8. Has the agency analyzed whether:

a. The rules are more stringent than corresponding federal law?

Yes. The Department indicates that the rules are not more stringent than corresponding federal law.

b. There is statutory authority to exceed the requirements of federal law?

Not applicable.

9. For rules adopted after July 29, 2010, has the agency analyzed whether:

a. The rules require issuance of a regulatory permit, license or agency authorization?

Not applicable. The rules do not require issuance of a permit or license.

b. It is in compliance with the general permit requirements of A.R.S. § 41-1037 or explained why it believes an exception applies?

Not applicable.

10. Has the agency indicated whether it completed the course of action identified in the previous five-year-review report?

Yes. The Department indicates that it did not complete the course of action proposed in the previous five-year-review report due to the loss of the Department's Rules Analyst and other rulemaking activities that the Department prioritized over this rulemaking.

11. Has the agency included a proposed course of action?

Yes. The Department indicates that it does not plan to take any action on these rules. During the current tenure of an interim director, the Department does not anticipate that this rulemaking will take priority over other required rulemakings. However, the Department indicates that it will seek public input on the current types of advertising venues and methods to determine whether R20-6-201 should be revised to reflect modern advertising trends.

Conclusion

The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. This analyst recommends the approval of the report.



GOVERNOR'S REGULATORY REVIEW COUNCIL M E M O R A N D U M

MEETING DATE: October 4, 2016

AGENDA ITEM: F-2

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: GRRC Economic Team

DATE : September 16, 2016

SUBJECT: **ARIZONA DEPARTMENT OF INSURANCE (F-16-0804)**
Title 20, Chapter 6, Article 1, Hearing Procedures and Rulemaking Petitions;
Article 2, Transaction of Insurance; Article 3, Financial Provisions and Procedures;
Article 18, Prepaid Dental Plan Organizations; Article 20, Captive Insurers;
Article 23, Threshold Rate Review – Individual Health Insurance

I reviewed the five-year-review report's economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments.

1. Economic Impact Comparison

Economic, small business, and consumer impact statements (EIS) from the most recent rulemakings were available for the Article 1, 2, 3, 18, 20, and 23 rules contained in the five-year-review report. The Department of Insurance ("Department") states that the rules have no adverse impact on the public because the costs are minimal.

The Department adopts rules that facilitate transparent insurance transactions. These rules prohibit types of statements that are deceptive and misleading when used by insurers in advertisements for disability insurance.

The rules in Article 1 detail the ability for an individual to petition the Department for a rulemaking. The rules apply to persons who appear before the Department for hearing procedures, either on their own behalf, or through legal counsel or a duly authorized corporate officer. Since the last five-year review, the Department has not received a petition for a rulemaking.

Article 2 details requirements for maintaining a system of control over content, form and dissemination of disability insurance within advertisements. Since the last rulemaking, the impact of these rules has been minimal, as insurance providers have generally been in compliance with requirements for clear translation of advertising documents.

Article 3 outlines the orderly reinsurance of policyholders in the event that an insurer withdraws from the insurance business in Arizona.

The rules in Article 18 establish concise regulations that pertain to dental plans and the maintenance of dental records. Proposed rulemakings have not significantly increased the premiums paid by the insured.

The rules in Article 20 establish fees for the issuance and renewal of a captive insurer license. Since the last rulemaking, there has been minimal impact on captive insurance companies.

Article 23 outlines the rules enacted by the federal Centers for Medicare & Medicaid Services (CMS) that designate Arizona as a state that conducts effective review of individual health insurance rate increases. The anticipated impact from the last rulemaking predicted having a minimal impact on health insurers, because the rules did not have any new requirements for health insurers that the existing federal regulations did not already have.

2. Has the agency determined that the rules impose the least burden and costs to persons regulated by the rules?

The Department has determined that the rules in Article 1, 2, 3, 18, 20, and 23 impose the least burden and costs to the regulated community. The cost to comply with these rules is minimal and necessary to establish fair insurance standards. The Department has stated that the benefits of each rule outweigh the probable costs.

Although the Department intends to amend some of its rules to clarify definitions and citations to statutory subsections, it does not anticipate this rulemaking will take immediate priority.

3. Was an analysis submitted to the agency under A.R.S. § 41-1056(A)(7)?

No analysis was submitted to the Department by another person that compares the rules' impact on this state's business competitiveness to the impact on businesses in other states under A.R.S. § 41-1056(A)(7).

4. Conclusion

After review, staff concludes that the report complies with A.R.S. § 41-1056 and recommends approval.



**Office of the Director
Arizona Department of Insurance**

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Douglas A. Ducey, Governor
Leslie R. Hess, Interim Director

May 26, 2016

Nicole A. Ong, Council Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Suite 402
Phoenix, Arizona 85007

RE: Arizona Department of Insurance
Five-Year Report on A.A.C. Title 20, Chapter 6, Articles 1, 2, 3, 18, 20 and 23

Dear Ms. Ong:

Under A.R.S. § 41-1056, the Department of Insurance ("Department") submits its Five-Year Report on the above-referenced rules. In accordance with A.A.C. R1-6-301 and the Document Checklist, in addition to this original cover letter, I have enclosed, in paper format, one copy of this cover letter and the Five-year Review Report and, in electronic format, one copy of this cover letter, the Five-Year Review Report, the Rules being reviewed, the General and specific statutes authorizing the rules, and the most recent Economic, Small Business, and Consumer Impact Statement (EIS) for each article.

The Department has not submitted a review of R20-6-111, R20-6-112, R20-6-206 and R20-6-308 so that those rules will expire under A.R.S. § 41-1056.

This letter shall also serve as confirmation that the Department is in compliance with A.R.S. § 41-1091. The Department files substantive policy statements with the Secretary of State's Office and publishes an annual directory of substantive policy statements.

If you have any questions or need additional information regarding this Five-Year Report, please feel free to contact Mary Kosinski, Executive Assistant for Regulatory Affairs, at (602) 364-3476.

Sincerely,

Leslie R. Hess
Interim Director

Enclosures

The Arizona Department of Insurance

Five-Year Review Report

A.A.C. Title 20, Chapter 6, Article 1, 2, 3, 18, 20 and 23

May 2016

ARTICLE 1. HEARING PROCEDURES AND RULEMAKING PETITIONS

A.A.C. R20-101, R20-6-102, R20-6-103, R20-6-106, R20-6-114, R20-6-115 and R20-6-160

Information that is Identical within Article 1 Rules

1. **Authorization:**

The Department adopted these rules under the Director's general rulemaking authority in A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. The specific authority for the rules is found in A.R.S. §§ 20-161, 41-1003, 41-1033 and A.R.S. Title 41, Chapter 6, Article 10.

2. **Objective of the Rules:**

R20-6-101. This rule establishes the applicability of the hearing procedures rules to contested cases before the Department and that, unless expressly authorized by rule or statute, the Arizona Rules of Civil Procedure do not apply to agency proceedings.

R20-6-102. This rule establishes who may appear before the Department, the obligations of attorneys who appear before the Department, what constitutes contemptuous conduct, and the hearing officer's authority to deal with that conduct.

R20-6-103. This rule establishes how and to whom service is to be made and documented and what constitutes a filing with the Department.

R20-6-106. This rule establishes requirements for filing an answer to a notice of hearing.

R20-6-114. This rule sets forth the procedure and grounds for rehearing or review of an order of the Director.

R20-6-115. This rule provides the manner and time frame within which a party may file a response to a request for rehearing.

R20-6-160. This rule sets forth the requirements for a person to petition the Department for a rulemaking.

3. **Analysis of Effectiveness in Achieving the Objectives:**

Many of the current rules, except for the rules that augment the Uniform Administrative Hearing Procedures Act found at A.R.S. Title 41, Chapter 6, Article 10 ("APA"), such as the rule for defaulting a contested case (R20-6-106) and the rules for granting a rehearing or review (R20-6-114 and R20-6-115), are duplicative of the APA.

However, Title 20 has statutes that mandate that the Director make certain findings after a hearing, for example the services customarily provided in the transaction of insurance (see

A.R.S. § 20-465) or whether a reasonable degree of price competition exists in the market (see A.R.S. § 20-383). These hearings are not appealable agency actions (as defined at A.R.S. § 41-1092(3)) or contested cases (as defined at A.R.S. § 41-1001(5)) subject to the APA but are essentially hearings for taking public comment. The Department would like to establish a procedure for conducting these mandated hearings in Article 1.

R20-6-160, the rule that allows a person to Petition for a Rulemaking has parts that are duplicative of A.R.S. 41-1033 (Title 41, Chapter 6, Article 3) and should be updated to eliminate any redundancy.

4. Analysis of Consistency with State and Federal Statutes and Rules:

There are no applicable federal statutes and rules. The rules need to be made consistent with A.R.S. Title 41, Articles 3 and 10 and to correct terminology and incorrect references. Article 1 is consistent with other Department statutes and rules.

5. Status of Enforcement of the Rules:

Because many of the rules duplicate the requirements of the APA, the Department primarily enforces only R20-6-106 (Answer to Notice of Hearing), R20-6-114 (Request for Rehearing or Review) and R20-6-115 (Response to Rehearing).

6. Clarity, Conciseness and Understandability of the Rules:

The rules are generally clear and understandable. Some rules adopted prior to 1995 should be allowed to expire specifically R20-6-111 and R20-6-1112. Other rules should be updated to be consistent with current rule writing standards in the Arizona Rulemaking Manual.

7. Written Criticisms of the Rules during the Last Five Years:

The Department has received no written criticisms of these rules during the past five years.

8. Economic, Small Business and Consumer Impact Summary:

The rules apply to persons who appear before the Department for hearing procedures, either on their own behalf or through legal counsel or a duly authorized corporate officer. The rules also apply to persons who petition the Department for rulemaking. Any economic impact would likely be as a result of statutory requirements that are the basis for these rules. For rules with an EIS, the economic impact has been consistent with that predicted when the rules were enacted.

9. Outsider's Analysis of Business Competitiveness:

The Department has not received any analysis submitted by another person regarding the rules' impact on Arizona business competitiveness as compared to the competitiveness of business in other states.

10. Completed Course of Action from Previous Five-Year Review:

The Department did not complete the course of action indicated in the two previous Five-Year Reviews. In May 2011, the Department obtained an exception to the Governor's rulemaking moratorium but failed to file the rulemaking with GRRC by its target date, March 2012. No rulemaking activity has occurred since that time due to a number of factors including the imposition of the Governor's Moratorium on Rulemaking, loss of the Department's Rules Analyst and other rulemaking activities that the Department prioritized over this rulemaking.

11. Probable Cost Benefit Analysis:

The rules, with the changes recommended in this report, will impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective. The rules, as proposed, will eliminate confusion with APA procedures and provide guidance for both the Department and the regulated public.

12. Stringency:

These rules are not more stringent than a corresponding federal law because no corresponding federal law exists.

13. Compliance with A.R.S. § 41-1037:

These rules predate 2010. These rules do not require issuance of a regulatory permit, license or agency authorization.

14. Proposed Course of Action:

With a new administration in place, the Department will need to petition for an exception to the current Governor's rulemaking moratorium. However, during the current tenure of an Interim Director, the Department does not anticipate that this rulemaking will take priority over any other required rulemakings.

Analysis of Individual Rules

R20-6-101. Scope of Article; Definitions

4. Analysis of Consistency with State and Federal Statutes and Rules:

This Article is not consistent with the APA which applies to all contested cases and appealable agency actions of the Department under A.R.S. § 20-161(A).

This rule should be amended to delete certain definitions like "contested case" and "hearing officer" which already appear in the APA and include references to the APA where applicable. Further, this rule should be amended to add clarifying definitions and new definitions to achieve the Department's objective to establish procedures for conducting mandated public comment hearings.

8. Economic, Small Business and Consumer Impact Summary:

R20-6-101 became effective on February 4, 1999. The Department has not identified anything since that time in conjunction with the adoption of the rule that has an economic impact on insurers, small businesses or consumers. The Department has received no information to date stemming from operation of the rule that has included comments or suggestions of economic impacts.

R20-6-102. Appearance and Practice before the Director

4. Analysis of Consistency with State and Federal Statutes and Rules:

This rule is duplicative of A.R.S. §§ 20-161(B) and 41-1092.07(B) for hearings subject to the APA. This rule should be amended to address parties who wish to appear before the Director for the purpose of having their comment presented in a public comment hearing.

8. Economic, Small Business and Consumer Impact Summary:

R20-6-102 became effective on January 23, 1992. The Department has not identified anything since that time in conjunction with the adoption of the rule that has an economic impact on insurers, small businesses or consumers. The Department has received no information to date stemming from operation of the rule that has included comments or suggestions of economic impacts.

R20-6-103. Filing; Service

4. Analysis of Consistency with State and Federal Statutes and Rules:

This rule is duplicative of A.R.S. § 41-1092.04 and A.A.C. R2-19-108 for hearings subject to the APA. This rule should be amended to address requirements for parties who wish to appear before the Director for the purpose of having their comment recorded in a public comment hearing.

8. Economic, Small Business and Consumer Impact Summary:

R20-6-103 became effective on January 23, 1992. The Department has not identified anything since that time in conjunction with the adoption of the rule that has an economic impact on insurers, small businesses or consumers. The Department has received no information to date stemming from operation of the rule that has included comments or suggestions of economic impacts.

R20-6-106. Answer to Notice of Hearing

4. Analysis of Consistency with State and Federal Statutes and Rules:

This rule is not duplicative of any of the provisions of the APA and should be retained to allow the Department to default cases where a party has been properly served and has failed to file an Answer. However, this rule should be amended to clarify that it applies to contested cases only.

8. Economic, Small Business and Consumer Impact Summary:

R20-6-106 became effective on January 23, 1992. The Department has not identified anything since that time in conjunction with the adoption of the rule that has an economic impact on insurers, small businesses or consumers. The Department has received no information to date stemming from operation of the rule that has included comments or suggestions of economic impacts.

R20-6-114. Request for Rehearing or Review

R20-6-115. Response to Request for Rehearing

4. Analysis of Consistency with State and Federal Statutes and Rules:

These rules work in conjunction with A.R.S. § 41-1092.09 and should be amended to remove any duplicate language. The Department wishes to retain these rules to define grounds upon which a rehearing of an administrative hearing can be granted and to augment and clarify the provisions of the APA.

8. Economic, Small Business and Consumer Impact Summary:

R20-6-114 and R20-6-115 became effective on January 23, 1992. The Department has not identified anything since that time in conjunction with the adoption of the rule that has an economic impact on insurers, small businesses or consumers. The Department has received no information to date stemming from operation of the rule that has included comments or suggestions of economic impacts.

R20-6-160. Petition for Rulemaking Action

4. Analysis of Consistency with State and Federal Statutes and Rules:

This rule works in conjunction with A.R.S. § 41-1033 to specify what information a petitioner needs to provide when seeking to have the Department initiate a rulemaking under the statute. However, some provisions are duplicative of that statute and should be eliminated. The rule should retain only those sections which augment A.R.S. § 41-1033.

6. Clarity, Conciseness and Understandability of the Rules:

The rule is generally clear, concise and understandable. However, the proposed changes to the rule would help reduce confusion by eliminating definitions of terms already defined in R20-6-101.

7. Written Criticisms of the Rules during the Last Five Years:

The Department has received no written criticisms of this rule during the last five years. In addition, the Department has not received a Petition for a rulemaking since the last five-year review.

8. **Economic, Small Business and Consumer Impact Summary:**

R20-6-160 became effective on February 4, 1999. The Department has not identified anything since that time in conjunction with the adoption of the rule that has an economic impact on insurers, small businesses or consumers. The Department has received no information to date stemming from operation of the rule that has included comments or suggestions of economic impacts.

ARTICLE 2. TRANSACTION OF INSURANCE

A.A.C. R20-6-201, R20-6-201.01, R20-6-201.02, R20-6-202, R20-6-203, R20-6-204, R20-6-205, R20-6-207, R20-6-208, R20-6-209, R20-6-210, R20-6-211, R20-6-212, R20-6-212.01, R20-6-213 and R20-6-214

Information that is Identical within Article 2 Rules

1. **Authorization:**

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-207 is provided by A.R.S. § 20-448. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110. Further, authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111. Further authority for R20-6-210 and R20-6-213 is provided in A.R.S. § 20-1110.01.

2. **Objective of the Rules:**

R20-6-201. This rule contains definitions and defines the types of statements that are deceptive and misleading when used by insurers in advertisements for disability insurance.

R20-6-201.01. This rule contains requirements for maintaining a system of control over content, form and dissemination of advertisements, and sets forth recordkeeping requirements for advertisements.

R20-6-201.02. This rule contains requirements and procedures for filing advertising materials and contents to be included in transmittal forms.

R20-6-202. This rule requires the disclosure of relevant facts and defines statements and omissions that are misleading and deceptive in the advertising, solicitation of and transaction of life insurance.

R20-6-203. This rule contains requirements for filing English translations when a filed form contains verbiage in a language other than English.

R20-6-204. This rule establishes requirements and procedures for the inclusion of insurers on the Director's list of unauthorized insurers that may write surplus lines insurance.

R20-6-205. This rule describes how the Director will calculate additions to the rates of tax that must be included in retaliation calculations by foreign and alien insurers. The rule requires each addition to the rate of tax to reflect the taxes, licenses or other obligations imposed by cities, counties or other political subdivisions of each other state or foreign country on domestic insurers or their agents, with one addition to the rate of

tax calculated from data for Arizona life insurers and a separate rate calculated from data for other Arizona insurers.

R20-6-207. This rule prohibits unfair discrimination by insurers on the basis of gender or marital status in the terms and conditions of insurance contracts and underwriting criteria.

R20-6-208. This rule sets forth requirements for group coverage discontinuance and replacement.

R20-6-209. This rule requires that insurers provide to buyers of life insurance various materials and information to assist buyers in selecting appropriate policies.

R20-6-210. This rule establishes the readability standards for a variety of insurance policy types so that the insurance contract can be reasonably understood by a person without special knowledge or training in insurance.

R20-6-211. This rule prevents any unfair discrimination by insurers toward blind or partially blind persons in the rates charged, the availability of, and the terms and conditions of, insurance contracts.

R20-6-212. This rule incorporates by reference requirements of the National Association of Insurance Commissioner model regulations for forms to be used in the replacement of life insurance policies and annuities.

R20-6-213. This rule establishes minimum standards for language used in life and disability policies to facilitate ease of reading.

R20-6-214. This rule establishes requirements for coordination of benefits.

4. Analysis of Consistency with State and Federal Statutes and Rules:

Except for R20-6-206, which should be allowed to expire, these rules are consistent with state statutes and rules

5. Status of Enforcement of the Rules:

The Department enforces these rules.

9. Outsider's Analysis of Business Competitiveness:

The Department has not received analysis submitted by another person regarding the rules' impact on Arizona business competitiveness as compared to the competitiveness in other states.

10. Completed Course of Action from Previous Five-Year Review:

The Department proposed a minor typographical error change in R20-6-214 in 2011. It proposed to inquire with the Office of the Secretary of State ("SOS") whether the

typographical error could be corrected. Since the Department cannot now locate any typographical errors in the rule, it appears that the SOS corrected the error.

12. Stringency:

The rule is not more stringent than a corresponding federal law because there is no corresponding federal law.

13. Compliance with A.R.S. § 41-1037:

Not applicable.

Analysis of Individual Rules

R20-6-201. Advertisements of Health Insurance

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective

6. Clarity, Conciseness and Understandability of the Rule:

This rule should be updated to address the significant changes in the method and venue of health insurer advertising resulting from the advent of social media.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes to seek public input on the current types of advertising venues and methods to determine if and how the rule could be updated to reflect modern advertising..

R20-6-201.01. Insurer Advertising Responsibility and Records

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule is clear, concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes no changes.

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

3. **Analysis of Effectiveness in Achieving Objective:**

This rule achieves its objective.

6. **Clarity, Conciseness and Understandability of the Rule:**

This rule is clear, concise and understandable.

7. **Written Criticisms of the Rules during the Last Five Years:**

The Department has not received written criticisms of this rule within the past five years.

8. **Economic, Small Business and Consumer Impact Summary:**

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. **Probable Cost Benefit Analysis:**

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. **Proposed Course of Action:**

The Department proposes no changes.

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

1. **Authorization:**

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

3. **Analysis of Effectiveness in Achieving Objective:**

This rule achieves its objective.

6. **Clarity, Conciseness and Understandability of the Rule:**

This rule is clear, concise and understandable.

7. **Written Criticisms of the Rule during the Last Five Years:**

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes no changes.

R20-6-203. Form Filings; Translations

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. \

3. Analysis of Effectiveness Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule is clear, concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes no changes.

R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule is clear, concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on January 5, 2000 and was amended effective August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes to change subsection (E)(1) to replace the requirement for an original or certified certificate of compliance with a current certificate. This will allow the Department to receive more updated information and allow electronic filing.

The Department proposes to revise subsections (E)(5) and (G)(1) to only require the submission of an annual statement if it has not been filed electronically with the National Association of Insurance Commissioners. This change will reduce duplicate efforts by insurers.

R20-6-205. Local or Regional Retaliatory Tax Information

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

3. Analysis of Effectiveness in Achieving Objective:

This rule may not always achieve its objective. The rule requires the addition to the rate of tax be calculated as the quotient of the local taxes and fees actually paid to subdivisions within another state or foreign country divided by the total premiums the insurer wrote in that state or foreign country. A domestic insurer may be encouraged to overpay burdens when minimum estimated or installment payment requirements carry substantial penalties for underpayments. When domestic insurers overpay in a jurisdiction, the ratio of actual payments to premiums written increases, thereby subjecting foreign insurers domiciled in the state to higher additions to the rates of tax that must be included in retaliation calculations.

6. Clarity, Conciseness and Understandability of the Rule:

Although the Department considers this rule to be clear, concise and understandable, one insurer criticized the application of the rule as written (see section 7 below).

7. Written Criticisms of the Rule during the Last Five Years:

One insurer (Metropolitan Life Insurance Company) argued that the phrase "tax obligation paid," as set forth in A.R.S. §20-230, and the phrase "tax, license, or other obligation imposed" as set forth in A.A.C. R20-6-205(A)(9) should be interpreted to mean that each addition to the rate of tax should be based on the tax liabilities incurred from, rather than the cash-basis payments made to, political subdivisions by domestic insurers in other states, despite language in A.A.C. R20-6-205(D) that specifies the calculation as being the quotient of the local or regional taxes reported as paid divided by the premiums written in the state or foreign country.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

This rule provides questionable adequate benefit to warrant the cost to persons regulated by the rule. In particular, every domestic insurer must expend significant resources to report each payment of each tax, fee, assessment or other burden the insurer incurred by each political subdivision of each other state or foreign country so that the Director has the information required to determine the reasonableness of information filed, to aggregate information filed by all domestic insurers and to calculate correct additions to the rates of tax applicable separately to life insurers and to all other insurers for each other state and

foreign country that permits political subdivisions to impose burdens on Arizona's domestic insurers.

14. Proposed Course of Action:

The Department proposes that this rule be amended to allow the Director to determine when the calculation of the addition to the rate of tax for life insurers or for all other insurers for another state or foreign country exceeds the maximum tax liability that a domestic insurer might reasonably be expected to incur in the other state or foreign country, and in such instances, to reduce the addition to the rate of tax to that maximum tax liability.

R20-6-207. Gender Discrimination

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-207 is provided by A.R.S. § 20-448.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule conflicts with certain provisions of the Affordable Care Act which prohibit using gender as an underwriting factor in major medical health insurance policies. The rule is still applicable to other types of disability insurance policies, however.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes that this rule be amended to align the rule with the new requirements in the Affordable Care Act that prohibit the use of gender as an underwriting criteria in major medical health insurance policies. The rule is still applicable as is to a

number of types of disability and health insurance, but certain provisions in the rule can no longer be applied to major medical health insurance.

R20-6-208. Group Coverage Discontinuance and Replacement

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule is clear, concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes no changes.

R20-6-209. Life Insurance Solicitation

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110. Further,

authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule is clear, concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes an amendment to this rule to make it more consistent with other rules in this Article by placing the subsection containing the definitions as the first subsection (Subsection A) of the rule. It will also alphabetize the definitions.

R20-6-210. Readable and Understandable Policy; Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110. Further, authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111. Further authority for R20-6-210 and R20-6-213 is provided in A.R.S. § 20-1110.01.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. **Clarity, Conciseness and Understandability of the Rule:**

This rule is clear, concise and understandable.

7. **Written Criticisms of the Rule during the Last Five Years:**

The Department has not received written criticisms of this rule within the past five years.

8. **Economic, Small Business and Consumer Impact Summary:**

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. **Probable Cost Benefit Analysis:**

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. **Proposed Course of Action:**

The Department proposes an amendment to this rule to alphabetize the definitions in subsection A.

R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness

1. **Authorization:**

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110. Further, authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111.

3. **Analysis of Effectiveness in Achieving Objective:**

This rule achieves its objective.

6. **Clarity, Conciseness and Understandability of the Rule:**

This rule is clear, concise and understandable.

7. **Written Criticisms of the Rule during the Last Five Years:**

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 1, 1979 and last amended on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes an amendment to this rule to alphabetize the definitions in subsection A.

R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110. Further, authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule contains references to older versions of the National Association of Insurance Commissioners' Life Insurance and Annuities Replacement Model Regulation ("NAIC Model Regulation"), but is otherwise concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on March 27, 1978 and last amended on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes that this rule be amended to update the references to the current version of the NAIC Model Regulation.

R20-6-212.01. Forms for Buyer's Guide for Annuities

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110. Further, authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule is clear, concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes no changes.

R20-6-213. Life and Disability Insurance Policy Language Simplification

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110. Further, authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111. Further authority for R20-6-210 and R20-6-213 is provided in A.R.S. § 20-1110.01.

3. Analysis of Effectiveness in Achieving Objective:

This rule achieves its objective.

6. Clarity, Conciseness and Understandability of the Rule:

This rule is clear, concise and understandable.

7. Written Criticisms of the Rule during the Last Five Years:

The Department has not received written criticisms of this rule within the past five years.

8. Economic, Small Business and Consumer Impact Summary:

This rule became effective on November 21, 1977 and was last amended on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes no changes.

R20-6-214. Coordination of Benefits

1. Authorization:

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

3. **Analysis of Effectiveness in Achieving Objective:**

This rule achieves its objective.

6. **Clarity, Conciseness and Understandability of the Rule:**

This rule is clear, concise and understandable.

7. **Written Criticisms of the Rule during the Last Five Years:**

The Department has not received written criticisms of this rule within the past five years.

8. **Economic, Small Business and Consumer Impact Summary:**

This rule became effective on October 26, 1979 and was last amended on August 4, 2007. The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the rulemaking.

11. **Probable Cost Benefit Analysis:**

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. **Proposed Course of Action:**

The Department proposes an amendment to the rule to make it more consistent with other rules in this Article by placing the subsection containing the definitions as the first subsection (Subsection A) of this rule.

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES

A.A.C. R20-6-303, R20-6-307

Information that is Identical for A.A.C. R20-6-303 and R20-6-307

1. **Authorization:**

The Department adopted these rules under the Director's general rulemaking authority pursuant to A.R.S. § 20-143. Additional authority for the adoption of R20-6-303 is provided by A.R.S. §§ 20-581 and 20-588.

2. **Objective of the Rules:**

R20-6-303. This rule provides for an orderly procedure for insurers to withdraw from the insurance business in Arizona and secure the release of deposits made pursuant to A.R.S. § 20-581 without placing policyholders, former policyholders or claimants in jeopardy.

R20-6-307. This rule and Table A, which identifies significant risks, prevents an insurer that cedes life or disability insurance from reporting an increase in assets or a decrease in liabilities as a result of a reinsurance transaction, if the reinsurance transaction does not provide for a transfer of insurance risk from the ceding insurer to the reinsurer. The rule also contains Table A which lists risk categories.

3. **Analysis of Effectiveness in Achieving Objectives:**

These rules generally achieve their objectives.

4. **Analysis of Consistency with State and Federal Statutes and Rules:**

These rules are consistent with state statutes and rules.

5. **Status of Enforcement of the Rules:**

The Department experiences no difficulty enforcing these rules.

6. **Clarity, Conciseness and Understandability of the Rules:**

These rules are well organized, do not contain unnecessary verbiage and are clear, concise and understandable in their present form. These rules are technical in nature and contain industry specific language necessary for proper enforcement of the rules and consistency with regulation in other states.

7. **Written Criticisms of the Rules during the Last Five Years:**

None.

8. **Economic, Small Business and Consumer Impact Summary:**

These rules are technical and procedural in nature. The Department has not identified anything that has happened in the past 5 years in conjunction with the adoption of the rules that has an economic impact upon the insurers, small businesses or consumers. The information received to date by the Department stemming from its enforcement of the rules has included no comments or suggestions that the rule contributes to costs different from those projected by the Department when it sought to adopt the rules.

9. **Outsider's Analysis of Business Competitiveness:**

None

10. **Course of Action from Previous Five-Year Review:**

Not applicable.

11. **Probable Cost Benefit Analysis:**

The rules' benefits outweigh, within this State, the costs of the rules and impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs necessary to achieve the underlying regulatory objectives.

12. **Stringency:**

These rules are not more stringent than a corresponding federal law because there is no corresponding federal law.

13. **Compliance with § 41-1037:**

Not applicable.

14. **Proposed Course of Action:**

R20-6-303

This rule should remain unchanged.

R20-6-307

This rule should remain unchanged.

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ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS

A.A.C. R20-6-1801, R20-6-1802, R20-6-1803, R20-6-1804, R20-6-1805, R20-6-1806, R20-6-1807, R20-6-1808, R20-6-1809, R20-6-1810, R20-6-1811, R20-6-1812 and R20-6-1813

Information That is Identical Within Article 18 Rules

1. **Authorization:**

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143 and specific authority under A.R.S. §§ 20-1001 through 20-1019 and 20-2510. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has powers expressly conferred or reasonably implied by Title 20.

2. **Objective of the Rules:**

R20-6-1801. The purpose and objective of this rule is to establish definitions for Article 18.

R20-6-1802. This rule establishes requirements for application for a Certificate of Authority.

R20-6-1803. This rule establishes requirements for the chief executive officer.

R20-6-1804. This rule establishes the qualifications and functions of the dental director.

R20-6-1805. This rule establishes the requirements for reporting changes in the written program of compliance and the information that must be submitted to the Department quarterly or annually.

R20-6-1806. This rule establishes basic dental services.

R20-6-1807. This rule establishes the requirements for a system for delivery of services.

R20-6-1808. This rule establishes the requirements for designating the geographic areas that will be served by the Organization's prepaid dental plan.

R20-6-1809. This rule establishes the requirements for the Organization's contracts with providers.

R20-6-1810. This rule establishes the requirements for maintenance of member dental records and certain business records.

R20-6-1811. This rule establishes the standards for quality improvement.

R20-6-1812. This rule establishes the requirements for confidentiality of records.

R20-6-1813. This rule establishes the requirements for assignment of members to providers.

3. Analysis of Effectiveness in Achieving the Objectives:

These rules are effective in achieving their objectives.

4. Analysis of Consistency with State and Federal Statutes and Rules:

These rules are consistent with state statutes and the Department's rules. No Federal Statutes or Rules apply.

5. Status of Enforcement of the Rules:

The Department enforces these rules.

6. Clarity, Conciseness and Understandability of the Rules:

The rules are clear, concise and understandable.

7. Written Criticisms of the Rules during the Last Five Years:

None.

8. Economic, Small Business and Consumer Impact Summary:

The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for that rulemaking.

9. Outsider's Analysis of Business Competitiveness:

None

10. Completed Course of Action from Previous Five-Year Review:

The Department did not propose any course of action in the previous Five-Year Report in 2011.

11. Probable Cost Benefit Analysis:

The rules, with the changes recommended in this report, will impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective. The rules, as proposed will eliminate confusion, reduce the requirement for

submission of duplicative information, reduce the frequency of reporting some information and will eliminate some reporting requirements altogether.

12. Stringency:

The rule is not more stringent than a corresponding federal law because there is no corresponding federal law.

13. Compliance with A.R.S. § 41-1037:

Not Applicable.

14. Proposed Course of Action:

The Department proposes changes to four rules: R20-6-1801 – Definitions; R20-6-1802 - Application for Certificate of Authority; R20-6-1805 - Required Reporting and R20-6-1811 - Quality Improvement.

The Department has no immediate plans to do this rulemaking.

Analysis of Individual Rules

R20-6-1801. Defintions

11. Probable Cost Benefit Analysis:

This rule, with the change recommended in this report, will impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

14. Proposed Course of Action:

The Department proposes a change to this rule to replace the word “Chapter” with “Article” in the opening sentence to reflect that the definitions only apply to Article 18.

R20-6-1802. Application for Certificate of Authority

11. Probable Cost Benefit Analysis:

The rule, with the changes recommended in this report, will impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective. The changes proposed will generally reduce duplicative information that the Prepaid Dental Plans must submit to the Department and reduce the regulatory burden to an applicant.

14. Proposed Course of Action:

The Department proposes deletion of the following subsections: (C), (D) and (F) because these sections are either duplicative of other A.R.S. Title 20 requirements or because they impose an unnecessary burden on the applicant. The remaining sections will need to be renumbered.

R20-6-1805. Required Reporting

11. Probably Cost Benefit Analysis:

The rule, with the changes recommended in this report, will impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective. The changes proposed will generally reduce duplicative information that the Prepaid Dental Plans must submit to the Department, change some reporting requirements from quarterly to annually and eliminate some requirements altogether.

The one proposed change from an annual reporting requirement to a quarterly reporting requirement is not expected to substantially increase the burden to Prepaid Dental Plans because they already maintain that data on a quarterly basis.

14. Proposed Course of Action:

The Department proposes changes to subsections (B)(3) and (B)(5) of this rule to more accurately reflect what it currently receives from the Prepaid Dental Plans on a quarterly basis.

The Department plans to delete subsection (B)(6) because the Department already maintains and publishes complaint data on its website.

The Department proposes to eliminate subsection (C)(2) as duplicative because the requirement for a recall system is already demonstrated in an organization's program of compliance to obtain a certificate of authority as well as through the facility reviews conducted under other rules.

The Department proposes to rewrite subsection (C)(3) to move the requirement pertaining to general dentists to the quarterly reporting requirement under subsection (B).

The Department proposes to strike subsection (C)(4) because compiling the data for this requirement has not proved to be relevant for Prepaid Dental Plan regulatory oversight.

R20-6-1808. Geographic Areas

11. Probably Cost Benefit Analysis:

The rule, with the changes recommended in this report, will impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective

14. Proposed Course of Action:

The Department proposes to rewrite subsection (B) to require a Prepaid Dental Plan to define its geographic areas only by local government jurisdictions, such as cities or counties.

R20-6-1811. Quality Improvement

11. Probable Cost Benefit Analysis:

The rule, with the change recommended in the report, will impose no new burden or cost to persons regulated under the rule.

14. Proposed Course of Action:

The Department proposes to replace the reference in subsection (E)(7)(e) from BODEX to the Council on Dental Education and Licensure, American Dental Association.

ARTICLE 20. CAPTIVE INSURERS

A.A.C. R20-6-2002

1. **Authorization:**

The Department adopted this rule under the Director's general rulemaking authority under A.R.S. § 20-143 and specific authority under A.R.S. §§ 20-167(H), 20-1098, 20-1098.01(J), 20-1098.05, 20-1098.06, 20-1098.07 and 20-1098.08.

2. **Objective of the Rule:**

R20-6-2002. This rule establishes fees for the issuance and renewal of a captive insurer license under A.R.S. § 20-167(H) and to clarify that costs a captive insurer must pay for any examination the Director conducts are in addition to the license issuance and renewal fees.

3. **Analysis of Effectiveness in Achieving the Objective:**

This rule effectively achieves its objective.

4. **Analysis of Consistency with State and Federal Statutes and Rules:**

This rule is generally consistent with state statutes and the Department's rules. As a result of a statutory change subsequent to rulemaking in 2005, two citations to statutory subsections are incorrect. The Department will promulgate a rulemaking after the Moratorium is lifted.

5. **Status of Enforcement of the Rule:**

The Department enforces this rule.

6. **Clarity, Conciseness and Understandability of the Rule:**

The rule is clear, concise and understandable.

7. **Written Criticisms of the Rule during the Last Five Years:**

None.

8. **Economic, Small Business and Consumer Impact Summary:**

The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for this rulemaking.

9. **Outsider's Analysis of Business Competitiveness:**

None

10. Completed Course of Action from Previous Five-Year Review :

The Department had proposed to correct two citations to statutory subsections that are incorrect by requesting that the Secretary of State make those corrections. Those corrections do not appear to have been made.

11. Probable Cost Benefit Analysis:

The rule's benefits outweigh, within this State, the costs of the rule and impose the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

12. Stringency:

The rule is not more stringent than a corresponding federal law because there is no corresponding federal law.

13. Compliance with A.R.S. § 41-1037:

Not applicable.

14. Proposed Course of Action:

The Department will promulgate a rulemaking to correct the statutory citations that have not been corrected by the Secretary of State once the Moratorium is lifted. The Department proposes to change the following incorrect statutory references in subsection A: first reference to A.R.S. § 20-1098 to A.R.S. § 20-1098.01; and second reference to A.R.S. § 20-1098 to A.R.S. § 20-1098(22).

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

A.A.C. R20-6-2301, R20-6-2302, R20-6-2303, R20-6-2304 and R20-6-2305

Information that is Identical within Article 23 Rules

1. **Authorization:**

The Department adopted this rule under the Director's general rulemaking authority under A.R.S. § 20-143 and specific authority under A.R.S. § 20-238. Additionally, 45 CFR 154.301(a)(5), a rule promulgated pursuant to the Affordable Care Act, allows a state to determine the standard for effective rate review by regulation.

2. **Objective of the Rules:**

R20-6-2301. The purpose and objective of this rule is to establish applicability of Article 23 to rates charged by health insurers for individual health insurance and to define relevant terms.

R20-6-2302. This rule establishes the requirement for the submittal of a preliminary justification when an insurer submits a threshold rate increase to the Department.

R20-6-2303. This rule establishes the timing by which an insurer must submit a preliminary justification to the Department, and establishes the Department's obligation to public portions of the preliminary justification and to provide a mechanism for public comment on proposed rate increases.

R20-6-2304. This rule gives a submitting insurer options for when the Department finds that a threshold rate increase is unreasonable.

R20-6-2305. This rule establishes the requirements for sufficient documentation the insurer must submit when it requests a threshold rate increase.

3. **Analysis of Effectiveness in Achieving the Objectives:**

These rules achieve their objectives.

4. **Analysis of Consistency with State and Federal Statutes and Rules:**

These rules are consistent with state statutes and rules and the Federal Affordable Care Act rule, 45 CFR 154.301(a)(5).

5. **Status of Enforcement of the Rules:**

The Department has no difficulty enforcing these rules.

6. **Clarity, Conciseness and Understandability of the Rules:**

These rules are generally clear and understandable.

7. **Written Criticisms of the Rules during the Last Five Years:**

None.

8. **Economic, Small Business and Consumer Impact Summary:**

The Department has not identified any economic impact that is significantly different from that projected in the economic impact statement for the original rulemaking. This is the rules' first 5 year review.

9. **Outsider's Analysis Business Competitiveness:**

None

10. **Completed Course of Action from Previous Five-Year Review:**

The rules became effective on October 3, 2012. This is the first Five-Year Report for Article 23.

11. **Probable Cost Benefit Analysis:**

The rules' benefits outweigh, within this State, the costs of the rules and impose the least burden and costs to persons regulated by the rules, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective.

12. **Stringency:**

The rules are not more stringent than the corresponding federal law because the corresponding federal law requires the Department to promulgate rules.

13. **Compliance with A.R.S. § 41-1037:**

Not applicable.

14. Proposed Course of Action:

The Department will seek some minor technical corrections to these rules in the future in order to conform with changes to the federal rules.

Analysis of Individual Rules

R20-6-2301. Applicability; Definitions

14. Proposed Course of Action:

The Department proposes to update or add new definitions to reflect changes to the federal rules. Specifically to add a new definition for “Plan” and to update definitions for “Product” and “Rate Increase.”

R20-6-2302. Disclosure of Preliminary Justification

14. Proposed Course of Action:

The Department proposes to add language to subsection A to include plans within a product.

R20-6-2305. Threshold Rate Increase Documentation Requirements

14. Proposed Course of Action:

The Department proposes to add language to subsection B.3. to include actuarial values and to add three more submission requirements to reflect the impacts of geographic factors and variations, the impact of changes within a single risk pool to all products or plans within the risk pool and the impact of reinsurance and risk adjustment payments and changes.

ARTICLE 1. HEARING PROCEDURES AND RULEMAKING PETITIONS

Section

R20-6-101.	Scope of Article; Definitions
R20-6-102.	Appearance and Practice before the Director
R20-6-103.	Filing; Service
R20-6-104.	Expired
R20-6-105.	Expired
R20-6-106.	Answer to Notice of Hearing
R20-6-107.	Expired
R20-6-108.	Expired
R20-6-109.	Expired
R20-6-110.	Expired
R20-6-113.	Expired
R20-6-114.	Request for Rehearing or Review
R20-6-115.	Response to Request for Rehearing
R20-6-116.	Reserved through
R20-6-158.	Reserved
R20-6-159.	Repealed
R20-6-160.	Petition for Rulemaking Action

ARTICLE 1. HEARING PROCEDURES AND RULEMAKING PETITIONS

R20-6-101. Scope of Article; Definitions

- A.** Scope. This Article and Title 20 of the Arizona Revised Statutes govern contested cases before the Department. Except as otherwise provided in R20-6-160 for rulemaking petitions, this Article does not apply to rulemaking or investigative proceedings before the Department. Unless expressly applicable by rule or statute, the Arizona Rules of Civil Procedure do not apply to contested cases.
- B.** Definitions. In this Article, the following definitions apply:
1. "Attorney General" means the Attorney General of Arizona, and the Attorney General's assistants or special agents.
 2. "Contested case" means any proceeding in which the legal rights, duties or privileges of a party are required by law to be determined by the Director after an opportunity for hearing.
 3. "Department" means the Arizona Department of Insurance.
 4. "Hearing Officer" means a person appointed by the Director to hear a contested case and make recommendations.
 5. "Party" has the meaning prescribed in A.R.S. § 41-1001(12).
 6. "Person" has the meaning prescribed in A.R.S. § 41-1001(13).
 7. "Director" means the Director of the Department or a hearing officer or any deputy, assistant or examiner of the Director acting in the Director's name in accordance with A.R.S. § 20-150.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-101 recodified from R4-14-101 (Supp. 95-1). Amended by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1).

R20-6-102. Appearance and Practice before the Director

- A.** Any person may appear in his own behalf or through counsel. An insurer may appear through legal counsel or through a duly authorized officer of the corporation.
- B.** When an attorney other than the Attorney General appears or intends to appear before the Director, he shall promptly advise the Director of his name, address and telephone number and the name and address of the person on whose behalf he intends to appear.
- C.** Conduct at any hearing which, in the discretion of the Director, is deemed contemptuous shall be grounds for exclusion from the hearing. Contemptuous conduct shall include willful noncompliance with an order of the Director or hearing officer, willful disruption or obstruction of any hearing, or any other willful conduct during any hearing which lessens the dignity or authority of the Director or hearing officer.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-102 recodified from R4-14-102 (Supp. 95-1).

R20-6-103. Filing; Service

- A.** No paper shall be deemed filed until received by the Director.
- B.** Unless otherwise provided by these rules, copies of all papers filed shall, at or before the time of filing, be served on the hearing officer, the Attorney General, and all parties to the proceeding.
- C.** Whenever under these rules service is required or permitted to be made upon a party represented by an attorney, the service shall be made upon the attorney.

- D. Service upon the attorney, or upon a party, shall be made personally in accordance with Rule 5(c) of the Arizona Rules of Civil Procedure, or by mail by enclosing a copy thereof in a sealed envelope and depositing same, postage prepaid, in the United States mail, addressed to the party to be served or his attorney at the address as shown by the records of the Director. Service by mail is complete upon deposit in the United States Mail.
- E. All notices of hearing and final decisions issued by the Director shall be served by mail.
- F. Proof of service shall be made by filing with the Director a written statement that service was made.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-103 recodified from R4-14-103 (Supp. 95-1).

R20-6-104. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-104 recodified from R4-14-104 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-105. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-105 recodified from R4-14-105 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-106. Answer to Notice of Hearing

- A. In any notice of hearing, the Director may require that one or more parties shall file a written answer to the allegations contained in the notice of hearing. Even if not directed to do so, any party may file such an answer.
- B. Except where a different period is provided by the notice of hearing, a party directed to file a written answer shall do so within 20 days after issuance of the notice of hearing. Where amendments to the assertions contained in the notice of hearing are made subsequent to service of the notice of hearing, one or more of the parties may be required to answer within a reasonable time the amended assertions.
- C. Unless otherwise directed by the Director, an answer filed under this rule shall briefly state the party's position or defense to the proceeding and shall specifically admit or deny each of the assertions contained in the notice of hearing. If the answering party is without or is unable to reasonably obtain knowledge or information sufficient to form a belief as to the truth of an assertion, he shall so state, which shall have the effect of a denial. Any assertion not denied shall be deemed to be admitted. When answering party intends in good faith to deny only a part of an assertion, he shall specify so much of it as is true and shall deny only the remainder.
- D. If a party fails to file an answer required by the Director within the time provided, such person shall be deemed in default and the proceeding may be determined against him by the Director and one or more of the assertions contained in the notice of hearing may be deemed to be admitted.
- E. Any defenses not raised in the answer shall be deemed to be waived.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-106 recodified from R4-14-106 (Supp. 95-1).

R20-6-107. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-107 recodified from R4-14-107 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-108. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-108 recodified from R4-14-108 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-109. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-109 recodified from R4-14-109 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-110. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-110 recodified from R4-14-110 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-113. Expired

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-113 recodified from R4-14-113 (Supp. 95-1). Section expired

under A.R.S. § 41-1056(E) at 17 A.A.R. 1421, effective May 31, 2011 (Supp. 11-3).

R20-6-114. Request for Rehearing or Review

- A. Within 30 days after service of the Director's order on the hearing, any aggrieved party may request a rehearing or review of the order. The request shall be in writing and shall be served upon the Director as provided by R20-6-103, and a copy shall be served upon all other parties to the hearing, including the Attorney General if the Attorney General is not the party filing the request.
- B. A request for rehearing or review shall be based upon one or more of the following grounds which have materially affected the rights of a party:
 - 1. Irregularity in the hearing proceedings, or any order or abuse of discretion whereby the party seeking rehearing or review was deprived of a fair hearing;
 - 2. Misconduct by the Director, the hearing officer or any party to the hearing;
 - 3. Accident or surprise which could not have been prevented by ordinary prudence;
 - 4. Newly discovered material evidence which could not have been discovered with reasonable diligence and produced at the hearing;
 - 5. Excessive or insufficient sanctions or penalties imposed;
 - 6. Error in the admission or rejection of evidence, or errors of law occurring at the hearing or during the course of the hearing;
 - 7. Bias or prejudice of the Director or hearing officer;
 - 8. That the order, decision, or findings of fact are not justified by the evidence or are contrary to law.
- C. A request for rehearing or review shall specify which of the grounds listed in subsection (B) it is based upon and shall set forth specific facts and laws in support of the request. A request may cite relevant portions of testimony from the hearing by referring to the pages or lines of the reporter's transcript of the hearing and may cite hearing exhibits by reference to the exhibit number.
- D. A request for rehearing shall specify the relief sought by the request, such as a different finding of fact, conclusion of law or order. A request for rehearing or review may seek multiple forms of relief in the alternative.
- E. When a request for rehearing is based upon affidavits, they shall be attached to and filed with the request unless leave for later filing of affidavits is granted by the Director or hearing officer. Leave may be granted ex parte.
- F. A request for rehearing or review of the Director's order on the hearing which is not timely made is deemed waived for the purpose of judicial review. A party who fails to request rehearing or review of the Director's order on the hearing shall be barred from raising a claim in any proceeding in which the Director, the hearing officer or the Department of Insurance is a party, except as otherwise required by law.
- G. A party may file a written request for a stay of the Director's decision. An order entered by the Director shall not be stayed by the filing of a stay request or a request for rehearing or review. The Director may stay an order pending the resolution of a request for rehearing or review or when justice requires.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-114 recodified from R4-14-114 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2).

R20-6-115. Response to Request for Rehearing

- A. Each party served with a request for rehearing pursuant to R20-6-114 shall be permitted to file a response within 15 days after the request for rehearing has been filed. This response shall be designated as a "response to request for rehearing or review" and shall be in writing. Affidavits may be attached to and filed with the response. If not filed in this manner, an affidavit shall be filed only if leave for later filing of affidavits is granted by the hearing officer or Director. Leave may be granted ex parte. The original response shall be filed with the Department as provided in R20-6-103, and one copy shall be served upon all other parties to the hearing, including the Attorney General if the Attorney General is not the party filing the response.
- B. The hearing officer or Director has the discretion to convene a hearing or hear oral argument to consider a request for rehearing.

Historical Note

Adopted effective January 23, 1992 (Supp. 92-1). R20-6-115 recodified from R4-14-115 (Supp. 95-1). Amended effective June 15, 1998 (Supp. 98-2).

**R20-6-116. Reserved
through**

R20-6-158. Reserved

R20-6-159. Repealed

Historical Note

Adopted effective February 17, 1977 (Supp. 77-1). R20-6-159 recodified from R4-14-159 (Supp. 95-1). Repealed effective June 15, 1998 (Supp. 98-2).

R20-6-160. Petition for Rulemaking Action

- A. The following definitions apply in this Section.
 - 1. "Department" means the Arizona Department of Insurance.
 - 2. "Director" means the Director of the Department of Insurance.

3. "Petitioner" means a person who petitions the Department for rulemaking action.
 4. "Rulemaking action" means the process for formulation and finalization of a new rule, or amendment or repeal of an existing rule.
- B.** Any person may petition the Department under A.R.S. § 41-1033 for rulemaking action.
- C.** A person who seeks rulemaking action shall file, with the Director, a petition with the following information:
1. The petitioner's name, address, and telephone number;
 2. The name and address of any organization the petitioner represents;
 3. A statement of the rulemaking action the petitioner seeks, including:
 - a. A citation to any existing rule, substantive policy statement, or Department practice to be amended or repealed; and
 - b. The specific language of a proposed new rule or rule amendment;
 4. The reasons for the rulemaking action, including an explanation of why an existing rule, substantive policy statement, or Department practice is inadequate, unreasonable, unduly burdensome, or unlawful; and
 5. The petitioner's dated signature.
- D.** The petitioner may submit additional supporting information, including:
1. Statistical data; and
 2. A list of other persons and entities likely to be affected by the proposed rulemaking action, with an explanation of the likely effects.
- E.** Within 60 days of the date the Department receives the petition, the Department shall send the petitioner a written decision indicating whether the Department is denying the petition or will initiate the requested rulemaking action, with the reasons for the decision.

Historical Note

New Section adopted by final rulemaking at 5 A.A.R. 618, effective February 4, 1999 (Supp. 99-1). Section heading corrected at Department Request, Office File No. M11-401, filed October 27, 2011 (Supp. 11-3).

ARTICLE 2. TRANSACTION OF INSURANCE

Section

- R20-6-201. Advertisements of Health Insurance
- R20-6-201.01. Insurer Advertising Responsibility and Records
- R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form
- R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance
- R20-6-203. Form Filings; Translations
- R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers
- R20-6-205. Local or Regional Retaliatory Tax Information
- R20-6-207. Gender Discrimination
- R20-6-208. Group Coverage Discontinuance and Replacement
- R20-6-209. Life Insurance Solicitation
- R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner
- R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness
- R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities
- R20-6-212.01. Forms for Buyer's Guide for Annuities
- R20-6-213. Life and Disability Insurance Policy Language Simplification
- R20-6-214. Coordination of Benefits
- Exhibit A. Expired
- R20-6-215. Renumbered
- R20-6-215.01. Renumbered
- R20-6-216. Renumbered
- R20-6-217. Renumbered
- R20-6-218. Repealed

ARTICLE 2. TRANSACTION OF INSURANCE

R20-6-201. Advertisements of Health Insurance

A. Definitions. The following definitions apply to this Section and to R20-6-201.01, R20-6-201.02, and R20-6-203:

1. "Advertisement" means materials and information used by an insurer to generate insurance business.
 - a. Advertisement includes the following information:
 - i. Printed and published material, audio visual material, or other forms of electronic communication that an insurer uses or displays in direct mail, newspapers, magazines, radio, television, billboards, Internet web sites, and similar media to inform the public about the insurer or its products;
 - ii. Descriptive literature and sales aids an insurer issues or releases for presentation to members of the public, including circulars, leaflets, booklets, depictions, illustrations, and form letters;
 - iii. Prepared sales talks and presentations and material for use by an insurer or prepared by an insurer for use by authorized producers; and
 - iv. Material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements;
 - b. "Advertisement" does not include the following:
 - i. Material used solely for training and educating an insurer's employees or producers;
 - ii. Material used in-house by insurers;
 - iii. Communications within an insurer's own organization not intended for dissemination to the public;
 - iv. Individual communications with current policy holders regarding a member's personal information other than material urging the policyholders to increase or expand coverages;
 - v. Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;
 - vi. Court-approved material ordered by a court to be disseminated to policyholders;
 - vii. Material in connection with promotion or sponsorship of a charitable event in which only the name of the insurer is displayed;
 - viii. A general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arranged. The announcement shall clearly indicate that it is preliminary to the issuance of a booklet and that does not describe the specific benefits under the contract or program nor the advantages as to the purchase of the contract or program;
 - ix. A general announcement by the sponsor that endorses the program;
 - x. Health and wellness material with general health and wellness information; or
 - xi. Press releases and news releases not intended to generate business.
2. "Disability insurance" has the same meaning prescribed in A.R.S. § 20-253.

3. "Elimination period" means the time between the date a loss occurs and the date that benefits begin to accrue for that loss.
4. "Exclusion" means a policy term stating a risk that an insurer has not assumed.
5. "Health insurance" means:
 - a. Disability insurance;
 - b. Insurance provided by a service corporation regulated under A.R.S. § 20-821 et seq.;
 - c. Insurance provided by a prepaid dental plan organization regulated under A.R.S. § 20-1001 et seq.; and
 - d. Insurance provided by a health care services organization regulated under A.R.S. § 20-1051 et seq.
6. "Insurance administrator" or "administrator" has the meaning prescribed in A.R.S. § 20-485(A)(1).
7. "Insurer" has the same meaning prescribed in A.R.S. § 20-104.
8. "Limitation" means a policy term, other than an exclusion or reduction, that decreases the risk assumed by the insurer or the insurer's obligation to provide benefits.
9. "Person" has the meaning in A.R.S. § 20-105.
10. "Policy" means any plan, certificate, contract, agreement, statement of coverage, evidence of coverage, subscription contract, membership coverage, rider, or endorsement that provides disability benefits, health insurance, medical, surgical or hospital expense benefits, long-term care benefits, or Medicare supplement benefits in the form of a cash indemnity, reimbursement, or service.
11. "Reduction" means a policy term that reduces the amount of an insured's benefits. A reduction means that the insurer has assumed the risk of a particular loss, but the amount or period of the insurer's coverage is less than what the insurer would have paid for the loss without the reduction.
12. "Spokesperson" means a person making a testimonial about or an endorsement of an insurer's product who:
 - a. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or independent contractor;
 - b. Has been formed by the insurer, is owned or controlled by the insurer or its employees, or is a person who owns or controls an insurer;
 - c. Is in a policy-making position and affiliated with the insurer in any capacity described in subsections (a) or (b); or
 - d. Is directly or indirectly compensated for making the testimonial or endorsement.

B. Scope.

1. This Section applies to all advertisements for health insurance.
2. This Section applies to the conduct of insurers, producers, and third-party administrators.

C. General requirements. Insurers, producers, and third-party administrators shall ensure that health insurance advertisements meet the requirements of this Section.

1. Advertisements shall be truthful and not misleading. The insurer shall not use words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology.
2. An advertisement shall not omit information or use words, phrases, statements, references, or illustrations if the omission of information or use of words, phrases, statements, references, or illustrations may mislead or deceive purchasers or prospective purchasers.
3. The words and phrases used to describe a policy shall accurately describe the benefits of the policy and not exaggerate any benefit through the use of phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills" or "this policy will replace your income," or similar words and phrases.
4. If a policy covers only one disease or a list of specified diseases, any advertisement for the policy shall not imply coverage beyond the specified diseases.
5. If a policy pays varying amounts for the same loss occurring under different conditions or pays benefits only when a loss occurs under certain conditions, any advertisement for the policy shall disclose the limited conditions.
6. If an advertisement specifies payment of a particular dollar amount for hospital room and board expenses, the advertisement shall also include the maximum daily benefit and the maximum time limit for which those expenses are covered.
7. An advertisement that refers to any dollar amount, period of time for which a benefit is payable, cost of policy, or specific policy benefit or the loss for which a benefit is payable shall also disclose any related exclusions, reductions, and limitations without which the advertisement would have the capacity and tendency to mislead or deceive.
8. An advertisement covered by subsection (C)(7) shall disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy. The advertisement shall disclose the existence of an elimination period.
9. An advertisement shall disclose any exclusion, reduction, or limitation applicable to a pre-existing condition; however, an insurer is not required to make disclosure in an advertisement that does not reference specific product information, benefit level, or dollar amounts.
10. If a policy has an exclusion, reduction, or limitation applicable to a preexisting condition, an advertisement shall not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim and shall not use the phrase "no medical examination required" or other similar phrase.
11. If an advertisement refers to renewability, cancellation, or termination of a policy, or states or illustrates time or age in connection with eligibility of applicants or continuation of the policy, the advertisement shall disclose the provisions

relating to renewability, cancellation, and termination and any modification of benefits, losses covered, or premiums because of age or for other reasons, in a manner that does not minimize or obscure the qualifying conditions.

12. An advertisement shall not make any offer prohibited under A.R.S. § 20-452(4).
 13. An advertisement shall not advertise any health insurance policy or form that has not been approved by the Department, unless the policy or form being advertised is exempt from approval or not subject to approval by order or statute.
 14. An advertisement shall not state or imply that a product being offered is an introductory, special, or initial offer that will entitle the applicant to receive advantages not described in the policy by accepting the offer.
 15. An advertisement designed to produce leads either by use of a coupon, a request to write or call the company, or subsequent advertisement before contact, shall disclose that a producer may contact the potential applicant.
- D.** Method of disclosure of required information. If an insurer is required by law to disclose particular information, the information shall be conspicuous and in close proximity to the statements to which the information relates, or under a prominent caption so that the required disclosure is not minimized, obscured, presented in an ambiguous fashion, or intermingled with the content of the advertisement.
- E.** Testimonials.
1. Testimonials used in advertisements shall be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced. The insurer shall provide the Department with the full name of the author and a copy of the full testimonial if the advertisement is filed with the Department or requested by the Department. If an insurer uses a testimonial, the insurer adopts the statements in the testimonial as the insurer's own statements. If a testimonial or endorsement is used more than one year after it is given, the insurer shall obtain a written confirmation from the author that the testimonial represents the current opinion of the author.
 2. The insurer shall disclose that a spokesperson has a financial interest or the proprietary or representative capacity of a spokesperson in an advertisement in the introductory portion of a testimonial or endorsement in the same form and with equal prominence as the endorsement. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, the insurer shall disclose that fact in the advertisement by language that states, "Paid Endorsement," or words of similar import in type, style, and size at least equal to that used for the spokesperson's name or the body of the testimonial or endorsement, whichever is larger. For television or radio advertising, the insurer shall place the required disclosure prominently in the introductory portion of the advertisement.
- F.** Statistics. An advertisement with information on the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use facts that are irrelevant to the sale of insurance and shall accurately reflect all of the relevant facts specific to the advertised policy or insurer. An advertisement shall not state or imply that statistics are derived from the policy being advertised unless that is true. The insurer shall identify in the advertisement the source of any statistics used.
- G.** Inspection of policy. An offer in an advertisement of free inspection of a policy or offer of a premium refund does not cure misleading or deceptive statements in the advertisement.
- H.** Identification of plan or number of policies.
1. If an advertisement offers a choice in the amount of benefits the advertisement shall disclose that the amount of benefits depends on the policy selected and that the premium will vary with the amount of the benefits.
 2. If an advertisement refers to benefits contained in more than one policy, other than a group master policy, the advertisement shall disclose that the benefits are provided only if multiple policies are purchased.
- I.** Disparaging comparisons and statements. An advertisement shall not make unfair, incomplete, or unsubstantiated comparisons of other insurers' policies or benefits or falsely disparage other insurers' policies, services, or business methods. A comparison is unsubstantiated if the insurer has no empirical study, analysis, or documentation supporting the comparative statement or comparison of policies or benefits.
- J.** Jurisdictional limits.
- If an insurer has an advertisement that is meant to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed, the advertisement shall indicate that the insurer is licensed in a specified state or states only, or is not licensed in a specified state or states, by use of language such as "This Company is licensed only in State A" or "This Company is not licensed in State B."
- K.** Identity of insurer. The insurer shall state the name of the actual insurer in all of its advertisements. An advertisement shall clearly identify the insurer and shall not use a trade name, an insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol, or other device that may mislead or deceive the public as to the insurer's identity.
- L.** Group insurance. An advertisement shall not state or imply that prospective policyholders become group or quasi-group members and enjoy special rates or underwriting privileges, unless it is true. An advertisement to join an association, trust, or group that is also an invitation to contract for insurance coverage shall disclose that the applicant will be purchasing both membership in the association, trust, or group and insurance coverage.
- M.** Government approval. An advertisement shall not state or imply any of the following:
1. That a governmental agency or regulator is connected with or has provided or endorsed a policy or endorsed an insurer;
 2. That a governmental agency or regulator has examined an insurer's financial condition and found it satisfactory. This subsection does not apply if an insurer is responding to a specific documented, public, false allegation about its financial condition.

- N. Endorsements. An advertisement may state that an individual, group, society, association, or other organization has approved or endorsed the insurer or its policy if the organization or group has done so in writing and if any proprietary relationship between the organization and the insurer is disclosed.
- O. Claims handling. An advertisement shall not contain false statements about the time within which claims are paid or statements that imply that claim settlements will be liberal or generous beyond the terms of the policy.
- P. Statements about the insurer. An advertisement shall not contain false or misleading statements about an insurer's assets, corporate structure, financial standing, length of time in business, or relative position in the insurance business.

Historical Note

Former General Rule Number 2. R20-6-201 recodified from R4-14-201 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.01. Insurer Advertising Responsibility and Records

- A. An insurer shall establish, and at all times maintain, a system of control over the content, form, and method of dissemination of all advertisements. The insurer whose policies are advertised is responsible for the advertisements, regardless of who writes, creates, designs, or presents the advertisement, except the insurer is not responsible for any advertisement placed by a person to whom the insurer gave no actual or apparent authority. Before using an advertisement about an insurer or its products, a producer shall get written approval from the insurer for use of advertisements that were not supplied by the insurer.
- B. An insurer shall maintain, at its home or principal office, the following:
 - 1. Advertisements disseminated by the insurer in Arizona or any other state, including:
 - a. Each printed, published, recorded, or prepared advertisement of individual policies; and
 - b. Typical printed, published, recorded, or prepared advertisements of blanket, franchise, and group policies.
 - 2. A notation attached to each advertisement specifying the manner and extent of distribution and the form number of any policy advertised; and
 - 3. Documentation supporting any testimonials, statistical claims, or comparisons shown in the advertising.
- C. An insurer shall maintain the advertisements, notations, and supporting documentation for at least three years from the date of first dissemination.

Historical Note

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-201.02. Procedures for Filing Advertising Materials; Transmittal Form

- A. An insurer that is required to file a health insurance advertisement with the Department as specified in A.R.S. §§ 20-826(T), 20-1018, 20-1057(X), 20-1110(E), or 20-1662 shall file the advertisement with a transmittal form prescribed by the Department.
- B. The transmittal form shall include the following information:
 - 1. Identifying information of the insurer, including name, address, National Association of Insurance Commissioners' identification number, and type of insurer;
 - 2. A contact person at the insurer with whom the Department can communicate about the advertisement;
 - 3. Description of the type of advertisement being filed;
 - 4. Planned use and dissemination of the advertisement, including date of first use, or a statement that the advertisement will not be used any earlier than a specified date;
 - 5. Description of product being advertised;
 - 6. Form number and name for the advertised product;
 - 7. A certification from an officer of the insurer that the advertisement complies with applicable laws; and
 - 8. The dated signature of the insurer's officer.

Historical Note

New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-202. Advertising, Solicitation, and Transaction of Life Insurance

- A. The definitions in R20-6-201(A) and the following definition apply in this Section:

"Life insurance" means a life insurance contract, including all benefits payable under the policy.
- B. Applicability
 - 1. This Section applies to:
 - a. All persons subject to regulation under A.R.S. Title 20; and
 - b. Advertising, promotion, solicitation, negotiation, and sale of life insurance policies, regardless of the form of dissemination.
 - 2. This Section does not apply to group insurance, franchise insurance, or to annuities without life contingencies.
- C. General provisions. A life insurance advertisement shall not mislead the public by:
 - 1. Omitting information that fairly describes the subject matter as a life insurance policy and the benefits available under the policy;

2. Placing undue emphasis on facts that, even if true, are not relevant to the sale of life insurance; or
 3. Placing undue emphasis on features of incidental or secondary importance to the life insurance aspects of the policy.
- D.** The Department deems the following acts misleading and deceptive:
1. Using any statement, including phrases such as “investment,” “investment plan,” “founders plan,” “charter plan,” “expansion plan,” “profit,” “profits,” or “profit sharing,” in a context or under circumstances or conditions that may mislead a purchaser or prospective purchaser to believe that the insurer is selling something other than a life insurance policy or will provide some benefit not included in the policy, or not available to other persons of the same class and equal expectation of life;
 2. Using any phrase as the name or title of a life insurance policy if the phrase does not include the words “life insurance,” unless other language in the same document expressly provides that the contract is a life insurance policy;
 3. Making any statement relating to the growth or earnings of the life insurance industry or to the tax status of life insurance companies in a context that would reasonably be understood as attempting to interest a prospective applicant in the purchase of shares of stock in the insurance company rather than in the purchase of a life insurance policy;
 4. Making any statement that reasonably tends to imply that the insured will enjoy a status common to a stockholder or will acquire a stock ownership interest in the insurance company by purchasing the policy, unless the statement is made with reference to policies of domestic life insurers engaged in a program allowed under A.R.S. § 20-453;
 5. Providing a policyholder with a premium receipt book, policy jacket, return envelope, or other printed or electronic material referring to the insurer’s “investment department,” “insured investment department,” or similar terminology in a manner implying that the policy is sold, issued, or serviced by the insurer’s investment department;
 6. Making any statement that reasonably tends to imply that, by purchasing a policy, the purchaser or prospective purchaser will become a member of a limited group of persons who may receive the payment of dividends, special advantages, benefits, or favored treatment unless the insurance contract specifically provides for the described payment of dividend, special advantages, benefits, or favored treatment;
 7. Stating or implying that only a limited number of persons or limited class of persons may buy a particular kind of policy, unless the limitation is related to recognized underwriting practices or specifically stated in the policy or rider;
 8. Describing premium payments in language that states the payment is a “deposit,” unless:
 - a. The payment establishes a debtor-creditor relationship between the insurance company and the policyholder; or
 - b. The term is used with the word “premium” in a manner as to clearly indicate the true character of the payment;
 9. Providing any illustration or projection of future dividends that:
 - a. Is not based on the company’s actual scale for payment of current dividends, and
 - b. Does not clearly indicate that the dividends are not guarantees;
 10. Using the words “dividends,” “cash dividends,” “surplus,” or similar phrases in a manner that states or implies that the payment of dividends is guaranteed or certain to occur;
 11. Stating, without qualification, that a purchaser of a policy will share in a stated percentage or portion of the insurer’s earnings;
 12. Making any statement that projected dividends under a participating policy will be or can be sufficient at any future time to assure the receipt of benefits such as a paid-up policy without further payment of premiums unless the statement also explains:
 - a. The benefits or coverage that would be provided at the future time, and
 - b. The conditions under which the receipt of benefits without further payment of premiums would occur;
 13. Describing a life insurance policy or premium payments in terms of “units of participation,” unless accompanied by other language clearly indicating that the references are to a life insurance policy or to premium payments, as applicable.
 14. Advising producers to avoid disclosing that life insurance is the subject of the solicitation or sale;
 15. Stating that an insured is guaranteed certain benefits if the policy is allowed to lapse, without explaining the non-forfeiture benefits;
 16. Using a dollar amount in printed material to be shown to a prospective policyholder, unless the amount is accompanied by language that:
 - a. States the nature of the dollar amount,
 - b. Prohibits including the use of dollar amounts not related to guaranteed values and properly projected dividend figures, and
 - c. Prohibits the use of figures showing growth of stock values, or other values not a part of the life insurance contract.
 17. Stating that a policy provides features not found in any other insurance policy, unless the insurer can demonstrate that other policies do not have the same feature;
 18. Making any statement or implication about an insurance policy that cannot be verified by reference to the policy contract, a sample of the policy being described, or the company’s officially published rate book and dividend illustrations;
 19. Stating that life insurance is “loss proof” or “depression proof,” except that an insurer may make statements that life insurance benefits, other than dividends, are guaranteed by the company regardless of economic conditions;
 20. Making any statement that a company makes a profit as a result of policy lapses or surrenders;
 21. Making comparisons to the past experience of other life insurance companies as a means of projecting possible experience for the company issuing the advertising; and
 22. Conduct or statements designed to mislead a prospective applicant or purchaser.

Historical Note

Former General Rule Number 68-14. R20-6-202 recodified from R4-14-202 (Supp. 95-1). Amended by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-203. Form Filings; Translations

- A. An insurer, rate service organization, or rating organization shall provide to the Department, at the time of filing, an English language translation of each form, advertisement, or other document or material that the insurer is required by statute or rule to file with the Department, if the filed document or material contains communication in a language other than English.
- B. The translation filed under subsection (A) shall compare the foreign language version in a side-by-side format with the English language translation. An insurer, rate service organization, or rating organization shall ensure that the translation is performed by a person with formal college-level or specialized training in the foreign language, including training in grammar and sentence syntax.
- C. With each translation, an insurer, rate service organization, or rating organization shall also provide to the Department a sworn statement signed by the translator who translated the document that includes the qualifications of the translator under subsection (B) and attests that the translation is identical in substance to the English document or material.
- D. If an insurer, rate service organization, or rating organization files a foreign language version of a document or material that the insurer has previously filed in English, the insurer is not required to refile the English version, but shall identify the English version, provide the side-by-side comparison under subsection (B), and file the sworn statement required under subsection (C).

Historical Note

Former General Rule Number 71-23; Repealed effective January 1, 1981 (Supp. 80-6). R20-6-203 recodified from R4-14-203 (Supp. 95-1). New Section made by final rulemaking at 13 A.A.R 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-204. Surplus Lines Brokers' Filing Requirements; List of Unauthorized Insurers

- A. Definitions.
 - 1. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
 - 2. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.
 - 3. "Listed insurer" means an unauthorized insurer who is on the list created by the Director under subsection (C)(1) and A.R.S. § 20-413.
 - 4. "Surplus lines broker" means a person licensed under A.R.S. § 20-411.
 - 5. "Surplus lines insurance" means the type of insurance described in A.R.S. § 20-407.
 - 6. "Unauthorized insurer" means an insurer that does not have a certificate of authority to transact insurance in Arizona.
- B. Filing requirements. An unauthorized insurer writing surplus lines insurance in Arizona and each surplus line broker shall comply with the filing requirements of this Section.
- C. List of unauthorized insurers.
 - 1. The Director shall create and maintain a list of unauthorized insurers that may write surplus lines insurance in this state under A.R.S. § 20-413. The list shall contain the names of unauthorized insurers for which a surplus lines broker has made the filings required by this Section.
 - 2. The Director shall retain a listed insurer on the list until:
 - a. The Director removes the insurer from the list under A.R.S. § 20-413 or subsection (H) or (I) below, or
 - b. The insurer requests the Director to remove its name from the list.
- D. Placing surplus lines insurance. A surplus lines broker shall place all surplus lines business with insurers listed under subsection (C). An insurer's removal from the list does not affect the validity of any contract existing at the time of removal.
- E. Requirements for foreign unauthorized insurers and insurance exchanges. A surplus lines broker shall file the following documents for a foreign unauthorized insurer:
 - 1. An original or a certified copy of the insurer's certificate of compliance from the supervisory official of the insurer's state of domicile;
 - 2. A current Certificate of Deposit, Capital, and Surplus for Foreign Insurers from the public officials or other persons who have supervision over the insurer in any other state;
 - 3. A certification from the surplus lines broker of the insurer's compliance with the financial requirements of A.R.S. § 20-413;
 - 4. The insurer's most recent report of financial examination, certified by the insurance supervisory official of its state of domicile; and
 - 5. A certified copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) annual statement for the insurer as of December 31 of the preceding year.
- F. Requirements for initial listing of alien unauthorized insurers. A surplus lines broker shall file a certification of the insurer's compliance with the financial requirements of A.R.S. § 20-413. For all alien insurers other than title insurers, the surplus lines broker may rely on the information contained in the most recent N.A.I.C. Financial Review of Alien Insurers as prima facie evidence of the insurer's compliance.
- G. Filing requirements to maintain listing. To ensure that a foreign or alien unauthorized insurer remains on the Director's list, a surplus lines broker shall file, before June 1 of each year:
 - 1. A copy of a full-size National Association of Insurance Commissioners (N.A.I.C.) convention blank annual statement (Form 2) for the insurer, as of December 31 of the preceding year; and

2. An affidavit, on a form approved by the Director, that meets the following requirements:
 - a. The surplus lines broker and a duly authorized officer of the unauthorized insurer shall sign the affidavit.
 - b. The insurer's officer shall state whether there have been any changes in the insurer's name, address, state of domicile, statutory producer, and any material changes in its operations since the insurer's initial qualification for listing or the last annual filing under this subsection. If there have been material changes in operations, the officer shall describe the changes. Material changes under this subsection include a change in any one or more of the following:
 - i. A director, officer, or controlling person;
 - ii. The insurer's holding company or affiliates;
 - iii. The insurer's charter documents, including its articles of incorporation, articles of agreement, or by-laws governing its conduct of business;
 - iv. The insurer's marketing or administration plans, operations, or agreements with third parties;
 - v. Any other matter material to the insurer meeting its obligations to its policyholders; and
 - vi. Any other matter that relates to any of the grounds for removal from the list as prescribed in A.R.S. § 20-413.
 - c. The insurer's officer shall state whether the insurer is in good standing in all jurisdictions where it conducts insurance business and whether the insurer has been, since the date of initial listing or the last annual filing under this subsection, or currently is, the subject of any action or order by any regulatory official in any jurisdiction. If the insurer has been or is the subject of a disciplinary action or order, the insurer's officer shall describe the matter in the affidavit and shall attach a copy of any applicable official document regarding the disciplinary action or order. Regulatory action or order under this subsection includes any one or a combination of the following:
 - i. Denial, suspension, or revocation of a license, permit, or certificate of authority;
 - ii. A corrective action or operation plan, consent order, memorandum of understanding, or cease and desist order;
 - iii. Action against the insurer's bond or securities held in trust by a regulatory official; and
 - iv. Supervision, conservatorship, receivership, or any other form of possession or control by a regulatory official in any jurisdiction.
 - d. The insurer's officer shall state whether the report of examination, if any, previously filed with the Director under subsection (E)(4) or with a previous annual filing, remains the most current, filed report. If a more recent report of examination exists, the surplus lines broker shall file a copy of the report with the affidavit.
- H.** Supplemental information; removal. A surplus lines broker and an unauthorized insurer shall provide any additional information the Director requests to determine whether the insurer meets the requirements of A.R.S. § 20-413, or to clarify information in documents filed under this Section. The Director may remove an insurer from the list if the surplus lines broker or insurer does not submit the requested information within 30 days after the date of a written request for information.
- I.** Removal for failure to make annual filing. The Director shall remove an unauthorized insurer from the list if a surplus lines broker fails to timely file the documents required by subsection (G). The Director shall not restore the insurer to the list until a surplus lines broker files all applicable documents required under subsections (E) or (F) and the insurer requalifies under A.R.S. § 20-413.
- J.** Organizations of surplus lines brokers; unauthorized insurer.
 1. A surplus lines broker may file records or reports that are subject to examination by the director under A.R.S. § 20-408 with any voluntary organization of surplus lines brokers. The Director may examine the records or reports filed with an organization of surplus lines brokers to ascertain compliance with A.R.S. Title 20, Chapter 2, Article 5. An examination performed under this authority shall not preclude examination of records of a surplus lines broker.
 2. Nothing in this subsection requires that a surplus lines broker become a member of any surplus lines organization to file or preserve or maintain any affidavit or statement.

Historical Note

Former General Rule Number 71-24; Former Section R4-14-204 repealed, new Section R4-14-204 adopted effective January 1, 1981 (Supp. 80-6). R20-6-204 recodified from R4-14-204 (Supp. 95-1). Amended effective July 14, 1998 (Supp. 98-3). Amended by final rulemaking at 6 A.A.R. 475, effective January 5, 2000 (Supp. 00-1). Amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-205. Local or Regional Retaliatory Tax Information

A. Definitions.

1. "Addition to the rate of tax" means the tax rate determined under subsection (D) to be applied under A.R.S. 20-230(A) and this Section to foreign or alien insurers domiciled in a foreign country or other state that impose local or regional taxes.
2. "Alien insurer" has the meaning prescribed in A.R.S. § 20-201.
3. "Arizona life insurer" means a domestic insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
4. "Department" means the Arizona Department of Insurance.
5. "Director" has the meaning prescribed in A.R.S. § 20-102.
6. "Domestic insurer" has the meaning prescribed in A.R.S. § 20-203.
7. "Foreign insurer" has the meaning prescribed in A.R.S. § 20-204.

8. "Foreign or alien life insurer" means a foreign or alien insurer authorized to issue life insurance policies in this state within the meaning of A.R.S. § 20-254 or annuities within the meaning of A.R.S. § 20-254.01, regardless of whether the insurer is authorized to transact disability insurance in this state.
 9. "Local or regional taxes" means any tax, license, or other obligation imposed upon domestic insurers or their producers by any:
 - a. City, county, or other political subdivision of a foreign country or other state; or
 - b. Combination of cities, counties, or other political subdivisions of a foreign country or other state.
 10. "Other Arizona insurer" means a domestic insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
 11. "Other foreign or alien insurer" means a foreign or alien insurer authorized to transact one or more lines of insurance in this state but not authorized to transact life insurance or annuities in this state.
 12. "Other state" means any state in the United States, the District of Columbia, and territories or possessions of the United States, excluding Arizona.
 13. "Premium Tax and Fees Report," includes the "Survey of Arizona Domestic Insurers" and the "Retaliatory Taxes and Fees Worksheet," and means the form prescribed by the Director and filed annually by insurers under A.R.S. § 20-224.
- B.** Scope. This Section applies to all foreign, alien, and domestic insurers and to Premium Tax and Fees Reports filed by all insurers.
- C.** Data to be reported by domestic insurers. As a part of its Premium Tax and Fees Report, each domestic insurer shall file a Survey of Arizona Domestic Insurers that reports the following data for the calendar year covered by the insurer's Premium Tax and Fees Report with respect to each foreign country or other state in which the insurer was required to pay any local or regional taxes:
1. Total local or regional taxes paid; and
 2. Total premiums taxed under the premium taxing statute of the foreign country or other state, as reported by the insurer in any premium tax report filed under the laws of the foreign country or other state.
- D.** Computation of statewide and foreign countrywide additions to the rate of tax. For each foreign country or other state having one or more local or regional taxes on domestic insurers, the Department shall compute on a statewide or foreign countrywide basis an addition to the rate of tax. The Department shall compute the addition to the rate of tax payable by Arizona life insurers separately from the addition to the rate of tax payable by other Arizona insurers. The addition to the rate of tax payable by each category of Arizona domestic insurers shall be the quotient of:
1. The aggregate local or regional taxes reported as paid to the foreign country or other state by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report divided by,
 2. The aggregate statewide or foreign countrywide premiums taxed under the premium taxing statute of the other state or foreign country reported by domestic insurers in each category for the calendar year covered by the Premium Tax and Fees Report.
- E.** Publication of additions to the rate of tax. The Department shall publish additions to the rate of tax determined under A.R.S. § 20-230(A) and this Section, based upon the survey information gathered from domestic insurers for the preceding calendar year under subsection (C). The Department shall publish the information annually on the Department web site, on or before November 1, and in the Retaliatory Taxes and Fees Worksheet for the next year's Premium Tax and Fees Report.
- F.** Foreign and Alien Insurers' Report of the Effect of Local or Regional Taxes. Each foreign or alien insurer domiciled in a foreign country or other state for which the Department publishes an addition to the rate of tax shall include in the "State or Country of Incorporation" column of its Retaliatory Taxes And Fees Worksheet for the calendar year covered by its Premium Tax and Fees Report an amount equal to:
1. The total premiums received in Arizona that would be taxed under the laws of the domiciliary jurisdiction, as reported in the "State or Country of Incorporation" column of its premium tax and fees report multiplied by,
 2. The applicable addition to the rate of tax published by the Department for the calendar year covered by the insurer's Premium Tax and Fees Report.
- G.** Contesting computation. A foreign or alien insurer subject to this Section may preserve the right to contest the computation of the addition to the rate of tax by submitting a notice of appeal under A.R.S. Title 41, Chapter 6, Article 10 before or at the time the retaliatory tax is paid. Subject to A.R.S. § 20-162, the filing of a notice of appeal to contest the computation of the applicable addition to the rate of tax does not relieve a foreign or alien insurer of the obligation to timely pay the retaliatory tax, and does not stay accrual of any applicable interest and penalties.

Historical Note

Former General Rule Number 71-25; Repealed effective March 19, 1976 (Supp. 76-2). R20-6-205 recodified from R4-14-205 (Supp. 95-1). Section R20-6-205 renumbered from R20-6-206 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-207. Gender Discrimination

- A.** The following definitions apply to this Section:
1. "Applicant" means a person who is applying for a policy.
 2. "Policy" means an insurance policy, plan, contract, certificate, evidence of coverage, subscription contract, or binder, including a rider or endorsement offered by an insurer.
 3. "Insurer" means any company that issues a policy.

- B.** Applicability and scope. This Section applies to any policy or certificate delivered or issued for delivery in this state.
- C.** Availability requirements.
 1. An insurer shall not deny availability of any insurance policy on the basis of the gender or marital status of the insured or prospective insured.
 2. An insurer shall not restrict, modify, exclude, reduce, or limit the amount of benefits payable, or any term, conditions or type of coverage on the basis of an applicant's or insured's gender or marital status, except to the extent the amount of benefits, term, conditions, or type of coverage vary as a result of the application of rate differentials permitted under A.R.S. Title 20.
 3. An insurer may consider marital status to determine whether a person is eligible for dependent coverage or benefits.
- D.** Prohibited practices. The following practices and any other practice that treats similarly situated persons differently based on gender unless the different treatment is specifically allowed by law, is prohibited.
 1. Denying coverage to a person of one gender who is self-employed, employed part-time, or employed by relatives, if coverage is offered to a person of the opposite gender who is similarly employed;
 2. Denying a policy rider to a person of one gender if the rider is available to a person of the opposite gender;
 3. Denying maternity benefits to an applicant or insured who buys a policy for individual coverage if the insurer offers comparable family coverage policies with maternity benefits;
 4. Denying, under group policies, dependent coverage to an employee of one gender if dependent coverage is available to an employee of the opposite gender;
 5. Denying a disability income policy to an employed person of one gender if a policy is offered to a person of the opposite gender who is similarly employed;
 6. Treating complications of pregnancy differently from any other illness or sickness covered under a policy;
 7. Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one gender;
 8. Offering lower maximum monthly benefits to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
 9. Offering more restrictive benefit periods or more restrictive definitions of disability to a person of one gender than to a person of the opposite gender who is in the same classification under a disability income policy;
 10. Establishing different conditions for a policyholder of one gender to exercise benefit options contained in the policy than for a person of the opposite gender;
 11. Limiting the amount of coverage an insured or prospective insured may purchase based upon the insured's or prospective insured's marital status unless the limitation is for the purpose of defining persons eligible for dependent's benefits; and
 12. Otherwise restricting, modifying, excluding or reducing the availability of any insurance contract, the amount of benefits payable, or any term, condition or type of coverage on account of gender or marital status in all lines of insurance.

Historical Note

Former General Rule Number 73-32. R20-6-207 recodified from R4-14-207 (Supp. 95-1). Former R20-6-207 renumbered to R20-6-206; new R20-6-207 renumbered from R20-6-209 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-208. Group Coverage Discontinuance and Replacement

- A.** Definitions. The following definitions apply in this Section:
 1. "Group insurance" means an insurance benefit that meets all the following conditions:
 - a. Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership;
 - b. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group;
 - c. Coverage is paid for by bulk payment of premiums to the insurer; and
 - d. An employer, union, or association sponsors the plan.
 2. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise, but does not include 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 onsite medical clinics; and
 - h. Other insurance coverage similar to the coverage specified in subsections (2)(a) through (g), of the Health Insurance Portability and Accountability Act of 1996 (Pub.L.No. 104-191) (HIPAA), under which benefits for medical care are secondary or incidental to other insurance benefits.

- i. The following benefits, if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the coverage:
 - i. Limited-scope dental or vision benefits;
 - ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of those benefits;
 - iii. Other similar, limited benefits specified in federal regulations issued under HIPAA.
 - j. The following benefits if provided under a separate policy, certificate, or contract of insurance with no coordination between provision of benefits and any exclusion of benefits under a group health plan maintained by the same plan sponsor and if the benefits are paid for an event regardless of whether the benefits are provided under a group health plan maintained by the same plan sponsor:
 - i. Coverage only for a specified disease or illness, or
 - ii. Hospital indemnity or other fixed indemnity insurance.
 - k. The following benefits if the benefits are offered as a separate policy, certificate, or contract of insurance:
 - i. Medicare supplemental policy as defined under § 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss;
 - ii. Coverage supplemental to the coverage provided under, 10 U.S.C. Title 10, Chapter 55; or
 - iii. Similar supplemental coverage provided to coverage under a group health plan.
3. "Health status-related factor" means any of the following:
- a. Health status;
 - b. Medical condition, including a physical or mental illness;
 - c. Claims experience;
 - d. Receipt of health care;
 - e. Medical history;
 - f. Genetic information;
 - g. Evidence of insurability, including conditions arising out of acts of domestic violence; or
 - h. Disability.
4. "Insurer" means an insurer that offers or provides group health insurance coverage, and includes an insurer that issues disability insurance as defined in A.R.S. § 20-253, a medical, dental, or optometric service corporation as defined in A.R.S. § 20-822, and a health care services organization as defined in A.R.S. § 20-1051.
- B.** This Section applies to all group insurance issued by an insurer.
- C.** Effective date of discontinuance for non-payment of premium.
- 1. If a group insurance policy provides for automatic discontinuance of the policy after a premium remains unpaid through the grace period allowed for payment, the insurer is liable for valid claims for covered losses incurred before the end of the grace period.
 - 2. If the insurer's actions after the end of the grace period indicate that the insurer considers the group insurance policy as continuing in force beyond the end of the grace period the insurer is liable for valid claims for losses beginning before the effective date of written notice of discontinuance to the policyholder or other entity responsible for paying premiums.
 - a. The following actions indicate that the insurer considers the policy in force:
 - i. Continued recognition, acknowledgement, or payment of subsequently incurred claims, or
 - ii. Continued enrollment of employees or dependents.
 - b. The following actions shall not indicate that the insurer considers that policy in force:
 - i. Recognition, payment, or acknowledgement of a claim by an insurer or processing a denial based on eligibility or other denial reasons set forth in the group benefit plan booklet; or
 - ii. Recognition, payment, or acknowledgement of claims due to the group's failure to notify the insurer that the employee or member is no longer eligible for coverage or the group policy is terminated.
 - 3. The effective date of discontinuance shall not be before midnight at the end of the third scheduled work day after the date on which the notice of discontinuance is delivered.
- D.** Requirements for notice of discontinuance.
- 1. An insurer's notice of discontinuance shall include a request to the group policyholder to notify covered employees of the date when the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy or contract, the insurer is not liable for claims for losses incurred after the date of discontinuance. If the plan involves employee contributions, the notice of discontinuance shall also advise that if the policyholder continues to collect employee contributions beyond the date of discontinuance, the policyholder is solely liable for benefits for the period which contributions were collected.
 - 2. The insurer shall also provide the policyholder with a supply of notice forms that the policyholder can distribute to the covered employees. The notice forms shall explain the discontinuance and the effective date, and advise employees to refer to their certificates or contracts to determine their rights on discontinuance.
- E.** Extension of benefits.
- 1. A group policy shall provide a reasonable provision for extension of benefits for an employee or dependent who is totally disabled on the date of discontinuance as follows:

- a. For a group life plan with a disability benefit extension of any type such as a premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy shall not terminate the benefit extension.
 - b. For a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability or hospital confinement shall not effect benefits payable for that disability or hospital confinement.
 - c. A hospital or medical expense coverage, other than dental and maternity expense, shall include a reasonable extension of benefits or accrued liability provision. A provision is reasonable if:
 - i. It provides an extension of at least 12 months under "major medical" and "comprehensive medical" type coverage; or
 - ii. Under other types of hospital or medical expense coverage, it provides either an extension of at least 90 days or an accrued liability for expenses incurred during a period of disability or during a period of at least 90 days starting with a specific event that occurred while coverage was in force, such as an accident.
 2. An insurer shall ensure that the policy and group insurance certificates includes a description of the extension of benefits or accrued liability provision.
 3. An insurer shall ensure that benefits payable during a period of extension or accrued liability are subject to the policy's regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or of maximum benefits.
 4. For hospital or medical expense coverage, an insurer may limit benefit payments to payments applicable to the disabling condition only.
- F. Continuance of coverage in situations involving replacement of one plan by another.**
1. When a group policyholder secures replacement coverage with a new insurer, self-insures, or foregoes provision of coverage, the replaced insurer is liable only to the extent of its accrued liabilities and extensions of benefits after the date of discontinuance.
 2. The succeeding insurer shall cover each individual who:
 - a. Was eligible for coverage under the prior plan on the date of discontinuance, and
 - b. Is eligible for coverage according to the succeeding insurer's plan of benefits with respect to a class of individuals eligible for coverage.
 3. For the purpose of successive health insurance coverage under subsection (F)(2), a succeeding insurer's plan of benefits shall:
 - a. Not have any non-confinement rules; and
 - b. Provide, as to any actively-at-work rules, that absence from work due to a health status-related factor is treated as being actively-at-work.
 4. Nothing in subsection (F)(2) prohibits an insurer from performing coordination of benefits.
 5. A succeeding insurer shall cover each individual not covered under the succeeding insurer's plan of benefits under subsection (F)(2) according to subsections (a) and (b) if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and is a member of a class of individuals eligible for coverage under the succeeding insurer's plan. Any reference in subsection (a) or (b) to an individual who was or was not totally disabled is a reference to the individual's status immediately before the effective date of coverage for the succeeding insurer.
 - a. The minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer's plan reduced by any benefits payable by the prior plan.
 - b. The succeeding insurer shall provide coverage until at least the earliest of the following dates:
 - i. The date the individual becomes eligible under the succeeding insurer's plan as described in subsection (F)(2);
 - ii. The date the individual's coverage would terminate according to the succeeding insurer's plan provisions applicable to individual termination of coverage such as at termination of employment or ceasing to be eligible dependent; or
 - iii. For an individual who was totally disabled, and covered by a type of coverage for which subsection (E) requires an extension of accrued liability, the end of any period of extension of benefits or accrued liability that is required of the prior insurer under subsection (E), or if the prior insurer's policy is not subject to subsection (E), would have been required of the insurer had its policy been subject to subsection (E) at the time the prior plan was discontinued and replaced by the succeeding insurer's plan;
 - c. For health insurance coverage, if an individual who was totally disabled at the time the prior insurer's plan was discontinued and replaced by the succeeding insurer's plan, and if subsection (E) requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding insurer shall be the level of benefits of the prior insurer's plan, reduced by any benefits paid by the prior plan.
 - d. If the succeeding insurer's plan has a preexisting conditions limitation, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding insurer's plan according to subsection (F) during the period the limitation applies under the new plan shall be the lesser of:
 - i. The benefits of the new plan determined without application of the preexisting conditions limitation, or
 - ii. The benefits of the prior plan.
 - e. The succeeding insurer, in applying any deductibles, coinsurance amounts applicable to out-of-pocket maximums, or waiting periods, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. For deductibles or coinsurance amounts applicable to out-of-pocket

maximums, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior plan during the 90 days before the effective date of the succeeding insurer's plan but only to the extent these expenses are recognized under the terms of the succeeding insurer's plan and are subject to similar deductible or coinsurance provisions.

- f. If the succeeding insurer is required under this Section to make a determination about the benefits in the prior plan, the succeeding insurer may ask the prior plan to provide a statement of the benefits available or other pertinent information sufficient to permit the succeeding insurer to verify the benefit determination. For the purposes of this Section, all definitions, conditions, and covered-expense provisions of the prior plan shall govern the benefit determination. The benefit determination is made as if the succeeding insurer had not replaced coverage.

Historical Note

Former General Rule Number 73-34. R20-6-208 recodified from R4-14-208 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-208 renumbered from R20-6-210 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-209. Life Insurance Solicitation

A. Scope.

1. This Section applies to any solicitation, negotiation, or procurement of life insurance occurring in Arizona. This Section applies to any issuer of life insurance contracts, including fraternal benefit societies.
2. Unless otherwise specifically included, the Section does not apply to:
 - a. Annuities,
 - b. Credit life insurance,
 - c. Group life insurance,
 - d. Life insurance policies issued in connection with a pension and welfare plan as defined by and subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 et seq.; or
 - e. Variable life insurance under which the death benefits and cash values vary according to unit values of investments held in a separate account.

B. In this Section, the following apply:

1. "Buyer's Guide" means a document that contains the language in the Appendix to this Section or language approved by the Director.
2. "Cash dividend" means the current illustrated dividend that can be applied toward payment of the gross premium.
3. "Equivalent Level Annual Dividend" is calculated as follows:
 - a. Accumulate the annual cash dividends at 5% interest compounded annually to the end of the 10th and 20th policy years;
 - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
 - c. Divide the results in subsection (b) by the number of thousands of the Equivalent Level Death Benefit to arrive at the "Equivalent Level Annual Dividend."
4. "Equivalent Level Death Benefit" means the amount of benefit of a policy or term life insurance rider calculated as follows:
 - a. Accumulate the guaranteed amount payable upon death, regardless of the cause of death, at the beginning of each policy year for 10 and 20 years at 5% interest compounded annually to the end of the 10th and 20th policy years, respectively.
 - b. Divide each accumulation in subsection (a) by an interest factor that converts the accumulation into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (a) over the periods stipulated in subsection (a). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
5. "Generic name" means a short title that is descriptive of the premium and benefit patterns of a policy or a rider.
6. "Life Insurance Surrender Cost Index" means the cost index that is calculated as follows:
 - a. Determine the guaranteed cash surrender value, if any, available at the end of the 10th and 20th policy years.
 - b. For policies participating in dividends, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual Cash Dividends at 5% interest compounded annually to the end of the period selected and add this sum to the amount determined in subsection (a).
 - c. Divide the result in subsection (b) (subsection (a) for guaranteed-cost policies) by an interest factor that converts into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subsection (b) or subsection (a) for guaranteed cost policies, over the periods stipulated in subsection (a)). If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
 - d. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5% interest compounded annually to the end of the period stipulated in subsection (a) and dividing the result by the respective factors stated in subsection (c). This amount is the annual premium payable for a level premium plan.

- e. Subtract the result of subsection (c) from subsection (d).
 - f. Divide the result of subsection (e) by the number of thousands of the Equivalent Level Death Benefit to arrive at the Live Insurance Surrender Cost Index.
7. The Life Insurance Net Payment Cost Index is calculated in the same manner as the comparable Life Insurance Cost Index except that the cash surrender value and any terminal dividend are set at zero.
8. "Policy Summary" means a written statement describing elements of the policy, including:
- a. The following prominently placed title: Statement of Policy Cost and Benefit Information.
 - b. The name and address of the insurance producer, or, if no producer is involved, a statement of the procedure to be followed to receive responses to inquiries regarding the Policy Summary.
 - c. The full name and home office or administrative office address of the company by which the life insurance policy is to be or has been written.
 - d. The generic name of the basic policy and each rider.
 - e. For the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns, including the years for which Life Insurance Cost Indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier, the following amounts, where applicable:
 - i. The annual premium for the basic policy;
 - ii. The annual premium for each optional rider;
 - iii. Guaranteed amount payable upon death at the beginning of the policy year regardless of the cause of death except for suicide, or other specifically enumerated exclusions provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately;
 - iv. Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;
 - v. Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. Dividends need not be displayed beyond the twentieth policy year; and
 - vi. Guaranteed endowment amounts payable under the policy that are not included under guaranteed cash surrender values in subsection (iv).
 - f. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether the rate is applied in advance or in arrears. If the policy loan interest rate is variable, the Policy Summary shall include the maximum annual percentage rate.
 - g. Life Insurance Cost Indexes for 10 and 20 years but not beyond the premium-paying period. Separate indexes shall be displayed for the basic policy and for each optional term life insurance rider. The indexes need not be included for optional riders that are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months, and guaranteed insurability benefits, nor for basic policies or optional riders covering more than one life.
 - h. The Equivalent Level Annual Dividend in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which Life Insurance Cost Indexes are displayed.
 - i. If the Policy Summary includes dividends, a statement that dividends are based on the insurer's current dividend scale and are not guaranteed and a statement in close proximity to the Equivalent Level Annual Dividend as follows: "An explanation of the intended use of the Equivalent Level Annual Dividend is included in the Life Insurance Buyer's Guide."
 - j. A statement in close proximity to the Life Insurance Cost Indexes as follows: "An explanation of the intended use of these indexes is provided in the Life Insurance Buyer's Guide."
 - k. The date on which the Policy Summary is prepared. The Policy Summary shall consist of a separate document. All information required to be disclosed shall not be minimized or obscure. Any amounts that remain level for two or more years of the policy may be represented by a single number that clearly indicates the amounts that are applicable for each policy year. Amounts in subsection (8)(e) shall be listed in total, not on a per thousand nor per unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.
- C. Disclosure requirements.**
- 1. The insurer shall provide to all prospective purchasers, a Buyer's Guide and a Policy Summary before accepting the applicant's initial premium or premium deposit, unless the policy for which application is made contains an unconditional refund provision of at least 10 days or unless the Policy Summary contains an unconditional refund offer, in which case the Buyer's Guide and Policy Summary shall be delivered with the policy or before delivery of the policy.
 - 2. The insurer shall provide a Buyer's Guide and a Policy Summary to any prospective purchaser upon request.
 - 3. If the Equivalent Level Death Benefit of a policy does not exceed \$5,000, the requirement for providing a Policy Summary is satisfied by delivery of a written statement containing the information described in subsections (D)(8)(b), (c), (d), (e)(i) through (e)(iii), (f), (g), (j), and (k).
- D. General rules.**
- 1. Each insurer shall maintain at its home office or principal office for at least three years after its last authorized use a copy of each form the insurer authorized for use.

2. A producer shall inform a prospective purchaser, before commencing a life insurance sales presentation, that the producer is acting as a life insurance producer and inform the prospective purchaser of the full name of the insurance company that the producer is representing. If an insurance producer is not involved in the sale, the insurer shall inform the prospective purchaser of the insurance company's full name.
 3. An insurer or producer shall not use terms such as financial planner, investment advisor, financial consultant, or financial counseling to imply that the insurance producer is generally engaged in an advisory business in which compensation is unrelated to sales unless that is true.
 4. If an insurer or producer refers to policy dividends, the reference shall include a statement that dividends are not guaranteed.
 5. An insurer shall not use a system or presentation that does not recognize the time value of money through the use of appropriate interest adjustments for comparing the cost of two or more life insurance policies unless the system or presentation is used to demonstrate the cash flow pattern of a policy and the presentation is accompanied by a statement disclosing that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today.
 6. In a presentation of benefits, an insurer shall not display guaranteed and non-guaranteed benefits as a single sum unless they are shown separately and in close proximity.
 7. An insurer shall include with a statement regarding the use of the Life Insurance Cost Indexes an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.
 8. An insurer shall include with a Life Insurance Cost Index that reflects dividends or an Equivalent Level Annual Dividend a statement that it is based on the company's current dividend scale and is not guaranteed.
 9. If an insurer reserves the right to change the premium for a basic policy or rider, the annual premium shall be the maximum annual premium.
- E. An insurer's failure to provide or deliver a Buyer's Guide or a Policy Summary as provided in subsection (C) constitutes an omission that misrepresents the benefits, advantages, conditions, or terms of an insurance policy.

APPENDIX

Life Insurance Buyer's Guide

The face page of the Buyer's Guide shall read as follows:

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

- Decide how much life insurance you should buy,
- Decide what kind of life insurance policy you need, and
- Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by (Company Name)

(Month and year of printing)

The Buyer's Guide shall contain the following language at the bottom of page 2:

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

Buying Life Insurance

When you buy life insurance, you want a policy that fits your needs without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes that are described in this guide. A good life insurance producer or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand what kinds are available. If one kind does not seem to fit your needs, ask about the other kinds that are described in this guide. If you feel that you need more information than is given here, you may want to check with a life insurance producer or company or books on life insurance in your public library.

This guide does not endorse any company or policy.

The remaining text of the buyer's guide shall begin on page 3 as follows:

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term insurance
2. Whole life insurance
3. Endowment insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the producer or company if it combines more than one kind of life insurance. The following is a brief description of the three basic kinds:

Term Insurance

Term insurance is death protection of a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued.

Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Whole Life Insurance

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money that you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance

An endowment insurance policy pays a sum or income to you – the policyholder – if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. **LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.**

What is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called “participating” policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called “guaranteed cost” or “non participating” policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance producers and companies:

1. Life Insurance Surrender Cost Index. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

Life Insurance Net Payment Cost Index. This Index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy’s Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

- (1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.
- (2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a “Shopper’s Guide” tells you that one company’s policy is a good buy for a particular age and amount, you should not assume that all of that company’s policies are equally good buys.
- (3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its producer. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.
- (4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or producer will provide service in the future, to you as a policyholder.
- (5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company that issued the old policy before you take action.

Important Things To Remember – A Summary

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums must closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy. If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance producer can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the producer or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

Historical Note

Adopted effective June 13, 1977 (Supp. 77-3). R20-6-209 recodified from R4-14-209 (Supp. 95-1). Former R20-6-209 renumbered to R20-6-207; new R20-6-209 renumbered from R20-6-211 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-210. Readable and Understandable Policy: Private Passenger Automobile, Homeowner, Personal Line Dwelling, and Mobile Homeowner

A. Definitions. The following definitions apply in this Section:

1. "Readable insurance policy" means a policy that can be read and reasonably understood by a person without special knowledge or training.
2. "Policy" means a contract or agreement for insurance, or an insurance certificate regardless of the name used, and includes all clauses, endorsements, and papers attached or incorporated.

B. Scope.

This Section applies to private passenger motor vehicle policies, homeowner policies, personal line dwelling policies, for four family units or less, and mobile homeowner policies delivered or issued for delivery in Arizona.

C. Compliance.

1. An insurer shall test the readability of its policy by use of the Flesch Readability Formula as set forth in Rudolf Flesch, *The Art of Readable Writing* (1949, as revised 1974).
2. An insurer shall not use a policy unless the policy has a total readability score of 40 or more on the Flesch scale.
3. An insurer shall include with each policy form filing required to be filed with the Director a checklist for the line of insurance setting forth the Flesch score.

D. Readability guidelines.

1. General organization of text.
 - a. A policy shall be divided into logically arranged sections for ease of locating content.
 - b. Each section shall be self-contained as to provisions relating solely to that section (for example, an exclusion section shall not be mixed with other parts of a policy).
 - c. General policy provisions applying to all or several like coverages shall be located in a common area.
 - d. The policy shall not contain non-essential provisions.
 - e. Defined words and terms shall be placed in a separate section at the beginning of the policy.
2. Visual aids to readability. The insurer shall ensure that each policy meets the following format requirements:
 - a. Type size shall be at least eight point.
 - b. The font shall be block print rather than script, and legible.
 - c. Captions and headings shall be distinguishable from the general text.
 - d. White space separating coverages, policy sections, and columns shall be sufficient to make a distinct separation.
 - e. Defined words and terms shall be distinguishable from the general text.
3. Language usage. The insurer shall ensure that each policy:
 - a. Is written in everyday, conversational language;
 - b. Uses short, simple sentences and words in common usage;
 - c. Uses an easy-to-read style, personal pronouns, and present tense active verbs.

Historical Note

Adopted effective May 28, 1979 (Supp. 79-1). R20-6-210 recodified from R4-14-210 (Supp. 95-1). Former R20-6-210 renumbered to R20-6-208; new R20-6-210 renumbered from R20-6-212 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-211. Discrimination on the Basis of Blindness or Partial Blindness

A. Definitions. The following definitions apply in this Section:

1. "Policy" means a contract or agreement for or effecting insurance, or a certificate of insurance, regardless of the name used, and includes all clauses, riders, endorsements, and attached papers.
2. "Person" has the same meaning prescribed in A.R.S. § 20-105.

B. Scope. This Section applies to all policies delivered or issued for delivery in this state.

C. Prohibition. An insurer shall not engage in the following prohibited acts or practices that constitute unfair discrimination between individuals of the same class:

1. Refusal to insure or refusal to continue to insure, or limiting the amount, extent, or kind of coverage available to an individual solely because of blindness or partial blindness; or
 2. Charging an individual a different rate for the same coverage solely because of blindness or partial blindness.
- D.** In this subsection, “refusal to insure” includes denial by an insurer of disability insurance coverage on the grounds that the policy defines “disability” as being presumed if the insured loses eyesight. An insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness if the insured was blind or partially blind when the policy was issued.
- E.** For all other conditions, including the underlying cause of the blindness or partial blindness, a person who is blind or partially blind is subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as a sighted person.

Historical Note

Adopted effective August 1, 1977 (Supp. 77-4). Amended effective March 27, 1976 (Supp. 78-2). Correction, Historical Note for Supp. 77-4 should read adopted effective January 1, 1979 filed August 1, 1977. Historical Note for Supp. 78-2 should read Appendix amended effective January 1, 1979 filed March 27, 1978 (Supp. 79-5). Editorial correction, (D)(7)(a), title now shown in italics (Supp. 81-1). R20-6-211 recodified from R4-14-211 (Supp. 95-1). Former R20-6-211 renumbered to R20-6-209; new R20-6-211 renumbered from R20-6-213 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-212. Forms for Replacement of Life Insurance Policies and Annuities

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

1. For the purpose of meeting the requirements of A.R.S. § 20-1241.03(C): Life Insurance and Annuities Replacement Model Regulation, Appendix A – Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-11 through 613-12, July 2000.
2. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(A): Life Insurance and Annuities Replacement Model Regulation, Appendix B – Notice Regarding Replacement: Replacing Your Life Insurance Policy or Annuity?, Volume III, pp. 613-13, July 2000.
3. For the purpose of meeting the requirements of A.R.S. § 20-1241.07(B)(2): Life Insurance and Annuities Replacement Model Regulation, Appendix C – Important Notice: Replacement of Life Insurance or Annuities, Volume III, pp. 613-14 through 613-15, 1998.

Historical Note

Adopted effective March 27, 1978 (Supp. 78-2). Editorial correction see subsection (A) citation to A.R.S. (Supp. 78-4). Editorial correction see subsections (B) and (F) citation to A.R.S. (Supp. 78-6). R20-6-212 recodified from R4-14-212 (Supp. 95-1). Former R20-6-212 renumbered to R20-6-210; new R20-6-212 renumbered from R20-6-215 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-212.01. Forms for Buyer’s Guide for Annuities

An insurer shall use the following forms of the National Association of Insurance Commissioners Model Regulations (and no future editions or amendments), which are incorporated by reference and available at the Department of Insurance, 2910 N. 44th St., Phoenix, AZ 85018 and the National Association of Insurance Commissioners, Publications Department, 2301 McGee St., Suite 800, Kansas City, MO 64108:

For the purpose of meeting the requirements of A.R.S. § 20-1242.02 regarding a Buyer’s Guide: Annuity Disclosure Model Regulation, Appendix - Buyer’s Guide to Fixed Deferred Annuities, Volume II, pp. 245-6 through 245-13, 1999, with attached Appendix I - Equity-Indexed Annuities, Volume II, pp. 245-14 through 245-20, 1999.

Historical Note

Section R20-6-212.01 renumbered from R20-6-215.01 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-213. Life and Disability Insurance Policy Language Simplification

A. Definitions. The following definitions apply in this Section:

1. “Company” or “insurer” means any life or disability insurance company, benefit insurer, benefit stock insurer, prepaid dental plan organizations, health care service organizations, and all similar type organizations.
2. “Director” means the Director of Insurance of Arizona.
3. “Policy” or “policy form” means any policy, contract, plan or agreement of life or disability insurance, including credit life insurance and credit disability insurance, delivered or issued for delivery in the state by any company subject to this rule; and any certificate issued under a group insurance policy delivered or issued for delivery in this state.

B. Applicability.

1. This Section and R20-6-212 apply to all life and disability insurance policies delivered or issued for delivery in this state by any company but do not apply to:
 - a. Any policy that is a security subject to federal jurisdiction;

- b. Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy however, this shall not exempt any certificate issued under a group policy delivered or issued for delivery in this state; or
 - c. Any group annuity contract that serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;
2. Except as provided in R20-6-210, no other rule of this state setting language simplification standards shall apply to any policy forms.
- C. Minimum policy language simplification standards.**
- 1. Except as stated in subsection (B), an insurer shall not deliver or issue for delivery a policy form that has not been approved by the Director unless:
 - a. The text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection (3);
 - b. It is printed, except for specification pages, schedules, and tables, in no less than 10 point type, one point leaded;
 - c. The style, arrangement and overall appearance of the policy do not give undue prominence to any portion of the text of the policy or to any endorsements or riders; and
 - d. The policy, if the policy has more than 3,000 words printed on three or fewer pages of text or if the policy has more than three pages regardless of the number of words, contains a table of contents or an index of the principal sections of the policy.
 - 2. An insurer shall measure a Flesch reading ease test score as follows:
 - a. For policy forms containing 10,000 words or less of text, an insurer shall analyze the entire form. For policy forms containing more than 10,000 words, an insurer may analyze the readability of two, 200-word samples per page instead of the entire form. The insurer shall separate the samples by at least 20 printed lines.
 - b. The insurer shall count the number of words and sentences in the text, then divide the total number of words by the total number of sentences, then multiply that figure by a factor of 1.015.
 - c. The insurer shall count and divide the total number of syllables by the total number of words, then multiply that figure by a factor of 84.6.
 - d. The sum of the figures computed under subsections (b) and (c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.
 - e. For subsections (b), (c), and (d), the insurer shall use the following procedures:
 - i. A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word;
 - ii. A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and
 - iii. A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.
 - f. The term "text" as used in this subsection shall include all printed matter except the following:
 - i. The name and address of the insurer, the name, number or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules or tables; and
 - ii. Policy language that is drafted to conform to the requirements of a federal law, regulation, or agency interpretation, policy language required by a collectively bargained agreement, medical terminology, words defined in the policy, and policy language required by law or regulation, if the insurer identifies the language or terminology excepted by this subsection and certifies, in writing, that the language or terminology is entitled to be excepted by this subsection.
 - 3. Any other reading test may be approved by the Director for use as an alternative to the Flesch reading test if it is comparable in result to the Flesch reading ease test.
 - 4. Filings subject to this subsection shall be accompanied by a certificate signed by an officer of the insurer stating that the filing meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved under subsection (G) of this Section. To confirm the accuracy of any certification, the Director may require the submission of further information to verify the certification in question.
 - 5. At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.
- D. The Director may authorize a lower score than the Flesch reading ease score required in subsection (C)(1)(a) if a lower score:**
- 1. Provides a more accurate reflection of readability of a policy form;
 - 2. Is warranted by the nature of a particular policy form or type or class of policy forms; or
 - 3. Is caused by certain policy language drafted to conform to the requirements of any state statute, rule, or agency interpretation of law.

Historical Note

Adopted effective November 21, 1977 (Supp. 77-6). Amended effective March 27, 1978 (Supp. 78-2). Amended subsection (E), deleted subsection (F) and added new subsections (F) and (G) effective December 3, 1986 (Supp. 86-6). R20-6-213 recodified from R4-14-213 (Supp. 95-1). Former R20-6-213 renumbered to R20-6-211; new R20-6-213 renumbered from R20-6-216 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-

- 2). Corrected error in R20-6-213(D) that referenced subsection (E)(1)(a), which was relabeled as (C)(1)(a) in Supp. 07-2 (Supp. 08-1).

R20-6-214. Coordination of Benefits

A. Applicability.

1. This Section applies to all:
 - a. Group disability insurance policies;
 - b. Group subscriber contracts of hospital and medical service corporations and health care services organizations;
 - c. Group disability policies of benefit insurers; and
 - d. Group-type contracts that contain a coordination of benefits provision, are not available to the general public, and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization. Group-type contracts that meet this description are included regardless of whether denominated as "franchise," "blanket," or some other designation.
2. This Section does not apply to:
 - a. Individual or family policies or individual or family subscriber contracts except as provided for in subsection (A)(1);
 - b. Group or group-type hospital indemnity benefits, written on a non-expense incurred basis, of \$30 per day or less unless characterized as reimbursement-type benefits and designed or administered to give the insured the right to elect indemnity-type benefits, instead of the reimbursement type benefits at the time of claim; or
 - c. School accident type coverages, written on a blanket, group, or franchise basis.

B. Definitions. In this Section, the following definitions apply:

1. "Allowable expense" means any necessary, reasonable, and customary item of expense, at least a portion of which is covered under one or more of the plans covering the person for whom claim is made or service provided.
 - a. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is deemed to be both an allowable expense and a benefit paid.
 - b. A plan that takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definition of an allowable expense.
2. "Claim determination period" means an appropriate period of time such as "calendar year" or "benefit period" as defined in the policy.
3. "Plan," within the coordination of benefits provisions of a group policy or subscriber contract, means the types of coverage that the insurer may consider in determining whether overinsurance exists with respect to a specific claim.
4. "School accident-type coverage" means coverage of grammar school and high school students for accidents only, including athletic injuries, either on a 24-hour basis or "to-and-from school," for which the parent pays the entire premium.

C. Order-of-benefit determination.

1. When a claim under a plan with a coordination of benefit provision involves another plan that also has a coordination of benefit provision, the insurer shall make the order-of-benefit determination as follows:
 - a. The plan that covers the person claiming benefits other than as a dependent shall determine benefits before those of the plan that covers the person as a dependent.
 - b. The plan of a parent whose birthday occurs earlier in a calendar year shall cover a dependent child before the benefits of a plan of a parent whose birthday occurs later in a calendar year. The word "birthday" as used in this subsection refers only to month and day in a calendar year, not the year in which the person was born.
 - c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
 - i. First, the plan of the parent with custody of the child;
 - ii. Then, the plan of the spouse of the parent with custody of the child; and
 - iii. Finally, the plan of the parent not having custody of the child.
 - d. Notwithstanding subsection (c), if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
2. The benefits of a plan that covers a person as an employee (or as that employee's dependent) are determined before those of a plan that covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this provision and if, as a result, the plans do not agree on the order of benefits, this subsection does apply.
3. If none of the provisions of subsection (C) determines the order of benefits, the benefits of the plan that covered a claimant longer are determined before those of the plan that covered that person for the shorter time.
4. If one of the plans is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

D. Excess and other nonconforming provisions. A plan with an order of benefit determination provision that complies with this Section, a complying plan, may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses an order-of-benefit determination provision that is inconsistent with this Section, a noncomplying plan, on the following basis:

1. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.
2. If the complying plan is the secondary plan, it shall pay or provide its benefits first, as the secondary plan. The payment shall be the limit of the complying plan's liability, except as provided in subsection (4).

3. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay benefits accordingly. The complying plan shall adjust any payments it makes based on the assumption whether information becomes available as the actual benefits of the noncomplying plan.
4. If the noncomplying plan pays benefits so that the claimant receives less in benefits than the claimant would have received had the noncomplying plan paid or provided its benefits as the primary plan, the complying plan shall advance to or on behalf of the claimant an amount equal to the difference. The complying plan shall not have a right to reimbursement from the claimant.

Historical Note

Adopted effective October 26, 1979 (Supp. 79-5). R20-6-214 recodified from R4-14-214 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1). Section R20-6-214 renumbered from R20-6-217 and amended by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215. Renumbered

Historical Note

Adopted effective September 7, 1981 (Supp. 81-3). Amended subsections (D) thru (H), deleted Agent's Statement and Exhibit D effective March 30, 1983 (Supp. 83-2). R20-6-215 recodified from R4-14-215 (Supp. 95-1). Amended by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215 renumbered to R20-6-212 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-215.01. Renumbered

Historical Note

New Section made by exempt rulemaking at 9 A.A.R. 5595, effective January 1, 2004 (Supp. 03-4). Former R20-6-215.01 renumbered to R20-6-212.01 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-216. Renumbered

Historical Note

Adopted effective as set forth in subsection (H) (Supp. 80-6). R20-6-216 recodified from R4-14-216 (Supp. 95-1). Former R20-6-216 renumbered to R20-6-213 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

R20-6-217. Renumbered

Historical Note

Adopted effective September 14, 1982 (Supp. 82-3). Amended subsections (C) and (D), deleted (F) effective January 1, 1987, filed December 16, 1986 (Supp. 86-6). R20-6-217 recodified from R4-14-217 (Supp. 95-1). Former R20-6-217 renumbered to R20-6-214 by final rulemaking at 13 A.A.R. 2061, effective August 4, 2007 (Supp. 07-2).

Editor's Note: The following Section expired under A.R.S. § 41-1056(E) on September 30, 2001 at 8 A.A.R. 491. The Notice of Rule Expiration was not received until January 9, 2002. Therefore, the repeal of the rule noted in the Historical Note is moot (Supp. 02-1).

R20-6-218. Repealed

Historical Note

Adopted effective November 9, 1984 (Supp. 84-6). R20-6-218 recodified from R4-14-218 (Supp. 95-1). Section repealed by final rulemaking at 7 A.A.R. 5443, effective November 16, 2001 (Supp. 01-4). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1) (see Editor's Note above).

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES

Section

- R20-6-301. Expired
- R20-6-302. Expired
- R20-6-303. Termination of Certificate of Authority and Release of Deposit
- R20-6-304. Reserved
- R20-6-305. Expired
- R20-6-306. Reserved
- R20-6-307. Life and Disability Reinsurance Agreements
- Table A. Risk Categories
- R20-6-309. Expired
- R20-6-309.01. Expired
- R20-6-309.02. Expired
- R20-6-309.03. Expired
- R20-6-309.04. Expired
- Appendix A. Expired

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES

R20-6-301. Expired

Historical Note

Former General Rule Number 3. R20-6-301 recodified from R4-14-301 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-302. Expired

Historical Note

Former General Rule 62-11. R20-6-302 recodified from R4-14-302 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-303. Termination of Certificate of Authority and Release of Deposit

- A. Domestic Insurers.** To request termination of a certificate of authority and, if applicable, release of statutory deposit, a domestic insurer shall file all of the following with the director:
1. A written request for termination of certificate of authority and release of deposit;
 2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
 3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.
 4. A plan of extinguishment for its outstanding liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no outstanding liabilities to policyholders or claimants under subsection (C);
 5. A certified copy of the insurer's Board of Directors resolution or other documentation of the insurer's official action taken according to the insurer's statutorily required organizational documents approving the insurer's:
 - a. Withdrawal from the insurance business,
 - b. Dissolution of the insurer,
 - c. Merger with an insurer authorized in Arizona to transact the insurer's previously written and active lines of business of the insurer requesting termination, or
 - d. Transfer of domicile to another state or country.
 6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication, or other documentation that the insurer intends to file with the Arizona Corporation Commission after issuance of the Director's order as provided in subsection (D)(2);
 7. If requested by the director, a written agreement that guarantees payment of substantially all liabilities of the domestic insurer, other than obligations extinguished under subsection (C).
- B. Foreign and Alien Insurers.** To request termination of its certificate of authority and, if applicable, release of its deposit, a foreign or alien insurer shall file all of the following with the director:
1. A written request for termination of certificate of authority and release of deposit;
 2. The insurer's original certificate of authority or an affidavit of lost certificate of authority;
 3. A statement of the insurer's financial condition as of a date within 60 days of the filing date of the request for termination that includes a written statement, signed by two officers of the insurer as authorized on the jurat page of the insurer's most recent annual statement, verifying that the statement of financial condition reflects the insurer's financial position as of the date signed.

4. A plan of extinguishment for its Arizona liabilities that satisfies the requirements of subsection (C) or a sworn affidavit stating that the insurer has no Arizona liabilities under subsection (C);
 5. A copy of an order issued by the insurance director or other appropriate regulatory authority in the insurer's state or country of domicile that approves or authorizes either the insurer's:
 - a. Withdrawal from the insurance business,
 - b. Dissolution of the insurer,
 - c. Merger (approval of the merger from the states of domicile of the insurers), or
 - d. Transfer of domicile, if applicable.
 6. A copy of the insurer's Articles of Dissolution, Articles of Merger, Articles of Amendment, Articles of Redomestication or other required documentation that the insurer filed in its state of domicile; and
 7. If requested by the director, a written agreement that guarantees payment of substantially all Arizona liabilities of the insurer, other than obligations extinguished under subsection (C).
- C. Insurer's Plan for Extinguishment of Liabilities.**
1. To extinguish substantially all liabilities under subsection (A)(4) or subsection (B)(4) as applicable, an insurer may:
 - a. Reinsure the insurer's business in force with another insurer by entering into an agreement of bulk reinsurance that shall be effective when filed with and approved in writing by the director.
 - i. The agreement shall provide for assumption of all policyholder claims by the reinsurer including claims incurred but unreported as of the effective date of the agreement.
 - ii. The agreement may include recapture provisions exercisable by the insurer in the event the termination of its certificate of authority is not completed.
 - iii. Unless the director otherwise approves, the agreement shall provide that the reinsurer be licensed in Arizona for the particular lines of business reinsured.
 - b. Merge with another insurer that:
 - i. Assumes the liabilities of the non-surviving insurer; and
 - ii. Is authorized in Arizona for the previously written and active lines of business assumed, unless otherwise approved by the director.
 - c. Use its deposit, any additional security deposit or both to secure payment of former policyholder, policyholder, or claimant liabilities that are not reinsured or otherwise secured.
 2. For purposes of this Section, "substantially all liabilities" under Title 20 means all policyholder and claimant obligations reported by the insurer in the statement of financial condition, whether or not liquidated in amount, and shall include former policyholder claims and rights to refunds.
- D. Consideration of the Request for Termination of Certificate of Authority and Release of Deposit under subsections (A) and (B).**
1. If the director determines that the insurer has extinguished substantially all liabilities as required under this Section and has otherwise demonstrated compliance with this Section and A.R.S. Title 20, the director shall grant the request to terminate the certificate of authority and, if appropriate, release the insurer's deposit, provided:
 - a. The insurer has no fees, taxes, assessments or filings outstanding to the Department; and
 - b. The insurer is not subject of any pending investigation or examination under Title 20 by the Department.
 2. The director's order shall condition the release of a domestic insurer's deposit upon receipt by the director of evidence of the official filing with the Arizona Corporation Commission of the documentation described in subsection (A)(6).
 3. If the director determines that the insurer is unable to extinguish substantially all liabilities as required under this Section, or otherwise has not complied with this Section or with A.R.S. Title 20, the director shall notify the insured in writing that the request has been denied and the reasons for the denial.
- E. Exclusions. This Section does not apply to:**
1. An insurer's exchange and substitution of cash or eligible securities under A.R.S. § 20-586;
 2. An insurer's withdrawal of excess deposits, either cash or eligible securities, under A.R.S. §§ 20-587 and 20-588(A)(2); or
 3. Releases of deposits made under A.R.S. § 20-588(A)(3).

Historical Note

Former General Rule 72-29. R20-6-303 recodified from R4-14-303 (Supp. 95-1). Section R20-6-303 repealed; new Section R20-6-303 made by final rulemaking at 14 A.A.R. 3432, effective October 4, 2008 (Supp 08-3).

R20-6-304. Reserved

R20-6-305. Expired

Historical Note

Adopted effective September 13, 1978, except that it shall apply to the accounting treatment for unearned premium reserves and reinsurance premium receivables for credit life disability insurance on January 1, 1979, and all annual statements filed for periods on or after that date (Supp. 78-5). R20-6-305 recodified from R4-14-305 (Supp. 95-1). Section expired under A.R.S. § 41-1056(E) at 8 A.A.R. 491, effective September 30, 2001 (Supp. 02-1).

R20-6-306. Reserved

R20-6-307. Life and Disability Reinsurance Agreements

- A.** Scope. This rule applies to all domestic life and disability insurers and reinsurers, and to all other licensed life and disability insurers and accredited reinsurers that are not subject to a substantially similar rule in their jurisdictions of domicile. This rule applies to the disability business of licensed property and casualty insurers. This rule does not apply to assumption reinsurance, yearly renewable term reinsurance, or nonproportional stop loss or catastrophe reinsurance, or similar forms of nonproportional reinsurance.
- B.** Definitions
1. "Agreement" means a reinsurance agreement and any amendment to a reinsurance agreement.
 2. "Credit Quality" means the risk that invested assets supporting the reinsured business will decrease in value but excludes decreases to changes in interest rate.
 3. "Department" means the Arizona Department of Insurance.
 4. "Director" means the Director of the Arizona Department of Insurance.
 5. "Disintermediation" means the risk that interest rates will rise and policy loans and surrenders will increase or maturing contracts will not renew at anticipated rates of renewal.
 6. "Lapse" means the risk that a policy will voluntarily terminate before the recoupment of a statutory surplus strain experienced at issuance of the policy.
 7. "Reinvestment" means the risk that interest rates will fall and funds reinvested will therefore earn less than expected.
- C.** Accounting Requirements
1. Unless authorized by the director, an insurer shall not, for reinsurance ceded, reduce any liability, or establish any asset in any statutory financial statement filed with the Department if, by the terms of the agreement, or in effect, any of the following conditions exist:
 - a. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover the ceding insurer's allocable renewal expenses anticipated at the time the business is reinsured on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured.
 - b. The ceding insurer is required to reimburse the reinsurer for negative experience under the agreement. Neither the offset of the ceding insurer's experience refunds against current and prior years' losses, nor payment by the ceding insurer of an amount equal to the reinsurer's current and prior years' losses upon voluntary termination of in-force reinsurance by the ceding insurer, shall be considered a reimbursement to the reinsurer for negative experience.
 - c. The ceding insurer may be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of a specified event, including the insolvency of the ceding insurer. Termination of the agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due shall not be considered a deprivation of surplus or assets within the meaning of this subsection.
 - d. The ceding insurer is required, at scheduled times, to terminate the agreement or recapture automatically all or part of the reinsurance ceded.
 - e. The ceding insurer may be required to pay the reinsurer amounts other than from income reasonably expected from the reinsured policies.
 - f. Significant risks inherent in the business reinsured are not transferred to the reinsurer. Table A identifies the risks deemed significant for representative types of business.
 - g. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not transfer the underlying assets to the reinsurer, segregate the underlying assets in a trust or escrow account, or otherwise segregate the underlying assets. The assets that support the reserves for classes of business that do not have a significant credit quality, reinvestment, or disintermediation risk, or for long-term care or long-term disability insurance, traditional non-par permanent, traditional par permanent, adjustable premium permanent, indeterminate premium permanent, or universal life fixed premium with no dump-in premiums allowed, may be held by the ceding company without segregation. To determine the reserves for classes of business, the supporting assets of which may be held without being segregated, the reserve interest rate adjustment formula shall reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reported in the ceding insurer's statutory financial statement.
 - h. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date.
 - i. The ceding insurer is required to make representations or warranties unrelated to the business reinsured.
 - j. The ceding insurer is required to make representations or warranties related to future performance of the business reinsured.
 2. An agreement entered into after the effective date of this rule to reinsure business issued before the effective date of the agreement shall be filed by the ceding insurer with the Director within 30 days after execution of the agreement. Each filing shall be accompanied by a description of the corresponding reduction in liabilities or other credit for reinsurance, and any other financial impact of the agreement, reported in the ceding insurer's statutory financial statements. When an increase in surplus net of federal income tax results from an agreement falling under this subsection, the ceding insurer shall separately identify the increase as a surplus item in the aggregate write-ins for gains and losses in surplus in the Capital and Surplus account of the ceding insurer's statutory financial statement. As earnings emerge from the business

reinsured, the ceding insurer shall report in its statutory financial statement recognition of surplus increase as income on a net of tax basis as reinsurance ceded.

D. Written Agreements

1. A ceding insurer shall not reduce any liability or establish any asset in any statutory financial statement filed with the Department, unless the ceding insurer and the reinsurer have executed an agreement or a binding letter of intent by the "as of" date of the statutory financial statement.
2. A ceding insurer shall not be allowed a credit for the reinsurance ceded based on a letter of intent unless the ceding insurer and the reinsurer execute an agreement within 90 days from the execution date of the letter of intent.
3. The agreement shall provide that:
 - a. The agreement constitutes the entire contract between the parties with respect to the business reinsured, and there are no understandings between the parties other than as expressed in the agreement; and
 - b. Any change or modification to the agreement shall be void unless made by written amendment signed by all parties.

Historical Note

Adopted effective February 3, 1993 (Supp. 93-1). R20-6-307 recodified from R4-14-307 (Supp. 95-1). Amended effective December 7, 1995 (Supp. 95-4).

Table A. Risk Categories

Risk Categories:

- | | |
|----------------|------------------------|
| (a). Morbidity | (d). Credit Quality |
| (b). Mortality | (e). Reinvestment |
| (c). Lapse | (f). Disintermediation |

	a	b	c	d	e	f
Disability Insurance, other than long-term care or long-term disability insurance	+	0	+	0	0	0
Long-term care or long-term disability insurance	+	0	+	+	+	0
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-par Permanent Life	0	+	+	+	+	+
Traditional Non-par Term Life	0	+	+	0	0	0
Traditional Par Permanent Life	0	+	+	+	+	+
Traditional Par Term Life	0	+	+	0	0	0
Adjustable Premium Permanent Life	0	+	+	+	+	+
Indeterminate Premium Permanent Life	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium, with dump-in premiums allowed	0	+	+	+	+	+
		+ - Significant		0 - Insignificant		

Historical Note

Adopted effective December 7, 1995 (Supp. 95-4). Corrected misspelled word "adjustable" as submitted in final rule (Supp.

98-3).

R20-6-309. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.01. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.02. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.03. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

R20-6-309.04. Expired

Historical Note

New Section adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Section expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

Appendix A. Expired

Table 1. Expired

Table 2. Expired

Table 3. Expired

Table 4. Expired

Table 5. Expired

Table 6. Expired

Historical Note

Appendix A adopted by final rulemaking at 6 A.A.R. 255, effective January 1, 2000 (Supp. 99-4). Appendix A (including Tables 1 through 6) expired under A.R.S. § 41-1056(E) at 13 A.A.R. 1278, effective September 30, 2006 (Supp. 07-1).

ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS

Article 18, consisting of Sections R20-6-1801 through R20-6-1813, made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

Section

- R20-6-1801. Definitions
- R20-6-1802. Application for Certificate of Authority
- R20-6-1803. Chief Executive Officer
- R20-6-1804. Dental Director
- R20-6-1805. Required Reporting
- R20-6-1806. Basic Dental Services
- R20-6-1807. System for Delivery of Services
- R20-6-1808. Geographic Areas
- R20-6-1809. Contract Requirements
- R20-6-1810. Records
- R20-6-1811. Quality Improvement
- R20-6-1812. Confidentiality of Records
- R20-6-1813. Assignment of Members

ARTICLE 18. PREPAID DENTAL PLAN ORGANIZATIONS

R20-6-1801. Definitions

In this Chapter, the following definitions apply:

“Appointment” means a first-available, initial, non-emergent, diagnostic visit to a dentist.

“Board certified” means a dentist who is recognized by the appropriate specialty board of the Commission on Accreditation of Dental Education of the American Dental Association.

“Board eligible” means a dentist who successfully completes an approved training program in a specialty field recognized by the American Dental Association.

“Chief executive officer” means the person who has the authority and responsibility for the operation of a prepaid dental plan Organization according to applicable legal requirements and policies approved by the governing authority.

“Dental hygienist” means a person who is licensed to practice dental hygiene under A.R.S. § 32-1281 et seq.

“Dentist” means a person who is licensed to practice dentistry under A.R.S. § 32-1201 et seq.

“Department” means the Arizona Department of Insurance.

“Diagnostic service” means a dental service intended to identify a dental abnormality, and includes a radiograph and a clinical exam.

“Director” means the director of the Arizona Department of Insurance.

“Emergency dental service” means a dental service intended to evaluate and stabilize a dental condition of recent onset, control bleeding, and relieve pain, and includes the provision of local anesthesia, and elimination of acute infection, but does not mean a medication that is prescribed by the dentist.

“General dentist” means a dentist whose practice is not limited to a specific area and who is not board certified.

“Governing authority” means the persons, including a board of trustees or board of directors, who have the ultimate authority and responsibility for the direction of a prepaid dental plan Organization.

“Organization” means a prepaid dental plan organization as defined in A.R.S. § 20-1001.

“Patient” means a person who is being attended by a dentist or dental hygienist to receive an examination, diagnosis, or dental treatment, or a combination of an examination, diagnosis, and dental treatment.

“Preventive service” means dental care intended to maintain dental health and prevent dental disease, including any combination of oral hygiene education, routine prophylaxis, and application of fluorides.

“Prophylaxis” means cleaning the teeth of a patient with healthy tissue using mild abrasives and dental instruments to remove plaque, calculus, and stains above the gum line.

“Provider directory” means an Organization’s published listing of all contracted network dentists.

“Radiograph” means a picture produced on a sensitive surface by a form of radiation other than light, including x-ray.

“Restorative service” means the use of a metal or composite filling or crown.

“Specialist” means a dentist whose practice is limited to one of the nine specialty categories recognized by the American Dental Association: endodontics, oral and maxillofacial surgery, oral and maxillofacial radiology, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics, prosthodontics, oral pathology, or dental public health.

“Treatment plan” means a statement of the services to be performed to eliminate or alleviate a patient’s symptoms or disease, based on a dentist’s assessment of the patient’s dental history, the clinical examination, and the dentist’s diagnosis.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1802. Application for Certificate of Authority

- A.** A person who wishes to operate as prepaid dental plan organization in Arizona shall file an application for certificate of authority under A.R.S. § 20-1003 for the director’s review and approval under A.R.S. § 20-1004. The application shall contain all the information required in A.R.S. § 20-1003 and R20-6-1802.
- B.** An authorized insurer shall issue the fidelity bond required under A.R.S. § 20-1004(A)(4).
- C.** An Organization shall not commence operation of, or service under, a prepaid dental plan without approval of the director under A.R.S. § 20-1004.
- D.** An application is deemed filed with the director when the director receives it. The applicant shall include fees under A.R.S. § 20-167 with the application.
- E.** An applicant not domiciled in this state shall file a power of attorney as required by A.R.S. § 20-1003(A)(11) on a Department-prescribed form, with the application.
- F.** Within 180 days after the director issues a certificate of authority to an Organization, the Organization shall notify the director in writing of each member appointed to the board of directors for the Organization under A.R.S. § 20-1003(A)(4).
- G.** At the time it submits its application for certificate of authority, an Organization shall submit a written program of compliance with supporting documents that specify how the Organization will comply with the provisions of this Article. The written program of compliance shall contain the following:
 - 1. The responsibilities of and qualifications for the following positions:
 - a. The Organization’s chief executive officer, and
 - b. The Organization’s dental director;
 - 2. A plan for provision of basic dental services required under R20-6-1806(A) and a copy of the schedule of benefits required under R28-6-1806(B);
 - 3. A description of the system for delivery of services under R20-6-1807;
 - 4. A description of the geographic area designated under R20-6-1808;
 - 5. A plan for compliance with contract requirements under R20-6-1809 and a copy of a contract with a general dentist and a specialist;
 - 6. A plan for compliance with records requirements under R20-6-1810; and
 - 7. The Organization’s quality improvement plan under R20-6-1811.
- H.** An application shall include the following information:
 - 1. The proposed number of members, and
 - 2. A copy of a letter from each network dentist that documents the dentist’s intent to contract with the Organization to provide services to patients under the Organization’s prepaid dental plan.
- I.** The director may require that an applicant for a certificate of authority under A.R.S. § 20-1003(A)(14) submit information that discloses biographical, employment and business financial history, criminal activity, fingerprints, or any information that relates to the ability to operate a prepaid dental plan for principals, principal officers, controlling persons, and insurance producers of the applicant, if necessary for the protection of residents of this State.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1803. Chief Executive Officer

- A.** The governing authority shall appoint a chief executive officer (CEO). The CEO shall have:
 - 1. The education and experience to manage the Organization, and
 - 2. Responsibility for the geographic area in Arizona that the Organization serves, including:
 - a. Implementing the policies of the governing authority, and
 - b. Maintaining adequate personnel to ensure compliance with applicable Arizona statutes and rules.
- B.** The governing authority shall notify the Department within ten days after the effective date of a change in the appointment of the CEO.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1804. Dental Director

- A.** The governing authority or CEO shall appoint as the Organization’s dental director a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia.
- B.** The dental director shall perform at least the following functions for the Organization’s geographic area in Arizona:
 - 1. Participate on the Organization’s quality improvement committee required under R20-6-1811;

2. Oversee the Organization's program and processes for:
 - a. Maintaining and improving clinical quality of care, including continuity of care;
 - b. Provider relations;
 - c. Facility and dental record reviews; and
 - d. Provider credentialing and recredentialing;
 3. Be knowledgeable about and participate in decisions regarding the Organization's operations;
 4. Comply with A.R.S. § 20-2510(B) and (C) when directly denying, on the basis of medical necessity, a health care provider's request for prior authorization; and
 5. Timely respond to matters within the Organization's Arizona geographic area that require personal onsite attention or ensure that a designee who meets the requirements specified in subsection (D) timely responds to those matters.
- C.** Matters that require personal onsite attention include:
1. Urgent patient care issues that require examination of dental records or X-rays;
 2. Prompt personal discussion with a provider of urgent concerns relating to credentialing, disciplinary problems, access to care, or quality of care.
- D.** Any designee acting under subsection (B)(5) shall:
1. Be a dentist licensed to practice dentistry in any state or territory of the United States or the District of Columbia;
 2. Have expedient access to the dental director, the CEO, and other organization management personnel as necessary to resolve any matter requiring personal onsite attention; and
 3. Have the education, experience, and Organizational knowledge required to address the matter requiring personal onsite attention.
- E.** The Organization shall notify the Department in writing within ten days after the effective date of a change in the appointment of the dental director or any designee.
- F.** The requirements for a designee under subsections (B)(5), (D), and (E) shall not apply to an Organization with fewer than 2,000 members in Arizona.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1805. Required Reporting

- A.** An Organization shall submit to the Department in writing for review any proposed change to the program of compliance. The Department shall notify the Organization in writing within 30 days of receipt of the proposed change whether the submission is administratively complete. The Department shall complete its substantive review and notify the Organization of approval or disapproval of the proposed change within 60 days of notification of administrative completeness.
- B.** An Organization shall provide the following information about the prepaid dental plan to the Department quarterly:
1. The total number of members and the number of members assigned to each general dentist's office;
 2. A list of all contracted network general dentists and specialists that notes those who have been added or deleted since the previous quarterly report;
 3. Verification that each specialist added to the network since the last quarterly report has graduated from a specialty graduate program accredited by the American Dental Association; Documentation of the Organization's quality improvement activities, including the number of providers who have been credentialed or re-credentialed since the last quarterly report, the number of facility reviews, and the number of chart reviews;
 4. The average wait time measured in weeks for an appointment for each network dentistry office;
 5. A copy of the current provider directory; and
 6. A complaint log with a summary of Organization responses by complaint category.
- C.** An Organization shall submit the following information to the Department at least annually:
1. Member satisfaction survey results and supporting data;
 2. Results of a survey of network general dentistry offices with supporting data confirming a recall system under R20-6-1809(B)(2);
 3. An electronic database that lists the name, address, and telephone number of each provider and whether the provider is accepting new members. The Organization shall submit the database for general dentists and specialists separately. The Organization shall submit any changes to this database to the Department quarterly; and
 4. A report that compiles all the copays listed in all the schedules of benefits offered by the Organization, with comparisons of the copays to the usual, customary, and reasonable fees, as determined by the Organization, for the procedures listed on the schedule of benefits.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1806. Basic Dental Services

- A.** A prepaid dental plan shall provide the basic dental services listed below:
1. Emergency dental services on a 24-hour-per-day basis,
 2. Diagnostic services,
 3. Preventive services, and
 4. Restorative services.

- B.** An Organization shall publish and make available to its members and purchasers a schedule of benefits that includes the dental plan's basic dental services and other available dental services and any associated copays.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1807. System for Delivery of Services

- A.** An Organization shall have a system for delivery of services that includes:
1. An adequate network of general dentists. To determine network adequacy, the Department shall consider the following:
 - a. Geographic distribution of network general dentists' offices,
 - b. The number of dental offices accepting new members,
 - c. The percentage of all network members who are able to schedule an appointment within nine weeks,
 - d. The availability of trained clinical support staff in the Arizona geographic area,
 - e. The ratio of population growth to the increase or decrease in the number of dentists in the Arizona geographic area, and
 - f. Current availability for appointments in all general dentist practices in Arizona; and
 2. Provision for using specialists for dental services that cannot be provided by the Organization's network of contracted specialists, if the services are covered benefits.
- B.** If a network dental office that is open to new members has an appointment wait time of longer than nine weeks, for three consecutive calendar quarters, the director may require the Organization to close the office to new members until the wait time is less than nine weeks.
- C.** If more than 15% of the network offices that are open to new members have an appointment wait time of longer than nine weeks, the Organization shall submit a plan to the Department under which the Organization will, within 90 days, reduce the wait time to less than nine weeks. If the Organization does not reduce the wait time to less than nine weeks within the 90 day period the Organization shall refer the members who are waiting for an appointment to another network general dentist or a non-network general dentist who can schedule the member for an appointment in less than nine weeks. The member may choose to continue dental care under the prepaid dental plan with the referred dentist for the remainder of the member's enrollment period. The Organization shall provide the non-network services to the referred member at a cost that is no greater than if the services are provided by the member's assigned network dentist.
- D.** An Organization shall pay for emergency dental services provided to a member by a dentist licensed in the jurisdiction where the services are provided, subject to plan limitations disclosed in the dental care plan, including emergency dental services that occur:
1. Within the geographic area served by the member's designated provider but the provider is unavailable, or
 2. Occurs outside of the member's designated geographic service area.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1808. Geographic Areas

- A.** An Organization shall designate the geographic areas in Arizona in which the Organization intends to provide dental services that are reasonably convenient to the prospective members. The Organization shall provide a description of the geographic areas and locations of all facilities in which dental care will be provided under the prepaid dental plan. This information shall accompany or be included in any advertisements or sales materials provided to prospective employer groups and prospective members.
- B.** An Organization shall define its geographic areas by citing at least one of the following:
1. Local government jurisdictions, such as cities or counties;
 2. Street boundaries; or
 3. Area within a specified radius of an intersection.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1809. Contract Requirements

- A.** An Organization shall have a written contract with each provider that documents the requirements for providing services under the prepaid dental plan and the terms of the agreements between the parties. The Organization shall ensure that the provider complies with all contract requirements.
- B.** In addition to the requirements in subsection (A), an Organization shall ensure that its contract with a provider includes the following provisions:
1. That the Organization has authority to review the provider's records,
 2. That the provider is responsible to implement and maintain a process to inform assigned members of the need to schedule periodic preventive dental services based on the member's oral health status, and
 3. That the provider is responsible to complete any procedure undertaken upon a member if the contract is terminated or expires.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1810. Records

- A. Dental records are the property of the provider and shall not be removed from the provider's possession, except:
 - 1. With the patient's permission, including for routing records to a dental or medical practitioner for consultation or evaluation; or
 - 2. When subpoenaed by a court or BODEX.
- B. An Organization shall maintain at its principal office a copy of each issued or delivered advertising matter or sales material, letter of solicitation, evidence of coverage, provider directory, certificate, agreement, or contract. The Organization shall note the date each advertising matter or sales material is filed with the Department and the date of distribution to any person. The advertising matter or sales material shall be maintained for at least three years.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1811. Quality Improvement

- A. An Organization shall have a governing authority.
- B. The governing authority shall appoint a quality improvement committee that consists of the chief executive officer or designee, the dental director, the person who manages the Organization's quality improvement process, and at least one dental health professional. The committee may also include network allied health professionals and members of the plan.
- C. The quality improvement committee shall:
 - 1. Meet at least quarterly,
 - 2. Review and evaluate dental services delivered under the Organization's plan, and
 - 3. Establish procedures for recordkeeping and distribution of committee reports.
- D. An Organization shall provide the director with a copy of the minutes of each quality improvement committee meeting within 30 days of the quality improvement committee meeting.
- E. An Organization shall maintain a written quality improvement plan that contains procedures for each of the following:
 - 1. Ensuring that a dentist licensed in any state or territory of the United States or District of Columbia reviews and evaluates dental care and services provided by each contracted general dentist at least once every three years;
 - 2. Allocation of the Organization's resources to analyze a problem or any identified deficiency;
 - 3. Implementing a corrective action plan and methods for monitoring improvement;
 - 4. Notifying a member in writing of the member's responsibility to cooperate with those providing dental care services and of the member's rights to:
 - a. Voice concerns about the Organization or care provided;
 - b. Be provided with information about the Organization, its services, providers, and member rights and responsibilities;
 - c. Participate in decisions about the member's dental care; and
 - d. Be treated with respect and have the right to privacy recognized;
 - 5. Monitoring and improving membership satisfaction;
 - 6. Maintaining an accurate provider directory that meets at least the following requirements:
 - a. Lists only credentialed providers who are currently scheduling members for diagnosis and treatment; and
 - b. Clearly designates providers who are not accepting new members;
 - 7. Review by the dental director of the following for initial credentialing of network providers:
 - a. Query to the National Practitioner Data Bank;
 - b. Query to BODEX;
 - c. Valid United States Drug Enforcement Administration certificate, if applicable;
 - d. Evidence of current malpractice insurance; and
 - e. Documentation that each specialist has graduated from an accredited specialty graduate program as required by BODEX.
 - 8. Recredentialing, at least every three years, that updates information obtained in subsections (E)(7)(b) through (d), for the dental director's review.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1812. Confidentiality of Records

An Organization shall not disclose information obtained pertaining to the diagnosis, treatment, or health of a member to any person except:

- 1. To the extent necessary to carry out this Article;
- 2. Upon the express written consent of the member, applicant, provider, or Organization, as appropriate; or
- 3. Under statute or court order for the production or discovery of evidence or as part of a civil or criminal investigation.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

R20-6-1813. Assignment of Members

- A. Within 30 days of enrollment, an Organization shall assign a member to the provider the member chooses. The Organization, however, shall choose and assign a provider to a member within 30 days of any of the following:

1. Receipt of a member enrollment form that does not designate a provider, or receipt of a member enrollment form that designates a provider who is unavailable;
 2. The date of the notice that the member's assigned provider intends to cease providing services; or
 3. The date the member's assigned provider becomes unavailable, for any reason.
- B.** An Organization shall give each member the option of selecting a network provider other than the provider assigned by the Organization under subsection (A).
- C.** An Organization shall maintain a continuous assignment process in compliance with subsection (A) and (B), allowing no more than 4% of members to be unassigned at any time.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 463, effective January 10, 2002 (Supp. 02-1).

ARTICLE 20. CAPTIVE INSURERS

Article 20, consisting of Sections R20-6-2001 and R20-6-2002, made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2).

Section

R20-6-2001. Reserved

R20-6-2002. Fees; Examination Costs

ARTICLE 20. CAPTIVE INSURERS

R20-6-2001. Reserved

R20-6-2002. Fees; Examination Costs

- A.** A corporation applying for a license to do business as a captive insurer, under A.R.S. § 20-1098, shall pay a nonrefundable fee of \$1,000.00 to the Department for issuance of the license. A captive insurer that is a protected cell captive insurer, as defined in A.R.S. § 20-1098, also shall pay to the Department a nonrefundable fee of \$1,000 for each participant contract application that establishes a protected cell under A.R.S. § 20-1098.05(B)(9). The fee is payable in full at the time the applicant submits the application for license to the Department under A.R.S. § 20-1098.01.
- B.** A captive insurer shall pay a nonrefundable annual renewal fee of \$5,500.00 to the Department at the time of filing its annual report under A.R.S. § 20-1098.07. Under A.R.S. § 20-1098.01(J), a captive insurer that is a protected cell captive insurer also shall pay to the Department a nonrefundable annual renewal fee of \$2,500.00 for each protected cell at the time of filing its annual report under A.R.S. § 20-1098.07.
- C.** A captive insurer shall pay a nonrefundable fee of \$200.00 to the Department at the time of filing for issuance of an amended certificate of authority.
- D.** In addition to the fees prescribed in subsections (A) and (B), an applicant for a captive insurer license or a licensed captive insurer shall pay the costs of any examination the Director conducts, under A.R.S. § 20-1098.08.

Historical Note

New Section made by final rulemaking at 8 A.A.R. 2478, effective July 1, 2002 (Supp. 02-2). Amended by final rulemaking at 11 A.A.R. 2977, effective September 13, 2005 (Supp. 05-3). Subsection (A) corrected at request of the Department, Office File No. M11-252, filed July 20, 2011 (Supp. 11-3).

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

Article 23, consisting of R20-6-2301 through R20-6-2305, made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

Section

- R20-6-2301. Applicability; Definitions
- R20-6-2302. Disclosure of Preliminary Justification
- R20-6-2303. Timing for Submission of Preliminary Justification
- R20-6-2304. Response to Unreasonableness Determination
- R20-6-2305. Threshold Rate Increase Documentation Requirements

ARTICLE 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE**R20-6-2301. Applicability; Definitions**

- A.** This Article applies to rates charged by health insurers for individual health insurance. This Article does not apply to rates charged by health insurers for the following:
1. Health insurance that a health insurer issues to an employer or to any group described in either A.R.S. § 20-1401 or A.R.S. § 20-1404(A), except health insurance issued to an association or its individual members as described in R20-6-2301(B)(7)(b);
 2. Grandfathered health plan coverage as defined in 45 CFR 147.140; or
 3. Health insurance that covers excepted benefits as described in section 2791(c) of the PHS Act, 42 U.S.C. 300gg-91(c).
- B.** In this Article, the following definitions apply:
1. “Department” means the Arizona Department of Insurance.
 2. “Blanket disability insurance” has the meaning prescribed in A.R.S. § 20-1404(A).
 3. “CMS” means the Centers for Medicare & Medicaid Services.
 4. “Federal medical loss ratio standard” means the applicable medical loss ratio standard determined under 45 CFR 158, Subpart B.
 5. “Health insurance” means disability insurance as defined in A.R.S. § 20-253, a health care plan as defined in A.R.S. § 20-1051(5) and disability insurance or a health care plan offered by a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
 6. “Health insurer” means an insurer, as that term is defined in A.R.S. § 20-104, authorized to transact disability insurance in Arizona, a health care services organization as defined in A.R.S. § 20-1051(7) or a hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation as defined in A.R.S. § 20-822(3).
 7. “Individual health insurance” means health insurance that a health insurer issues to either:
 - a. An individual, to cover:
 - i. The individual, or
 - ii. The individual’s dependents, or
 - iii. The individual and the individual’s dependents.
 - b. An association or its individual members to cover the individual members and their dependents, and which the Department would regulate under A.R.S. Title 20, Chapter 6 as individual health insurance if the health insurer did not issue it to an association or individual members of an association.
 8. “PHS Act” means Part A of Title XXVII of the Public Health Service Act, 42 U.S.C. Chapter 6A.
 9. “Product” means a package of health insurance benefits with a discrete set of rating and pricing methodologies that a health insurer offers as individual insurance in Arizona.
 10. “Preliminary justification” means a justification that consists of the parts described in R20-6-2302(A).
 11. “Rate increase” means an increase of the rates for an individual health insurance product that a health insurer offers in Arizona that:
 - a. Results from a change to the underlying rate structure of the product, and
 - b. May result in premium changes for the product.
 12. “Secretary” means the Secretary of the United States Department of Health and Human Services.
 13. “Threshold rate increase” means a rate increase that meets or exceeds an Arizona-specific threshold as noticed by the Secretary in 45 CFR 154.200, provided:
 - a. The average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold; and
 - b. If a rate increase that does not otherwise meet or exceed the Arizona-specific threshold meets or exceeds the Arizona-specific threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the Arizona-specific threshold and is subject to threshold rate review that shall include a review of the aggregate rate increases during the applicable 12-month period.
 14. “Threshold rate review” means the review by the Department under this Article of a threshold rate increase.
 15. “Unreasonable rate increase” means a rate increase that results in benefits that are not reasonable in relation to the premium the health insurer charges for the product. The following factors are relevant in determining whether a rate increase results in benefits that are unreasonable in relation to premium:
 - a. The rate increase results in a projected medical loss ratio below the federal medical loss ratio standard after accounting for any adjustments allowable under federal law;
 - b. One or more of the assumptions on which the health insurer based the rate increase is not supported by sound actuarial reasoning, data and analysis;

- c. The choice of assumptions or combination of assumptions on which the insurer based the rate increase is unreasonable;
- d. The health issuer provides data or documentation that is incomplete, inadequate or otherwise does not provide a basis upon which the Department can determine the reasonableness of a rate increase; or
- e. The increase results in premium differences between insureds within similar risk categories that are unfairly discriminatory under A.R.S. Title 20, Chapter 2, Article 6.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2302. Disclosure of Preliminary Justification

- A.** Preliminary Justification. For each threshold rate increase for each affected product, a health insurer shall submit to the Department and to CMS, on a form and in the manner prescribed by the Secretary in 45 CFR 154.215, a preliminary justification that contains all of the following:
1. Preliminary Justification Part I. A summary of the content of the threshold rate increase that includes:
 - a. Historical and projected claims experience;
 - b. Trend projections related to utilization, and service or unit cost;
 - c. Any claims assumptions related to benefit changes;
 - d. Allocation of the overall rate increase to claims and non-claims costs;
 - e. Per enrollee per month allocation of current and projected premium; and
 - f. Three year history of rate increases for the product associated with the rate increase.
 2. Preliminary Justification Part II. A written description that justifies the rate increase and that contains a simple and brief narrative describing the data and assumptions the health insurer used to develop the rate increase, and includes the following:
 - a. An explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in subsection (A)(1); and
 - b. A brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.
- B.** A health insurer may submit a single, combined preliminary justification that contains all the information in subsections (A)(1) and (2) for threshold rate increases that affect more than one product if the health insurer has aggregated the claims experience of all products to calculate the rate increases and the rate increases are the same for all products.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2303. Timing for Submission of Preliminary Justification

- A.** If R20-6-607 applies to a threshold rate increase, the health insurer shall submit its preliminary justification to the Department and to CMS on the date on which the health insurer files the rate increase request under R20-6-607.
- B.** If R20-6-607 does not apply to a threshold rate increase, the health insurer shall submit the preliminary justification to the Department and to CMS at least 60 days prior to the date the health insurer intends to implement the threshold rate increase in Arizona.
- C.** The Department shall provide access from its website to the Parts I and II of the Preliminary Justifications of the proposed rate increases that it reviews and have a mechanism for receiving public comments on those proposed rate increases.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2304. Response to Unreasonableness Determination

If the health insurer receives from CMS a notice that the Department has determined that the health insurer's threshold rate increase is unreasonable, the health insurer shall select one of the following three options:

1. Option to not implement the rate increase determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS that it will not implement the rate increase and request the Department to withdraw the rate increase request;
2. Option to implement a smaller rate increase than the rate determined unreasonable. Within 30 days of receiving from CMS the Department's determination, the health insurer shall notify the Department and CMS, on a form and in the manner prescribed by the Secretary, that it intends to implement a rate increase that is smaller than the one determined unreasonable. One of the following shall apply to this option:
 - a. If the health insurer selects this option and the smaller rate increase is not a threshold rate increase, the smaller rate increase is not subject to this Article;
 - b. If the health insurer selects this option, and R20-6-607 applied to the rate increase the Department determined to be unreasonable, the health insurer shall revise the rate increase filing to reflect the smaller rate increase or file a new rate increase. If the smaller rate increase is a threshold rate increase, the health insurer shall submit a new preliminary justification on the date the health insurer revises the rate increase filing or files a new rate increase; or
 - c. If the health insurer selects this option, and R20-6-607 did not apply to the rate increase the Department determined to be unreasonable, and the smaller increase is a threshold rate increase, the health insurer shall submit to the Department and to CMS a new preliminary justification at least 60 days prior to the date the health insurer intends to implement the smaller increase in Arizona.
3. Option to implement the rate increase determined unreasonable. Within 10 business days after the health insurer either implements the rate increase that the Department determined unreasonable, or receives from CMS the Department's determination, the health insurer shall:

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- a. Submit, to the Department and to CMS, a final justification in response to the Department's determination. The information in the final justification shall be the same as the information submitted by the insurer under R20-6-2302(A)(1) and (2) in the preliminary justification supporting the rate increase; and
- b. Prominently post on its website, on a form and in the manner prescribed by the Secretary under 45 CFR 154.230 the following information:
 - i. The Department's determination that the rate increase is unreasonable and Department's explanation of the Department's analysis of the relevant factors set forth in R20-6-2305(A)(1) and (2), and
 - ii. The health insurer's final justification for implementing the rate increase.
- c. Continue to make the information in subsection (3)(b) available to the public on its website for at least three years.

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

R20-6-2305. Threshold Rate Increase Documentation Requirements

- A. For a threshold rate increase, a health insurer shall submit to the Department documentation that is sufficient to allow the Department to assess:
 1. The reasonableness of the assumptions used by the health insurer to develop the proposed rate increase and the validity of the historical data underlying the assumptions, and
 2. The health insurer's data related to past projections and actual experience.
- B. To the extent applicable to the submission under review by the Department, the health insurer shall submit documentation that includes all of the following:
 1. The impact of medical trend changes by major service categories;
 2. The impact of utilization changes by major service categories;
 3. The impact of cost-sharing changes by major service categories;
 4. The impact of benefit changes;
 5. The impact of changes in enrollee risk profile;
 6. The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
 7. The impact of changes in reserve needs;
 8. The impact of changes in administrative costs related to programs that improve health care quality;
 9. The impact of changes in other administrative costs;
 10. The impact of changes in applicable taxes, licensing or regulatory fees;
 11. Medical loss ratio;
 12. The health insurance insurer's capital and surplus; and
 13. Other relevant documentation at the discretion of the Director.
- C. A health insurer shall submit all documentation required under subsection (A) or (B) at the same time that:
 1. The health insurer submits the preliminary justification required under R20-6-2302, or
 2. The health insurer submits any new preliminary justification required under R20-6-2304(2)(b) and (c).

Historical Note

New Section made by final rulemaking at 18 A.A.R. 2721, effective October 3, 2012 (Supp. 12-4).

Arizona Department of Insurance

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Authorizing Statutes

Article 1. HEARING PROCEDURES AND RULEMAKING PETITIONS

A.A.C. R20-101, R20-6-102, R20-6-103, R20-6-106, R20-6-114, R20-6-115 and R20-6-160

The Department adopted these rules under the Director's general rulemaking authority in A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20. The specific authority for the rules is found in A.R.S. §§ 20-161, 41-1003, 41-1033 and A.R.S. Title 41, Chapter 6, Article 10.

General Authority

20-142. Powers and duties of director; payment of examination and investigation costs; home health services

- A. The director shall enforce the provisions of this title.
- B. The director shall have powers and authority expressly conferred by or reasonably implied from the provisions of this title.
- C. The director may conduct examinations and investigations of insurance matters, including examinations and investigations of adjusters, agents and brokers and any other persons who are regulated under this title, in addition to examinations and investigations expressly authorized, as the director deems proper in determining whether a person has violated any provision of this title or for the purpose of securing information useful in the lawful administration of any provision of this title. The examined party shall pay the cost of examinations that are conducted pursuant to this subsection except for examinations of adjusters, agents and brokers. The examined party shall pay the cost of examining adjusters, agents and brokers only if the party has violated any provision of this title. The state shall pay the cost of an investigation.
- D. The director shall establish guidelines for insurers on home health services that shall be used by the director pursuant to sections 20-826, 20-1342, 20-1402 and 20-1404. The director may use home health services as defined in section 36-151. Guidelines shall include but not be limited to:
 1. Home health services that are prescribed by a physician or a registered nurse practitioner.
 2. Home health services that are determined to cost less if provided in the home than the average length of in-hospital service for the same service.

3. Skilled professional care in the home that is comparable to skilled professional care provided in-hospital and that is reviewed and approved at thirty day intervals by a physician.

E. Pursuant to section 41-1750, subsection G, the director may receive criminal history record information in connection with the issuance, renewal, suspension or revocation of a license or certificate of authority or the consideration of a merger or acquisition. The director may require a person to submit a full set of fingerprints to the department. The department of insurance shall submit the fingerprints to the department of public safety for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

20-143. Rule-making power

A. The director may make reasonable rules necessary for effectuating any provision of this title.

B. The director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by one hundred or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities exchange act of 1934, as amended, and as may be amended. Such rule shall not apply to any such company having a class of equity securities which are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended. Whenever such equity securities of any such company are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended, then, no person shall solicit or permit the use of his name to solicit, in any manner whatsoever, any proxy, consent or authorization in respect of any equity security of such company without having first complied with the rules prescribed by the securities and exchange commission pursuant to section 14 of the securities exchange act of 1934, as amended, or as may be amended.

C. All rules made pursuant to this section shall be subject to title 41, chapter 6.

D. In addition to any other penalty provided, wilful violation of any rule made by the director is a violation of this title.

Specific Authority

20-161. Hearings

A. The director may hold hearings for any purpose deemed by him to be necessary and within the scope of this title and shall hold a hearing if required by any provision of this title. Hearings shall be conducted pursuant to title 41, chapter 6, article 10.

B. In a hearing conducted pursuant to this section, an insurer may be represented by a corporate officer.

41-1003. Required rule making

Each agency shall make rules of practice setting forth the nature and requirements of all formal procedures available to the public.

A.R.S. Title 41, Chapter 6, Article 10: Uniform Administrative Hearing Procedures

41-1092. Definitions

In this article, unless the context otherwise requires:

1. "Administrative law judge" means an individual or an agency head, board or commission that sits as an administrative law judge, that conducts administrative hearings in a contested case or an appealable agency action and that makes decisions regarding the contested case or appealable agency action.
2. "Administrative law judge decision" means the findings of fact, conclusions of law and recommendations or decisions issued by an administrative law judge.
3. "Appealable agency action" means an action that determines the legal rights, duties or privileges of a party and that is not a contested case. Appealable agency actions do not include interim orders by self-supporting regulatory boards, rules, orders, standards or statements of policy of general application issued by an administrative agency to implement, interpret or make specific the legislation enforced or administered by it or clarifications of interpretation, nor does it mean or include rules concerning the internal management of the agency that do not affect private rights or interests. For the purposes of this paragraph, administrative hearing does not include a public hearing held for the purpose of receiving public comment on a proposed agency action.
4. "Director" means the director of the office of administrative hearings.
5. "Final administrative decision" means a decision by an agency that is subject to judicial review pursuant to title 12, chapter 7, article 6.
6. "Office" means the office of administrative hearings.
7. "Self-supporting regulatory board" means any one of the following:
 - (a) The Arizona state board of accountancy.
 - (b) The state board of appraisal.
 - (c) The board of barbers.
 - (d) The board of behavioral health examiners.

- (e) The Arizona state boxing and mixed martial arts commission.
- (f) The state board of chiropractic examiners.
- (g) The board of cosmetology.
- (h) The state board of dental examiners.
- (i) The state board of funeral directors and embalmers.
- (j) The Arizona game and fish commission.
- (k) The board of homeopathic and integrated medicine examiners.
- (l) The Arizona medical board.
- (m) The naturopathic physicians medical board.
- (n) The state board of nursing.
- (o) The board of examiners of nursing care institution administrators and adult care home managers.
- (p) The board of occupational therapy examiners.
- (q) The state board of dispensing opticians.
- (r) The state board of optometry.
- (s) The Arizona board of osteopathic examiners in medicine and surgery.
- (t) The Arizona peace officer standards and training board.
- (u) The Arizona state board of pharmacy.
- (v) The board of physical therapy.
- (w) The state board of podiatry examiners.
- (x) The state board for private postsecondary education.
- (y) The state board of psychologist examiners.
- (z) The board of respiratory care examiners.
- (aa) The office of pest management.

- (bb) The state board of technical registration.
- (cc) The Arizona state veterinary medical examining board.
- (dd) The acupuncture board of examiners.
- (ee) The Arizona regulatory board of physician assistants.
- (ff) The board of athletic training.
- (gg) The board of massage therapy.

41-1092.01. Office of administrative hearings; director; powers and duties; fund

A. An office of administrative hearings is established.

B. The governor shall appoint the director pursuant to section 38-211. At a minimum, the director shall have the experience necessary for appointment as an administrative law judge. The director also shall possess supervisory, management and administrative skills, as well as knowledge and experience relating to administrative law.

C. The director shall:

1. Serve as the chief administrative law judge of the office.
2. Make and execute the contracts and other instruments that are necessary to perform the director's duties.
3. Subject to chapter 4, article 4 of this title, hire employees, including full-time administrative law judges, and contract for special services, including temporary administrative law judges, that are necessary to carry out this article. An administrative law judge employed or contracted by the office shall have graduated from an accredited college of law or shall have at least two years of administrative or managerial experience in the subject matter or agency section the administrative law judge is assigned to in the office.
4. Make rules that are necessary to carry out this article, including rules governing ex parte communications in contested cases.
5. Submit a report to the governor, speaker of the house of representatives and president of the senate by November 1 of each year describing the activities and accomplishments of the office. The director's annual report shall include a summary of the extent and effect of agencies' utilization of administrative law judges, court reporters and other personnel in proceedings under this article and recommendations for changes or improvements in the administrative procedure act or any agency's practice or policy with respect to the administrative procedure act.

6. Secure, compile and maintain all decisions, opinions or reports of administrative law judges issued pursuant to this article and the reference materials and supporting information that may be appropriate.

7. Develop, implement and maintain a program for the continuing training and education of administrative law judges and agencies in regard to their responsibilities under this article. The program shall require that an administrative law judge receive training in the technical and subject matter areas of the sections to which the administrative law judge is assigned.

8. Develop, implement and maintain a program of evaluation to aid the director in the evaluation of administrative law judges appointed pursuant to this article that includes comments received from the public.

9. Annually report the following to the governor, the president of the senate and the speaker of the house of representatives by December 1 for the prior fiscal year:

(a) The number of administrative law judge decisions rejected or modified by agency heads.

(b) By category, the number and disposition of motions filed pursuant to section 41-1092.07, subsection A to disqualify office administrative law judges for bias, prejudice, personal interest or lack of expertise.

(c) By agency, the number and type of violations of section 41-1009.

10. Schedule hearings pursuant to section 41-1092.05 upon the request of an agency or the filing of a notice of appeal pursuant to section 41-1092.03.

D. The director shall not require legal representation to appear before an administrative law judge.

E. Except as provided in subsection F of this section, all state agencies supported by state general fund sources, unless exempted by this article, and the registrar of contractors shall use the services and personnel of the office to conduct administrative hearings. All other agencies shall contract for services and personnel of the office to conduct administrative hearings.

F. An agency head, board or commission that directly conducts an administrative hearing as an administrative law judge is not required to use the services and personnel of the office for that hearing.

G. Each state agency, and each political subdivision contracting for office services pursuant to subsection I of this section, shall make its facilities available, as necessary, for use by the office in conducting proceedings pursuant to this article.

H. The office shall employ full-time administrative law judges to conduct hearings required by this article or other laws as follows:

1. The director shall assign administrative law judges from the office to an agency, on either a temporary or a permanent basis, at supervisory or other levels, to preside over contested cases and appealable agency actions in accordance with the special expertise of the administrative law judge in the subject matter of the agency.

2. The director shall establish the subject matter and agency sections within the office that are necessary to carry out this article. Each subject matter and agency section shall provide training in the technical and subject matter areas of the section as prescribed in subsection C, paragraph 7 of this section.

I. If the office cannot furnish an office administrative law judge promptly in response to an agency request, the director may contract with qualified individuals to serve as temporary administrative law judges. These temporary administrative law judges are not employees of this state.

J. The office may provide administrative law judges on a contract basis to any governmental entity to conduct any hearing not covered by this article. The director may enter into contracts with political subdivisions of this state, and these political subdivisions may contract with the director for the purpose of providing administrative law judges and reporters for administrative proceedings or informal dispute resolution. The contract may define the scope of the administrative law judge's duties. Those duties may include the preparation of findings, conclusions, decisions or recommended decisions or a recommendation for action by the political subdivision. For these services, the director shall request payment for services directly from the political subdivision for which the services are performed, and the director may accept payment on either an advance or reimbursable basis.

K. The office shall apply monies received pursuant to subsections E and J of this section to offset its actual costs for providing personnel and services.

41-1092.02. Appealable agency actions; application of procedural rules; exemption from article

A. This article applies to all contested cases as defined in section 41-1001 and all appealable agency actions, except contested cases with or appealable agency actions of:

1. The state department of corrections.
2. The board of executive clemency.
3. The industrial commission of Arizona.
4. The Arizona corporation commission.
5. The Arizona board of regents and institutions under its jurisdiction.
6. The state personnel board.

7. The department of juvenile corrections.

8. The department of transportation.

9. The department of economic security except as provided in section 46-458.

10. The department of revenue regarding:

(a) Income tax or withholding tax.

(b) Any tax issue related to information associated with the reporting of income tax or withholding tax unless the taxpayer requests in writing that this article apply and waives confidentiality under title 42, chapter 2, article 1.

11. The board of tax appeals.

12. The state board of equalization.

13. The state board of education, but only in connection with contested cases and appealable agency actions related to applications for issuance or renewal of a certificate and discipline of certificate holders pursuant to sections 15-203, 15-534, 15-534.01, 15-535, 15-545 and 15-550.

14. The board of fingerprinting.

15. The department of child safety except as provided in sections 8-506.01 and 8-811.

B. Unless waived by all parties, an administrative law judge shall conduct all hearings under this article, and the procedural rules set forth in this article and rules made by the director apply.

C. Except as provided in subsection A of this section:

1. A contested case heard by the office of administrative hearings regarding taxes administered under title 42 shall be subject to the provisions under section 42-1251.

2. A final decision of the office of administrative hearings regarding taxes administered under title 42 may be appealed by either party to the director of the department of revenue, or a taxpayer may file and appeal directly to the board of tax appeals pursuant to section 42-1253.

D. Except as provided in subsections A, B, E, F and G of this section and notwithstanding any other administrative proceeding or judicial review process established in statute or administrative rule, this article applies to all appealable agency actions and to all contested cases.

E. Except for a contested case or an appealable agency action regarding unclaimed property, sections 41-1092.03, 41-1092.08 and 41-1092.09 do not apply to the department of revenue.

F. The board of appeals established by section 37-213 is exempt from:

1. The time frames for hearings and decisions provided in section 41-1092.05, subsection A, section 41-1092.08 and section 41-1092.09.

2. The requirement in section 41-1092.06, subsection A to hold an informal settlement conference at the appellant's request if the sole subject of an appeal pursuant to section 37-215 is the estimate of value reported in an appraisal of lands or improvements.

G. Auction protest procedures pursuant to title 37, chapter 2, article 4.1 are exempt from this article.

41-1092.03. Notice of appealable agency action or contested case; hearing; informal settlement conference; applicability

A. Except as provided in subsection D of this section, an agency shall serve notice of an appealable agency action or contested case pursuant to section 41-1092.04. The notice shall:

1. Identify the statute or rule that is alleged to have been violated or on which the action is based.

2. Identify with reasonable particularity the nature of any alleged violation, including, if applicable, the conduct or activity constituting the violation.

3. Include a description of the party's right to request a hearing on the appealable agency action or contested case.

4. Include a description of the party's right to request an informal settlement conference pursuant to section 41-1092.06.

B. A party may obtain a hearing on an appealable agency action or contested case by filing a notice of appeal or request for a hearing with the agency within thirty days after receiving the notice prescribed in subsection A of this section. The notice of appeal or request for a hearing may be filed by a party whose legal rights, duties or privileges were determined by the appealable agency action or contested case. A notice of appeal or request for a hearing also may be filed by a party who will be adversely affected by the appealable agency action or contested case and who exercised any right provided by law to comment on the action being appealed or contested, provided that the grounds for the notice of appeal or request for a hearing are limited to issues raised in that party's comments. The notice of appeal or request for a hearing shall identify the party, the party's address, the agency and the action being appealed or contested and shall contain a concise statement of the reasons for the appeal or request for a hearing. The agency shall notify the office of the appeal or request for a hearing and the office shall schedule an appeal or contested case hearing pursuant to section 41-1092.05, except as provided in section 41-1092.01, subsection F.

C. If good cause is shown an agency head may accept an appeal or request for a hearing that is not filed in a timely manner.

D. This section does not apply to a contested case if the agency:

1. Initiates the contested case hearing pursuant to law other than this chapter and not in response to a request by another party.
2. Is not required by law, other than this chapter, to provide an opportunity for an administrative hearing before taking action that determines the legal rights, duties or privileges of an applicant for a license.

41-1092.04. Service of documents

Unless otherwise provided in this article, every notice or decision under this article shall be served by personal delivery or certified mail, return receipt requested, or by any other method reasonably calculated to effect actual notice on the agency and every other party to the action to the party's last address of record with the agency. Each party shall inform the agency and the office of any change of address within five days of the change.

41-1092.05. Scheduling of hearings; prehearing conferences

A. Except as provided in subsections B and C, hearings for:

1. Appealable agency actions shall be held within sixty days after the notice of appeal is filed.
2. Contested cases shall be held within sixty days after the agency's request for a hearing.

B. Hearings for appealable agency actions of or contested cases with self-supporting regulatory boards that meet quarterly or less frequently shall be held at the next meeting of the board after the board receives the written decision of an administrative law judge or the issuance of the notice of hearing, except that:

1. If the decision of the administrative law judge is received or the notice of hearing is issued within thirty days before the board meets, the hearing shall be held at the following meeting of the board.
2. If good cause is shown, the hearing may be held at a later meeting of the board.

C. The date scheduled for the hearing may be advanced or delayed on the agreement of the parties or on a showing of good cause.

D. The agency shall prepare and serve a notice of hearing on all parties to the appeal or contested case at least thirty days before the hearing. The notice shall include:

1. A statement of the time, place and nature of the hearing.
2. A statement of the legal authority and jurisdiction under which the hearing is to be held.
3. A reference to the particular sections of the statutes and rules involved.

4. A short and plain statement of the matters asserted. If the agency or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. After the initial notice and on application, a more definite and detailed statement shall be furnished.

E. Notwithstanding subsection D, a hearing shall be expedited as provided by law or upon a showing of extraordinary circumstances or the possibility of irreparable harm if the parties to the appeal or contested case have actual notice of the hearing date. Any party to the appeal or contested case may file a motion with the director asserting the party's right to an expedited hearing. The right to an expedited hearing shall be listed on any abatement order. The Arizona health care cost containment system administration may file a motion with every member grievance and eligibility appeal that cites federal law and that requests that a hearing be set within thirty days after the motion is filed.

F. Prehearing conferences may be held to:

1. Clarify or limit procedural, legal or factual issues.
2. Consider amendments to any pleadings.
3. Identify and exchange lists of witnesses and exhibits intended to be introduced at the hearing.
4. Obtain stipulations or rulings regarding testimony, exhibits, facts or law.
5. Schedule deadlines, hearing dates and locations if not previously set.
6. Allow the parties opportunity to discuss settlement.

41-1092.06. Appeals of agency actions and contested cases; informal settlement conferences; applicability

A. If requested by the appellant of an appealable agency action or the respondent in a contested case, the agency shall hold an informal settlement conference within fifteen days after receiving the request. A request for an informal settlement conference shall be in writing and shall be filed with the agency no later than twenty days before the hearing. If an informal settlement conference is requested, the agency shall notify the office of the request and the outcome of the conference, except as provided in section 41-1092.01, subsection F. The request for an informal settlement conference does not toll the sixty day period in which the administrative hearing is to be held pursuant to section 41-1092.05.

B. If an informal settlement conference is held, a person with the authority to act on behalf of the agency must represent the agency at the conference. The agency representative shall notify the appellant in writing that statements, either written or oral, made by the appellant at the conference, including a written document, created or expressed solely for the purpose of settlement negotiations are inadmissible in any subsequent administrative hearing. The parties

participating in the settlement conference shall waive their right to object to the participation of the agency representative in the final administrative decision.

41-1092.07. Hearings

- A. A party to a contested case or appealable agency action may file a nonperemptory motion with the director to disqualify an office administrative law judge from conducting a hearing for bias, prejudice, personal interest or lack of technical expertise necessary for a hearing.
- B. The parties to a contested case or appealable agency action have the right to be represented by counsel or to proceed without counsel, to submit evidence and to cross-examine witnesses.
- C. The administrative law judge may issue subpoenas to compel the attendance of witnesses and the production of documents. The subpoenas shall be served and, on application to the superior court, enforced in the manner provided by law for the service and enforcement of subpoenas in civil matters. The administrative law judge may administer oaths and affirmations to witnesses.
- D. All parties shall have the opportunity to respond and present evidence and argument on all relevant issues. All relevant evidence is admissible, but the administrative law judge may exclude evidence if its probative value is outweighed by the danger of unfair prejudice, by confusion of the issues or by considerations of undue delay, waste of time or needless presentation of cumulative evidence. The administrative law judge shall exercise reasonable control over the manner and order of cross-examining witnesses and presenting evidence to make the cross-examination and presentation effective for ascertaining the truth, avoiding needless consumption of time and protecting witnesses from harassment or undue embarrassment.
- E. All hearings shall be recorded. The administrative law judge shall secure either a court reporter or an electronic means of producing a clear and accurate record of the proceeding at the agency's expense. Any party that requests a transcript of the proceeding shall pay the costs of the transcript to the court reporter or other transcriber.
- F. Unless otherwise provided by law, the following apply:
1. A hearing may be conducted in an informal manner and without adherence to the rules of evidence required in judicial proceedings. Neither the manner of conducting the hearing nor the failure to adhere to the rules of evidence required in judicial proceedings is grounds for reversing any administrative decision or order if the evidence supporting the decision or order is substantial, reliable and probative.
 2. Copies of documentary evidence may be received in the discretion of the administrative law judge. On request, parties shall be given an opportunity to compare the copy with the original.
 3. Notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the agency's specialized knowledge. Parties shall be notified either before or during the hearing or by reference in preliminary reports

or otherwise of the material noticed including any staff memoranda or data and they shall be afforded an opportunity to contest the material so noticed. The agency's experience, technical competence and specialized knowledge may be used in the evaluation of the evidence.

4. On application of a party or the agency and for use as evidence, the administrative law judge may permit a deposition to be taken, in the manner and on the terms designated by the administrative law judge, of a witness who cannot be subpoenaed or who is unable to attend the hearing. Subpoenas for the production of documents may be ordered by the administrative law judge if the party seeking the discovery demonstrates that the party has reasonable need of the materials being sought. All provisions of law compelling a person under subpoena to testify are applicable. Fees for attendance as a witness shall be the same as for a witness in court, unless otherwise provided by law or agency rule. Notwithstanding section 12-2212, subpoenas, depositions or other discovery shall not be permitted except as provided by this paragraph or subsection C of this section.

5. Informal disposition may be made by stipulation, agreed settlement, consent order or default.

6. Findings of fact shall be based exclusively on the evidence and on matters officially noticed.

7. A final administrative decision shall include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings.

G. Except as otherwise provided by law:

1. At a hearing on an agency's denial of a license or permit or a denial of an application or request for modification of a license or permit, the applicant has the burden of persuasion.

2. At a hearing on an agency action to suspend, revoke, terminate or modify on its own initiative material conditions of a license or permit, the agency has the burden of persuasion.

3. At a hearing on an agency's imposition of fees or penalties or any agency compliance order, the agency has the burden of persuasion.

4. At a hearing held pursuant to title 41, chapter 23 or 24, the appellant or claimant has the burden of persuasion.

H. Subsection G of this section does not affect the law governing burden of persuasion in an agency denial of, or refusal to issue, a license renewal.

[41-1092.08. Final administrative decisions; review](#)

A. The administrative law judge of the office shall issue a written decision within twenty days after the hearing is concluded. The written decision shall contain a concise explanation of the reasons supporting the decision. The administrative law judge shall serve a copy of the decision on the agency. Upon request of the agency, the office shall also transmit to the agency the record

of the hearing as described in section 12-904, except as provided in section 41-1092.01, subsection F.

B. Within thirty days after the date the office sends a copy of the administrative law judge's decision to the head of the agency, executive director, board or commission, the head of the agency, executive director, board or commission may review the decision and accept, reject or modify it. If the head of the agency, executive director, board or commission declines to review the administrative law judge's decision, the agency shall serve a copy of the decision on all parties. If the head of the agency, executive director, board or commission rejects or modifies the decision the agency head, executive director, board or commission must file with the office, except as provided in section 41-1092.01, subsection F, and serve on all parties a copy of the administrative law judge's decision with the rejection or modification and a written justification setting forth the reasons for the rejection or modification.

C. A board or commission whose members are appointed by the governor may review the decision of the agency head, as provided by law, and make the final administrative decision.

D. Except as otherwise provided in this subsection, if the head of the agency or a board or commission does not accept, reject or modify the administrative law judge's decision within thirty days after the date the office sends a copy of the administrative law judge's decision to the head of the agency, executive director, board or commission, as evidenced by receipt of such action by the office by the thirtieth day the office shall certify the administrative law judge's decision as the final administrative decision. If the board or commission meets monthly or less frequently, if the office sends the administrative law judge's decision at least thirty days before the next meeting of the board or commission and if the board or commission does not accept, reject or modify the administrative law judge's decision at the next meeting of the board or commission, as evidenced by receipt of such action by the office within five days after the meeting the office shall certify the administrative law judge's decision as the final administrative decision.

E. For the purposes of subsections B and D of this section, a copy of the administrative law judge's decision is sent on personal delivery of the decision or five days after the decision is mailed to the head of the agency, executive director, board or commission.

F. The decision of the agency head is the final administrative decision unless either:

1. The agency head, executive director, board or commission does not review the administrative law judge's decision pursuant to subsection B of this section or does not reject or modify the administrative law judge's decision as provided in subsection D of this section, in which case the administrative law judge's decision is the final administrative decision.

2. The decision of the agency head is subject to review pursuant to subsection C of this section.

G. If a board or commission whose members are appointed by the governor makes the final administrative decision as an administrative law judge or upon review of the decision of the agency head, the decision is not subject to review by the head of the agency.

H. A party may appeal a final administrative decision pursuant to title 12, chapter 7, article 6, except as provided in section 41-1092.09, subsection B and except that if a party has not requested a hearing upon receipt of a notice of appealable agency action pursuant to section 41-1092.03, the appealable agency action is not subject to judicial review.

I. This section does not apply to the Arizona peace officer standards and training board established by section 41-1821.

41-1092.09. Rehearing or review

A. Except as provided in subsection B of this section:

1. A party may file a motion for rehearing or review within thirty days after service of the final administrative decision.

2. The opposing party may file a response to the motion for rehearing within fifteen days after the date the motion for rehearing is filed.

3. After a hearing has been held and a final administrative decision has been entered pursuant to section 41-1092.08, a party is not required to file a motion for rehearing or review of the decision in order to exhaust the party's administrative remedies.

B. A party to an appealable agency action of or contested case with a self-supporting regulatory board shall exhaust the party's administrative remedies by filing a motion for rehearing or review within thirty days after the service of the administrative decision that is subject to rehearing or review in order to be eligible for judicial review pursuant to title 12, chapter 7, article 6. The board shall notify the parties in the administrative decision that is subject to rehearing or review that a failure to file a motion for rehearing or review within thirty days after service of the decision has the effect of prohibiting the parties from seeking judicial review of the board's decision.

C. Service is complete on personal service or five days after the date that the final administrative decision is mailed to the party's last known address.

D. Except as provided in this subsection, the agency head, executive director, board or commission shall rule on the motion within fifteen days after the response to the motion is filed or, if a response is not filed, within five days of the expiration of the response period. A self-supporting regulatory board shall rule on the motion within fifteen days after the response to the motion is filed or at the board's next meeting after the motion is received, whichever is later.

41-1092.10. Compulsory testimony; privilege against self-incrimination

A. A person may not refuse to attend and testify or produce evidence sought by an agency in an action, proceeding or investigation instituted by or before the agency on the ground that the testimony or evidence, documentary or otherwise, required of the person may tend to incriminate the person or subject the person to a penalty or forfeiture unless it constitutes the compelled

testimony or the private papers of the person that would be privileged evidence either pursuant to the fifth amendment of the Constitution of the United States or article II, section 10, Constitution of Arizona, and the person claims the privilege before the production of the testimony or papers.

B. If a person asserts the privilege against self-incrimination and the agency seeks to compel production of the testimony or documents sought, the office or agency as provided in section 41-1092.01, subsection F may issue, with the prior written approval of the attorney general, a written order compelling the testimony or production of documents in proceedings and investigations before the office or agency as provided in section 41-1092.01, subsection F or apply to the appropriate court for such an order in other actions or proceedings.

C. Evidence produced pursuant to subsection B of this section is not admissible in evidence or usable in any manner in a criminal prosecution, except for perjury, false swearing, tampering with physical evidence or any other offense committed in connection with the appearance made pursuant to this section against the person testifying or the person producing the person's private papers.

41-1092.11. Licenses; renewal; revocation; suspension; annulment; withdrawal

A. If a licensee makes timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally determined by the agency, and, in case the application is denied or the terms of the new license limited, until the last day for seeking review of the agency order or a later date fixed by order of the reviewing court.

B. Revocation, suspension, annulment or withdrawal of any license is not lawful unless, before the action, the agency provides the licensee with notice and an opportunity for a hearing in accordance with this article. If the agency finds that the public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, the agency may order summary suspension of a license pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.

41-1092.12. Private right of action; recovery of costs and fees; definitions

A. If an agency takes an action against a party that is arbitrary, capricious or not in accordance with law, the action is an appealable agency action if all of the following apply:

1. Within ten days after the action that is arbitrary, capricious or not in accordance with law, the party notifies the director of the agency in writing of the party's intent to file a claim pursuant to this section. This notice shall include a description of the action the party claims to be arbitrary, capricious or not in accordance with law and reasons why the action is arbitrary, capricious or not in accordance with law.

2. The agency continues the action that is arbitrary, capricious or not in accordance with law more than ten days after the agency receives the notice.

3. The action is not excluded from the definition of appealable agency action as defined in section 41-1092.

B. This section only applies if an administrative remedy or an administrative or a judicial appeal of final agency action is not otherwise provided by law.

C. If the party prevails, the agency shall pay reasonable costs and fees to the party from any monies appropriated to the agency and available for that purpose or from other operating monies of the agency. If the agency fails or refuses to pay the award within fifteen days after the demand, and if no further review or appeal of the award is pending, the prevailing party may file a claim with the department of administration. The department of administration shall pay the claim within thirty days in the same manner as an uninsured property loss under title 41, chapter 3.1, article 1, except that the agency is responsible for the total amount awarded and shall pay it from its operating monies. If the agency had appropriated monies available for paying the award at the time it failed or refused to pay, the legislature shall reduce the agency's operating appropriation for the following fiscal year by the amount of the award and shall appropriate that amount to the department of administration as reimbursement for the loss.

D. If the administrative law judge determines that the appealable agency action is frivolous, the administrative law judge may require the party to pay reasonable costs and fees to the agency in responding to the appeal filed before the office of administrative hearings.

E. For the purposes of this section:

1. "Action against the party" means any of the following that results in the expenditure of costs and fees:

(a) A decision.

(b) An inspection.

(c) An investigation.

(d) The entry of private property.

2. "Agency" means the department of environmental quality established pursuant to title 49, chapter 1, article 1.

3. "Costs and fees" means reasonable attorney and professional fees.

4. "Party" means an individual, partnership, corporation, association and public or private organization at whom the action was directed and who has expended costs and fees as a result of the action against the party.

Arizona Department of Insurance

5 year review – 2016

Authorizing Statutes

Article 2. Transaction of Insurance

A.A.C. R20-6-201, R20-6-201.01, R20-6-201.02, R20-6-202, R20-6-203, R20-6-204, R20-6-205, R20-6-207, R20-6-208, R20-6-209, R20-6-210, R20-6-211, R20-6-212, R20-6-212.01, R20-6-213 and R20-6-214

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has the powers expressly conferred or reasonably implied by Title 20.

Additional authority for the adoption of R20-6-207 is provided by A.R.S. § 20-448.

Additional authority for the adoption of R20-6-208 through R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. §§ 20-441 through 20-460 and 20-1110.

Further, authority for the adoption of R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 is provided by A.R.S. § 20-1111.

Further authority for R20-6-210 and R20-6-213 is provided in A.R.S. § 20-1110.01.

General Authority

[20-142. Powers and duties of director; payment of examination and investigation costs; home health services](#)

A. The director shall enforce the provisions of this title.

B. The director shall have powers and authority expressly conferred by or reasonably implied from the provisions of this title.

C. The director may conduct examinations and investigations of insurance matters, including examinations and investigations of adjusters, agents and brokers and any other persons who are regulated under this title, in addition to examinations and investigations expressly authorized, as the director deems proper in determining whether a person has violated any provision of this title or for the purpose of securing information useful in the lawful administration of any provision of this title. The examined party shall pay the cost of examinations that are conducted pursuant to this subsection except for examinations of adjusters, agents and brokers. The examined party shall pay the cost of examining adjusters, agents and brokers only if the party has violated any provision of this title. The state shall pay the cost of an investigation.

D. The director shall establish guidelines for insurers on home health services that shall be used by the director pursuant to sections 20-826, 20-1342, 20-1402 and 20-1404. The director may

use home health services as defined in section 36-151. Guidelines shall include but not be limited to:

1. Home health services that are prescribed by a physician or a registered nurse practitioner.
2. Home health services that are determined to cost less if provided in the home than the average length of in-hospital service for the same service.
3. Skilled professional care in the home that is comparable to skilled professional care provided in-hospital and that is reviewed and approved at thirty day intervals by a physician.

E. Pursuant to section 41-1750, subsection G, the director may receive criminal history record information in connection with the issuance, renewal, suspension or revocation of a license or certificate of authority or the consideration of a merger or acquisition. The director may require a person to submit a full set of fingerprints to the department. The department of insurance shall submit the fingerprints to the department of public safety for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

20-143. Rule-making power

A. The director may make reasonable rules necessary for effectuating any provision of this title.

B. The director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by one hundred or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities exchange act of 1934, as amended, and as may be amended. Such rule shall not apply to any such company having a class of equity securities which are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended. Whenever such equity securities of any such company are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended, then, no person shall solicit or permit the use of his name to solicit, in any manner whatsoever, any proxy, consent or authorization in respect of any equity security of such company without having first complied with the rules prescribed by the securities and exchange commission pursuant to section 14 of the securities exchange act of 1934, as amended, or as may be amended.

C. All rules made pursuant to this section shall be subject to title 41, chapter 6.

D. In addition to any other penalty provided, wilful violation of any rule made by the director is a violation of this title.

Specific Authority

R20-6-207

20-448. [Unfair discrimination; definitions](#)

A. A person shall not make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable or in any other of the terms and conditions of the contract.

B. A person shall not make or permit any unfair discrimination respecting hemophiliacs or between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of disability insurance or in the benefits payable or in any of the terms or conditions of the contract, or in any other manner whatever. The provisions of this subsection regarding hemophiliacs do not apply to any policy or subscription contract which provides only benefits for specific diseases or for accidental injuries or which provides only indemnity for blood transfusion services or replacement of whole blood products, fractions or derivatives.

C. As to kinds of insurance other than life and disability, a person shall not make or permit any unfair discrimination in favor of particular persons or between insureds or subjects of insurance having substantially like insuring, risk and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged.

D. An insurer shall not refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay or developmental disability.

E. The rejection of an application or the determining of rates, terms or conditions of a life or disability insurance contract on the basis of a genetic condition, developmental delay or developmental disability constitutes unfair discrimination, unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay or developmental disability.

F. In addition to the provisions in subsection E of this section, the rejection of an application or the determination of rates, terms or conditions of a disability insurance contract on the basis of a genetic condition constitutes unfair discrimination in the absence of a diagnosis of the condition related to information obtained as a result of a genetic test.

G. An insurer that offers life, disability, property or liability insurance contracts shall not deny a claim incurred or deny, refuse, refuse to renew, restrict, cancel, exclude or limit coverage or charge a different rate for the same coverage solely on the basis that the insured or proposed insured is or has been a victim of domestic violence or is an entity or individual that provides counseling, shelter, protection or other services to victims of domestic violence. If an insurer that offers life, disability, property or liability insurance contracts denies a claim incurred or denies, refuses, refuses to renew, restricts, cancels, excludes or limits coverage or charges a different rate

for the same coverage on the basis of a mental or physical condition and the insured or the proposed insured is or has been a victim of domestic violence, the insurer shall submit a written explanation to the insured or proposed insured of the reasons for the insurer's actions, in accordance with section 20-2110. The fact that an insured or proposed insured is or has been the victim of domestic violence is not a mental or physical condition. Nothing contained in this subsection is intended to provide any private right or cause of action to or on behalf of any applicant or insured. It is the specific intent of this subsection to provide solely an administrative remedy to the director for any violation of this section. Nothing in this subsection prevents an insurer from refusing to issue a life insurance policy insuring a person who has been the victim of domestic violence if either of the following is true:

1. The family or household member who commits the act of domestic violence is the applicant for or prospective owner of the policy or would be the beneficiary of the policy and any of the following is true:

(a) The applicant or prospective beneficiary of the policy is known, on the basis of police or court records, to have committed an act of domestic violence.

(b) The insurer has knowledge of an arrest or conviction for a domestic violence related offense by the family or household member.

(c) The insurance company has other reasonable grounds to believe, and those grounds are corroborated, that the applicant or proposed beneficiary of a policy is a family or household member committing acts of domestic violence.

2. The applicant or prospective owner of the policy lacks an insurable interest in the insured.

H. Nothing in subsection G of this section prevents an insurer that:

1. Offers life or disability insurance contracts from underwriting coverage on the basis of an insured's or proposed insured's mental or physical condition if the underwriting:

(a) Does not consider whether or not the mental or physical condition was caused by an act of domestic violence.

(b) Is the same for an insured or proposed insured who is not the victim of domestic violence as it is for an insured or proposed insured who is the victim of domestic violence.

(c) Does not violate any other rule or law.

2. Offers property or liability insurance contracts from underwriting coverage on the basis of the insured's claims history or characteristics of the insured's property and using rating criteria consistent with section 20-384.

I. Any determination made pursuant to section 20-2537 by the external independent review organization shall not be considered in connection with the evaluation of whether any person subject to this article has complied with this section.

J. A property or liability insurer may exclude coverage for losses caused by an insured's intentional or fraudulent act. The exclusion shall not deny an insured's otherwise covered property loss if the property loss is caused by an act of domestic violence by another insured under the policy and the insured who claims the property loss cooperates in any investigation relating to the loss and did not cooperate in or contribute to the creation of the property loss. The insurer may apply reasonable standards of proof for claims filed under this subsection. The insurer may limit the payment to the insured's insurable interest in the property minus any payment made to any mortgagee or other party with a secured interest in the property. This subsection does not require an insurer to pay any amount that is more than the amount of the loss or property coverage limits. An insurer who pays a claim under this subsection has the right of subrogation against any person except the victim of the domestic violence.

K. All insurers shall adopt and adhere to written policies that are consistent with chapter 11 of this title and that specify the procedures to be followed by employees, contractors, producers, agents and brokers to ensure the privacy of and to help protect the safety of a victim of domestic violence when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a victim of domestic violence. Insurers shall distribute the written policies to employees, contractors, producers, agents and brokers who have access to personal or privileged information regarding domestic violence.

L. For the purposes of this section:

1. "Developmental delay" means a delay of at least one and one-half standard deviations from the norm.

2. "Developmental disability" has the same meaning prescribed in section 36-551.

3. "Domestic violence" means any act that is a dangerous crime against children as defined in section 13-705 or an offense defined in section 13-1201 through 13-1204, 13-1302 through 13-1304, 13-1502 through 13-1504 or 13-1602, section 13-2810, section 13-2904, subsection A, paragraph 1, 2, 3 or 6, section 13-2916 or section 13-2921, 13-2921.01, 13-2923 or 13-3623, if any of the following applies:

(a) The relationship between the victim and the defendant is one of marriage or former marriage or of persons residing or having resided in the same household.

(b) The victim and the defendant have a child in common.

(c) The victim or the defendant is pregnant by the other party.

(d) The victim is related to the defendant or the defendant's spouse by blood or court order as a parent, grandparent, child, grandchild, brother or sister, or by marriage as a parent-in-law,

grandparent-in-law, stepparent, step-grandparent, stepchild, step-grandchild, brother-in-law or sister-in-law.

(e) The victim is a child who resides or has resided in the same household as the defendant and is related by blood to a former spouse of the defendant or to a person who resides or has resided in the same household as the defendant.

4. "Gene products" means gene fragments, nucleic acids or proteins derived from deoxyribonucleic acids that would be a reflection of or indicate DNA sequence information.

5. "Genetic condition" means a specific chromosomal or single-gene genetic condition.

6. "Genetic test" means an analysis of an individual's DNA, gene products or chromosomes that indicates a propensity for or susceptibility to illness, disease, impairment or other disorders, whether physical or mental, or that demonstrates genetic or chromosomal damage due to environmental factors, or carrier status for a disease or disorder.

R20-6-208, R20-6-209, R20-6-210, R20-6-211, R20-6-212, R20-6-213

20-441. Purpose of article; definition

A. Among the purposes of this article is the regulation of trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March 9, 1945, 59 Stat. 33, by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

B. For the purposes of this article, "insurance company" or "insurer" means any:

1. Stock, mutual, reciprocal or title insurer.
2. Fraternal benefit society.
3. Health care services organization.
4. Hospital, medical, dental and optometric service corporation.
5. Prepaid dental plan organization.
6. Mechanical reimbursement reinsurer.
7. Prepaid legal plan.
8. Lloyd's association.
9. Service company as defined in this title.

10. Any other entity licensed under this title.

20-442. Unfair trade practices prohibited

No person shall engage in this state in any trade practice which is prohibited by this article, or defined in this article as, or determined pursuant to this article to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

20-443. Misrepresentations and false advertising of policies; false disclosure of compensation

A. A person shall not make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular, sales material or statement:

1. Misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised or the dividends or share of the surplus to be received.
2. Making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies.
3. Making any misleading representation or any misrepresentation as to the financial condition of any insurer or as to the legal reserve system upon which any life insurer operates.
4. Using any name or title of any policy or class of policies misrepresenting the true nature of the policy.
5. Making any misrepresentation to any policyholder for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, surrender, retain or convert any insurance policy.
6. Referring to the coverage or any of the provisions of chapter 3, article 6 or 7 of this title in connection with the sale or attempted sale of any policy of insurance, except in connection with the notice prescribed in section 20-400.10, subsection E, section 20-410, subsection B and section 20-422, subsection C.

B. An insurance producer, consultant or third party administrator shall not falsely disclose the method or amount of compensation associated with a health benefits plan as defined in section 20-2301.

20-443.01. Misrepresentation in sale of insurance; violation; classification

A. It is unlawful for a person to knowingly make any misrepresentation as proscribed by section 20-443 in the sale of insurance.

B. A person who violates this section is guilty of a class 5 felony.

20-443.02. Stranger originated life insurance

A. Intentionally practicing or planning to initiate a life insurance policy for the benefit of a person or entity that lacks an insurable interest and that, at the time of policy origination, has no insurable interest in the insured is a violation of section 20-1104. Stranger originated life insurance practices include situations in which life insurance is purchased with resources or guarantees from or through a person or entity that, at the time of policy inception, could not lawfully initiate the policy himself or itself, and if, at the time of policy inception, there is an agreement to directly or indirectly transfer the ownership of the policy or the policy benefits to a person or entity that lacks an insurable interest. Trusts that are created to give the appearance of insurable interest and that are used to initiate policies for the benefit of investors with no insurable interest violate section 20-1104 and the prohibition against wagering on life. Intentionally practicing or planning does not include a policy owner's lawful assignment of the policy owner's life insurance policy.

B. Stranger originated life insurance practices do not include:

1. A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death provisions contained in the life insurance policy, whether issued with the original policy or as a rider.

2. A premium finance loan or any loan made for a policy on or before the date of issuance of the policy by a bank or other licensed financial institution if any of the following apply:

(a) Default on the loan or the transfer of the policy in connection with the default is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this section.

(b) The loan proceeds are used solely to pay premiums for the policy and to pay any costs or expenses incurred by the lender or the borrower in connection with the financing.

(c) The owner has not agreed on the date of the premium finance loan to sell, directly or indirectly, the policy or any portion of the policy's death benefit on any date following the issuance of the policy.

(d) The owner does not receive on the date of the premium finance loan a guarantee of the future value of the sale of the policy.

3. A collateral assignment of a life insurance policy by an owner.

4. A loan made by a lender that does not violate title 6, chapter 14, article 1, if the loan does not violate this section.

5. An agreement if all the parties:

(a) Are closely related to the insured by blood or law.

(b) Have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties.

6. Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee.

7. A bona fide business succession planning arrangement that is between one or more of the following:

(a) Shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders.

(b) Partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners.

(c) Members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members.

8. An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, that performs significant services for the service recipient's trade or business.

C. Nothing in this section prohibits the assignment of a life insurance policy that is not part of a stranger originated life insurance practice as prescribed by subsection A of this section.

20-444. False or deceptive advertising of insurance or status as insurer

A. No person shall make, publish, disseminate, circulate or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, any advertisement, announcement, sales material or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

B. No person that is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer.

20-445. Defamation

No person shall make, publish, disseminate or circulate, directly or indirectly, or aid, abet or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article, sales material or literature which is false or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance, or any domestic corporation or group being formed

pursuant to this code for the purpose of becoming an insurer. This provision shall not be deemed to restrict the right, lawfully exercised, of newspapers, magazines, radio and television stations, and similar public media for news dissemination, objectively to publish and disseminate news.

20-446. Acts tending to result in unreasonable restraint or monopoly of insurance business

No person shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

20-447. False financial statements or records

A. No person shall file with any public official, or make, publish, disseminate, circulate or deliver to any person, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person, or placed before the public, any false statement of the financial condition of an insurer with intent to deceive.

B. No person shall make any false entry in any book, report or statement of any insurer or other person required to have records under this title, with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer or person is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omit to make a true entry of any material fact pertaining to the business of the insurer or person in any book, report or statement thereof.

20-448. Unfair discrimination; definitions

A. A person shall not make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable or in any other of the terms and conditions of the contract.

B. A person shall not make or permit any unfair discrimination respecting hemophiliacs or between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of disability insurance or in the benefits payable or in any of the terms or conditions of the contract, or in any other manner whatever. The provisions of this subsection regarding hemophiliacs do not apply to any policy or subscription contract which provides only benefits for specific diseases or for accidental injuries or which provides only indemnity for blood transfusion services or replacement of whole blood products, fractions or derivatives.

C. As to kinds of insurance other than life and disability, a person shall not make or permit any unfair discrimination in favor of particular persons or between insureds or subjects of insurance having substantially like insuring, risk and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged.

D. An insurer shall not refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay or developmental disability.

E. The rejection of an application or the determining of rates, terms or conditions of a life or disability insurance contract on the basis of a genetic condition, developmental delay or developmental disability constitutes unfair discrimination, unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay or developmental disability.

F. In addition to the provisions in subsection E of this section, the rejection of an application or the determination of rates, terms or conditions of a disability insurance contract on the basis of a genetic condition constitutes unfair discrimination in the absence of a diagnosis of the condition related to information obtained as a result of a genetic test.

G. An insurer that offers life, disability, property or liability insurance contracts shall not deny a claim incurred or deny, refuse, refuse to renew, restrict, cancel, exclude or limit coverage or charge a different rate for the same coverage solely on the basis that the insured or proposed insured is or has been a victim of domestic violence or is an entity or individual that provides counseling, shelter, protection or other services to victims of domestic violence. If an insurer that offers life, disability, property or liability insurance contracts denies a claim incurred or denies, refuses, refuses to renew, restricts, cancels, excludes or limits coverage or charges a different rate for the same coverage on the basis of a mental or physical condition and the insured or the proposed insured is or has been a victim of domestic violence, the insurer shall submit a written explanation to the insured or proposed insured of the reasons for the insurer's actions, in accordance with section 20-2110. The fact that an insured or proposed insured is or has been the victim of domestic violence is not a mental or physical condition. Nothing contained in this subsection is intended to provide any private right or cause of action to or on behalf of any applicant or insured. It is the specific intent of this subsection to provide solely an administrative remedy to the director for any violation of this section. Nothing in this subsection prevents an insurer from refusing to issue a life insurance policy insuring a person who has been the victim of domestic violence if either of the following is true:

1. The family or household member who commits the act of domestic violence is the applicant for or prospective owner of the policy or would be the beneficiary of the policy and any of the following is true:

(a) The applicant or prospective beneficiary of the policy is known, on the basis of police or court records, to have committed an act of domestic violence.

(b) The insurer has knowledge of an arrest or conviction for a domestic violence related offense by the family or household member.

(c) The insurance company has other reasonable grounds to believe, and those grounds are corroborated, that the applicant or proposed beneficiary of a policy is a family or household member committing acts of domestic violence.

2. The applicant or prospective owner of the policy lacks an insurable interest in the insured.

H. Nothing in subsection G of this section prevents an insurer that:

1. Offers life or disability insurance contracts from underwriting coverage on the basis of an insured's or proposed insured's mental or physical condition if the underwriting:

(a) Does not consider whether or not the mental or physical condition was caused by an act of domestic violence.

(b) Is the same for an insured or proposed insured who is not the victim of domestic violence as it is for an insured or proposed insured who is the victim of domestic violence.

(c) Does not violate any other rule or law.

2. Offers property or liability insurance contracts from underwriting coverage on the basis of the insured's claims history or characteristics of the insured's property and using rating criteria consistent with section 20-384.

I. Any determination made pursuant to section 20-2537 by the external independent review organization shall not be considered in connection with the evaluation of whether any person subject to this article has complied with this section.

J. A property or liability insurer may exclude coverage for losses caused by an insured's intentional or fraudulent act. The exclusion shall not deny an insured's otherwise covered property loss if the property loss is caused by an act of domestic violence by another insured under the policy and the insured who claims the property loss cooperates in any investigation relating to the loss and did not cooperate in or contribute to the creation of the property loss. The insurer may apply reasonable standards of proof for claims filed under this subsection. The insurer may limit the payment to the insured's insurable interest in the property minus any payment made to any mortgagee or other party with a secured interest in the property. This subsection does not require an insurer to pay any amount that is more than the amount of the loss or property coverage limits. An insurer who pays a claim under this subsection has the right of subrogation against any person except the victim of the domestic violence.

K. All insurers shall adopt and adhere to written policies that are consistent with chapter 11 of this title and that specify the procedures to be followed by employees, contractors, producers, agents and brokers to ensure the privacy of and to help protect the safety of a victim of domestic violence when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a victim of domestic violence. Insurers shall distribute the written policies to employees, contractors, producers, agents and brokers who have access to personal or privileged information regarding domestic violence.

L. For the purposes of this section:

1. "Developmental delay" means a delay of at least one and one-half standard deviations from the norm.

2. "Developmental disability" has the same meaning prescribed in section 36-551.

3. "Domestic violence" means any act that is a dangerous crime against children as defined in section 13-705 or an offense defined in section 13-1201 through 13-1204, 13-1302 through 13-1304, 13-1502 through 13-1504 or 13-1602, section 13-2810, section 13-2904, subsection A, paragraph 1, 2, 3 or 6, section 13-2916 or section 13-2921, 13-2921.01, 13-2923 or 13-3623, if any of the following applies:

(a) The relationship between the victim and the defendant is one of marriage or former marriage or of persons residing or having resided in the same household.

(b) The victim and the defendant have a child in common.

(c) The victim or the defendant is pregnant by the other party.

(d) The victim is related to the defendant or the defendant's spouse by blood or court order as a parent, grandparent, child, grandchild, brother or sister, or by marriage as a parent-in-law, grandparent-in-law, stepparent, step-grandparent, stepchild, step-grandchild, brother-in-law or sister-in-law.

(e) The victim is a child who resides or has resided in the same household as the defendant and is related by blood to a former spouse of the defendant or to a person who resides or has resided in the same household as the defendant.

4. "Gene products" means gene fragments, nucleic acids or proteins derived from deoxyribonucleic acids that would be a reflection of or indicate DNA sequence information.

5. "Genetic condition" means a specific chromosomal or single-gene genetic condition.

6. "Genetic test" means an analysis of an individual's DNA, gene products or chromosomes that indicates a propensity for or susceptibility to illness, disease, impairment or other disorders, whether physical or mental, or that demonstrates genetic or chromosomal damage due to environmental factors, or carrier status for a disease or disorder.

[20-448.01. Required insurance procedures relating to HIV information; confidentiality; violations; penalties; definitions](#)

A. In this section unless the context otherwise requires:

1. "Confidential HIV-related information" means information concerning whether a person has had an HIV-related test or has HIV infection, HIV-related illness or acquired immune deficiency syndrome and includes information which identifies or reasonably permits identification of that person or the person's contacts.

2. "HIV" means the human immunodeficiency virus.
3. "HIV-related test" means a laboratory test or series of tests for the virus, components of the virus or antibodies to the virus thought to indicate the presence of HIV infection.
4. "Protected person" means a person who takes an HIV-related test or who has been diagnosed as having HIV infection, acquired immune deficiency syndrome or HIV-related illness.
5. "Person" includes all entities subject to regulation under title 20, the employees, contractors and agents thereof, and anyone performing insurance related tasks for such entities, employees, contractors or agents.

B. Except as otherwise specifically authorized or required by this state or by federal law, no person may require the performance of, or perform an HIV-related test without first receiving the specific written informed consent of the subject of the test who has capacity to consent or, if the subject lacks capacity to consent, of a person authorized pursuant to law to consent for that person. Written consent shall be in a form as prescribed by the director.

C. No person who obtains confidential HIV-related information in the course of processing insurance information or insurance applications or pursuant to a release of confidential HIV-related information may disclose or be compelled to disclose that information except to the following:

1. The protected person or, if the protected person lacks capacity to consent, a person authorized pursuant to law to consent for the protected person.
2. A person to whom disclosure is authorized in writing pursuant to a release as set forth in subsection E of this section, including but not limited to a physician designated by the insured or a medical information exchange for insurers operated under procedures intended to ensure confidentiality, provided that in the case of a medical information exchange:
 - (a) The insurer will not report that blood tests of an applicant showed the presence of the AIDS virus antibodies, but only that unspecified blood test results were abnormal.
 - (b) Reports must use a general code that also covers results of tests for many diseases or conditions, such as abnormal blood counts that are not related to HIV, AIDS, AIDS related complex or similar diseases.
3. A government agency specifically authorized by law to receive the information. The agency is authorized to redisclose the information only pursuant to this section or as otherwise permitted by law.
4. A person regulated by this title to which disclosure is ordered by a court or administrative body pursuant to section 36-665.

5. The industrial commission or parties to an industrial commission claim pursuant to the provisions of section 23-908, subsection D and section 23-1043.02.

D. Test results and application responses may be shared with the underwriting departments of the insurer and reinsurers, or to those contractually retained medical personnel, laboratories, and insurance affiliates, excluding agents and brokers, which are involved in underwriting decisions regarding the individual's application if disclosure is reasonably necessary to make the underwriting decision regarding such application, and claims information may be shared with claims personnel and attorneys reviewing claims if disclosure is reasonably necessary to process and resolve claims.

E. A release of confidential HIV-related information pursuant to subsection C, paragraph 2 of this section shall be signed by the protected person or, if the protected person lacks capacity to consent, a person authorized pursuant to law to consent for the protected person. A release shall be dated and shall specify to whom disclosure is authorized, the purpose for disclosure and the time period during which the release is effective. A general authorization for the release of medical or other information is not a release of confidential HIV-related information unless the authorization specifically indicates its purpose as a general authorization and an authorization for the release of confidential HIV-related information and complies with the requirements of this section.

F. A person to whom confidential HIV-related information is disclosed pursuant to this section shall not disclose the information to another person except as authorized by this section. This subsection does not apply to the protected person or a person who is authorized pursuant to law to consent for the protected person.

G. If a disclosure of confidential HIV-related information is made pursuant to the provisions of a written release as permitted by subsection C, paragraph 2 of this section, the disclosure shall be accompanied by a statement in writing which warns that the information is from confidential records which are protected by state law that prohibits further disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by law.

H. The person making a disclosure in accordance with subsection C, paragraphs 3, 4 and 5, and subsection G of this section shall keep a record of all disclosures for the time period prescribed by the director. On request, a protected person or his legal representative shall have access to the record.

I. Except as otherwise provided pursuant to this section or subject to an order or search warrant issued pursuant to section 36-665, no person who receives confidential HIV-related information pursuant to a release of confidential HIV-related information may disclose that information to another person or legal entity or be compelled by subpoena, order, search warrant or other judicial process to disclose that information to another person or legal entity.

J. The director shall adopt rules to implement the allowable tests and testing procedures, written consent to perform a human immunodeficiency virus related test, procedures for confidentiality

and disclosure of medical information and procedures for gathering underwriting information and may adopt additional rules reasonable and necessary to implement this section.

K. Notwithstanding any other provision of law to the contrary, nothing in this section shall be interpreted to restrict the director's authority to full access to records of any entity subject to regulation under title 20, including but not limited to all records containing confidential HIV-related information. The director may only redisclose confidential HIV-related information in accordance with this section.

L. A protected person, whose rights provided in this section have been violated by a person or entity described in subsection A, paragraph 5 of this section, has those individual remedies specified in section 20-2118 against such a person or entity.

20-448.02. Genetic testing; informed consent; definitions

A. Except as otherwise specifically authorized or required by this state or by federal law, a person shall not require the performance of or perform a genetic test without first receiving the specific written informed consent of the subject of the test who has the capacity to consent or, if the person subject to the test lacks the capacity to consent, of a person authorized pursuant to law to consent for that person. Written consent shall be in a form as prescribed by the director. The results of a genetic test performed pursuant to this subsection are privileged and confidential and may not be released to any party without the expressed consent of the subject of the test.

B. As used in this section:

1. "Gene products" means gene fragments, nucleic acids or proteins derived from deoxyribonucleic acids that would be a reflection of or indicate DNA sequence information.
2. "Genetic test" means an analysis of an individual's DNA, gene products or chromosomes that indicates a propensity for or susceptibility to illness, disease, impairment or other disorders, whether physical or mental, or that demonstrates genetic or chromosomal damage due to environmental factors, or carrier status for disease or disorder.

20-449. Rebates on life or disability insurance

Except as otherwise expressly provided by law, no person shall knowingly permit or offer to make or make any contract of life insurance, life annuity or disability insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or pay or allow, or give or offer to pay, allow or give, directly or indirectly, as an inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract.

20-450. Practices not prohibited as discrimination or rebates in life and disability insurance; wellness programs

A. Nothing in section 20-448 or 20-449 shall be construed as including within the definition of discrimination or rebates any of the following practices:

1. In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or part out of surplus accumulated from nonparticipating insurance, but any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer and its policyholders.
2. In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.
3. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.
4. Issuing life or disability policies on a salary savings or payroll deduction plan at a reduced rate commensurate with the savings made by the use of such plan.

B. Section 20-448 or 20-452 does not prohibit any person from providing or offering to provide:

1. In the case of group disability insurance, rewards or incentives under a wellness program that satisfies the requirements for an exception from the general prohibition against discrimination based on a health factor under the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936), including any federal regulations that are adopted pursuant to that act.
2. In the case of individual disability insurance, rewards or incentives under a wellness program that satisfies the equivalent of the requirements for an exception from the general prohibition against discrimination based on a health factor under the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936), including any federal regulations that are adopted pursuant to that act.

20-451. Rebates on other than life or disability insurance

No insurer or employee, insurance producer or representative thereof shall knowingly charge, demand or receive a premium for any policy of insurance, other than life or disability insurance, except in accordance with any applicable filing on file with the director. No such insurer, employee, insurance producer or representative shall offer, pay, allow or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified in the policy of insurance, except to the extent provided for in an applicable filing. No insured named in a policy of insurance nor any representative or employee of the insured shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit or reduction of premium, or any such

special favor or advantage or valuable consideration or inducement. Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed insurance producers nor as prohibiting any insurer from allowing or returning to its participating policyholders, members or subscribers dividends, savings or unabsorbed premium deposits. As used in this section "insurance" includes suretyship and "policy" includes bond.

20-452. Prohibited inducements

Except as permitted in sections 20-453 and 20-454, any insurer, insurance producer or other person, as an inducement to insurance or in connection with any insurance transaction, shall not provide in any policy for or offer, sell, buy or offer or promise to buy, sell, give, promise or allow to the insured or prospective insured or to any other person on behalf of the insured or prospective insured in any manner:

1. Any employment.
2. Any shares of stock or other securities issued or at any time to be issued or any interest therein or rights thereto.
3. Any advisory board contract, or any similar contract, agreement or understanding, offering, providing for or promising any special profits.
4. Any prizes, goods, wares, merchandise or tangible property of an aggregate value of more than twenty-five dollars.

20-452.01. Designation of particular insurer or person transacting insurance prohibited

No person engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property, and no trustee, director, officer, agent or other employee, or affiliate of, any such person shall require, as a condition precedent to financing the purchase of such property or to lending money upon the security thereof, or as a condition prerequisite for the renewal or extension of any such loan or for the performance of any other act in connection therewith, that the person for whom such purchase is to be financed or to whom the money is to be loaned, or for whom such extension, renewal or other act is to be granted or performed, negotiate any insurance or renewal thereof covering such property through a particular insurer or person transacting insurance.

20-452.02. Exceptions

Section 20-452.01 shall not prevent:

1. The exercise by any person engaged in such business of his right to approve or disapprove of the insurer selected to underwrite the insurance, nor of his right to furnish such insurance or to renew any insurance required by the contract of sale or trust deed or other loan agreement if the borrower or purchaser shall have failed to furnish the insurance or renewal thereof within such reasonable time or form as may be specified in the sale or loan agreement.

2. Any lender from recommending to any borrower or prospective borrower the placing of insurance with a specified insurer, or through a specified insurer or person transacting insurance, as long as such recommendation does not violate the provisions of section 20-452.01.

3. The free choice of insurer or person transacting insurance by any borrower or purchaser at any time, and he may revoke any designation of insurer or person transacting insurance at any time, irrespective of the provisions of any loan or purchase agreement or trust deed.

20-452.03. Evidence of nonviolation

In any trial, hearing or proceeding to determine a violation of section 20-452.01, a written statement or authorization signed by the person for whom any purchase is financed, to whom any money is loaned or for whom any extension, renewal or other act in connection with a loan is to be granted or performed, declaring that such person voluntarily chooses the insurer or person transacting insurance through whom the insurance or its renewal was transacted, and that the choice of such insurer or person transacting insurance was not made a condition precedent to such purchase, loan, extension, renewal or other act, shall be prima facie evidence that no violation of section 20-452.01 has occurred, if the borrower or purchaser in his own handwriting shall have written the name of his chosen insurer or person transacting insurance on a written statement or authorization of such insurer or person transacting insurance.

20-452.04. Investigation by director of alleged violations

The director may investigate any person, whether licensed or not, for the purpose of determining if there has been any violation of section 20-452.01; however, if such investigation be upon a complaint, the complainant must be party to the contract of sale, trust deed, mortgage, or loan agreement, and must make such complaint within three months of the execution or any modification thereof.

20-453. Programs for purchase by policyholders of securities of insurance companies

Notwithstanding the provisions of section 20-452 and notwithstanding any other provision of law, domestic life insurers, whether of the stock, mutual, fraternal or limited capital stock type, shall not be prohibited from engaging in a program whereby the holders of their life insurance policies are offered the right from time to time to buy for cash or to exchange dividends on such policies or other policy values resulting therefrom for securities in domestic corporations engaged in or organized to engage in the insurance business, but no such insurer shall engage in any such program unless the right to buy or the dividends or other policy values subject to exchange result from ownership of or are payable on account of a policy that from its inception is or that, within a period of not to exceed six years from its issue date, becomes a life insurance policy on a permanent plan other than term. From and after being placed on such permanent plan, every such policy shall be in full compliance with sections 20-1231 and 20-1231.01 (standard nonforfeiture law) computed as from the date of being placed on such permanent plan. No such offering shall be deemed to be exempt from title 44, chapter 12.

20-454. Programs for purchase by policyholders of securities of companies not engaged in insurance

Notwithstanding the provisions of section 20-452 and notwithstanding any other provision of law, domestic life insurers, whether of the stock, mutual, fraternal or limited capital stock type that on January 1, 1955 are engaged pursuant to the requirements of title 44, chapter 12 in a program whereby the holders of their life insurance policies are offered the right from time to time to buy for cash or to exchange dividends on such policies or other policy values resulting therefrom for securities in domestic corporations neither engaged in nor organized to engage in the insurance business shall be permitted, subject to the requirements of title 44, chapter 12, to continue to engage in such program notwithstanding the adoption of this title, but no such insurer shall so engage unless the right to buy or the dividends or other policy values subject to exchange result from ownership of or are payable on account of a policy that from its inception is or that, within a period of not to exceed six years from its issue date, becomes a life insurance policy on a permanent plan other than term. From and after being placed on such permanent plan, every such policy shall be in full compliance with sections 20-1231 and 20-1231.01 (standard nonforfeiture law), computed as from the date of being placed on such permanent plan. No such program shall be engaged in by the insurer subsequent to January 1, 1960, except that any such insurer may, subject to title 44, chapter 12, cause to be delivered stock in such corporation for an indefinite period subsequent to such limiting date if the right to acquire the stock arises as a result of a policy actually issued and delivered prior to such date.

20-455. Interlocking ownership or management; multiple directorship

A. Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer or insurers, or have a common management with any other insurer or insurers, unless such retention, investment, acquisition or common management is inconsistent with any other provision of this title, or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.

B. Any person otherwise qualified may be a director of two or more insurers which are competitors, unless the effect thereof is to substantially lessen competition between insurers generally or tend to create a monopoly.

20-456. Cease and desist order for defined or prohibited practices; civil penalty

A. If after a hearing the director finds that the person charged has engaged or is engaging in any act or practice defined in or prohibited under this article as an illegal or unfair method of competition or an unfair or deceptive act or practice, the director shall order the person to cease and desist from the proscribed acts or practices.

B. If the act or practice is a violation of section 20-443, 20-443.01, 20-444, 20-445, 20-446, 20-447, 20-448, 20-448.01, 20-448.02, 20-449, 20-451, 20-452 or 20-467 or a general business practice of committing or performing acts or omissions proscribed by sections 20-461 and 20-468 and 20-469, the director may also impose a civil penalty of not more than one thousand

dollars for each act or violation but not to exceed an aggregate penalty of ten thousand dollars unless the person intentionally violates any section enumerated in this subsection, in which case the director may impose a civil penalty of up to five thousand dollars for each act or violation but not to exceed an aggregate penalty of fifty thousand dollars in any six month period.

C. No order of the director pursuant to this section or order of a court to enforce it, or holding of a hearing, may in any manner relieve or absolve any person affected by the order or hearing from any other liability, penalty or forfeiture under law.

20-457. Premature disposal of premium notes prohibited

An insurer and its insurance producer shall not hypothecate, sell or dispose of a promissory note received in payment of any part of a premium on a policy of insurance applied for prior to the delivery of the policy.

20-458. Fraudulent statement in application; classification

Any life insurance producer, examining physician or other person who knowingly makes a false or fraudulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

20-459. Deferred dividends; life

On and after January 1, 1961, no person shall make or issue or offer to make or issue any contract of life insurance or of life annuity which provides that any premiums, dividends, excess interest, mortality savings, gains from lapses, loadings, or earnings and accumulations therefrom, be payable only to those of a group of policyholders who make premium payments to the end of any period of time in excess of one year.

20-460. Free choice of insurance producer

No casualty or property insurance company, including any subsidiary of any such company, may offer any insurance program in this state to exclusive insurance producers without offering the same insurance program through all of its other authorized insurance producers authorized for similar types of insurance coverage with the exception of employer-employee programs making use of central premium collection.

20-1110. Approval of forms

A. Any life or disability insurance policy form, life or disability insurance application form where written application is required and is to be made a part of the policy and printed rider or endorsement form shall not be delivered or issued for delivery in this state by a life or disability insurer unless it has been filed with and approved by the director. The director may also require that proof of death or loss forms shall be filed with and approved by the director.

B. This section shall not apply to policies, riders, endorsements or forms of unique character designed and used for insurance on a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies, and are used at the request of the individual policyholder, contract holder or certificate holder.

C. Every filing shall be made not less than thirty days in advance of any delivery. The form is approved thirty days after filing unless the director, within the thirty day period, has issued an order affirmatively approving or disapproving the form. The director may extend by not more than an additional fifteen days the period for review of the form, by giving notice of the extension before expiration of the initial thirty day period. The director may at any time, after notice and for cause shown, withdraw the director's approval. This subsection also applies to contracts and policy forms filed with the department under section 20-826, subsection A by a corporation holding a certificate of authority under chapter 4, article 3 of this title. This subsection does not apply to contracts or policy forms issued by a hospital service corporation, medical service corporation or hospital and medical service corporation pursuant to section 20-1063.

D. Any order of the director disapproving the form or withdrawing a previous approval shall state the reasons for the action.

E. A life or disability insurer shall not issue or deliver any advertising matter or sales material to any person in this state until the life or disability insurer files the advertising matter or sales material with the director. This subsection does not require a life or disability insurer to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the life or disability insurer to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At least five days before issuing an order pursuant to this subsection, the director shall provide the life or disability insurer with a written notice of the basis of the order to provide the life or disability insurer with an opportunity to cure the alleged deficiency in the advertising matter or sales material within a single five day period for the particular advertising matter or sales material at issue. The life or disability insurer may appeal the director's order pursuant to title 41, chapter 6, article 10. Except as otherwise provided in this subsection, a life or disability insurer may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

F. The director, by order, may exempt from the requirements of this section for so long as the director deems proper any insurance document or form as specified in the order, to which, in the

director's opinion, this section may not practicably be applied, or the filing and approval of which are, in the director's opinion, not desirable or necessary for the protection of the public.

G. This section shall apply also to any form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of that jurisdiction informs the director that the form is not subject to approval or disapproval by that official, and on the director's order requiring the form to be submitted to the director for the purpose. The applicable same standards shall apply to these forms as apply to forms for domestic use.

20-1110.01. Rules and regulations; form and readability of policies

A. The director shall adopt and promulgate rules and regulations governing the form and readability of various types of insurance policies including title insurance policies. Such rules and regulations may provide that the readability requirements established pursuant to this subsection may be met by use of an outline of coverage or brochure which accompanies the policy and is provided to the policyholder.

B. The rules and regulations adopted and promulgated by the director pursuant to subsection A of this section shall neither require standardized forms of policies nor mandate or prohibit the inclusion of any coverage provisions in policies issued in this state.

R20-6-209, R20-6-210, R20-6-211, R20-6-212 and R20-6-213 Additional Authority

20-1111. Grounds for disapproval of forms

A. The director shall disapprove any form of policy, application, rider or endorsement or withdraw any previous approval thereof only:

1. If it is in any respect in violation of or does not comply with this title.
2. If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.
3. If it has any title, heading or other indication of its provisions which is misleading.
4. If the purchase of such policy is being solicited by false, deceptive or misleading advertising matter, sales material or representations.

B. The director may disapprove any proof of death or loss form only if it imposes unreasonable requirements, or is in violation of this title, or contains deceptive or ambiguous matter.

C. The director may disapprove any advertising matter or sales material which is in violation of this title.

R20-6-210 and R20-6-213 Additional Authority

20-1110.01. Rules and regulations; form and readability of policies

A. The director shall adopt and promulgate rules and regulations governing the form and readability of various types of insurance policies including title insurance policies. Such rules and regulations may provide that the readability requirements established pursuant to this subsection may be met by use of an outline of coverage or brochure which accompanies the policy and is provided to the policyholder.

B. The rules and regulations adopted and promulgated by the director pursuant to subsection A of this section shall neither require standardized forms of policies nor mandate or prohibit the inclusion of any coverage provisions in policies issued in this state.

Arizona Department of Insurance

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Authorizing Statutes

ARTICLE 3. FINANCIAL PROVISIONS AND PROCEDURES

A.A.C. R20-6-303, R20-6-307

The Department adopted these rules under the Director's general rulemaking authority pursuant to A.R.S. § 20-143. Additional authority for the adoption of R20-6-303 is provided by A.R.S. §§ 20-581 and 20-588.

General Authority

20-143. Rule-making power

A. The director may make reasonable rules necessary for effectuating any provision of this title.

B. The director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by one hundred or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities exchange act of 1934, as amended, and as may be amended. Such rule shall not apply to any such company having a class of equity securities which are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended. Whenever such equity securities of any such company are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended, then, no person shall solicit or permit the use of his name to solicit, in any manner whatsoever, any proxy, consent or authorization in respect of any equity security of such company without having first complied with the rules prescribed by the securities and exchange commission pursuant to section 14 of the securities exchange act of 1934, as amended, or as may be amended.

C. All rules made pursuant to this section shall be subject to title 41, chapter 6.

D. In addition to any other penalty provided, wilful violation of any rule made by the director is a violation of this title.

Specific Authority for Rule R20-6-303

20-581. Deposits of insurers

The state treasurer shall accept and hold in trust, when made through the director, deposits of securities or funds by insurers as follows:

1. Deposits required for authority to transact insurance in this state.
2. Deposits of domestic, foreign or alien insurers when made pursuant to the laws of other states, provinces and countries as prerequisite for authority to transact insurance in such state, province or country.
3. Deposits in such additional amounts as are permitted to be made by section 20-587.

20-588. Release of deposits

A. Any deposit made in this state under this title shall be released and returned:

1. To the insurer upon extinguishment by reinsurance or otherwise of substantially all liability of the insurer for the security of which the deposit is held.
2. To the insurer to the extent such deposit is in excess of the amount required.
3. Upon proper order of a court of competent jurisdiction to the receiver, conservator, rehabilitator or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

B. No release of deposited funds shall be made except upon application to and the written order of the director. The director shall have no personal liability for any such release of any such deposit or part thereof so made by him in good faith.

Arizona Department of Insurance

5 year review – 2016

Authorizing Statutes

Article 18. PREPAID DENTAL PLAN ORGANIZATIONS

A.A.C. R20-6-1801, R20-6-1802, R20-6-1803, R20-6-1804, R20-6-1805, R20-6-1806, R20-6-1807, R20-6-1808, R20-6-1809, R20-6-1810, R20-6-1811, R20-6-1812 and R20-6-1813

The Department adopted these rules under the Director's general rulemaking authority under A.R.S. § 20-143 and specific authority under A.R.S. §§ 20-1001 through 20-1019 and 20-2510. Under A.R.S. § 20-142, the Director has the authority to enforce Title 20 and has powers expressly conferred or reasonably implied by Title 20.

General Authority

[20-142. Powers and duties of director; payment of examination and investigation costs; home health services](#)

A. The director shall enforce the provisions of this title.

B. The director shall have powers and authority expressly conferred by or reasonably implied from the provisions of this title.

C. The director may conduct examinations and investigations of insurance matters, including examinations and investigations of adjusters, agents and brokers and any other persons who are regulated under this title, in addition to examinations and investigations expressly authorized, as the director deems proper in determining whether a person has violated any provision of this title or for the purpose of securing information useful in the lawful administration of any provision of this title. The examined party shall pay the cost of examinations that are conducted pursuant to this subsection except for examinations of adjusters, agents and brokers. The examined party shall pay the cost of examining adjusters, agents and brokers only if the party has violated any provision of this title. The state shall pay the cost of an investigation.

D. The director shall establish guidelines for insurers on home health services that shall be used by the director pursuant to sections 20-826, 20-1342, 20-1402 and 20-1404. The director may use home health services as defined in section 36-151. Guidelines shall include but not be limited to:

1. Home health services that are prescribed by a physician or a registered nurse practitioner.

2. Home health services that are determined to cost less if provided in the home than the average length of in-hospital service for the same service.

3. Skilled professional care in the home that is comparable to skilled professional care provided in-hospital and that is reviewed and approved at thirty day intervals by a physician.

E. Pursuant to section 41-1750, subsection G, the director may receive criminal history record information in connection with the issuance, renewal, suspension or revocation of a license or certificate of authority or the consideration of a merger or acquisition. The director may require a person to submit a full set of fingerprints to the department. The department of insurance shall submit the fingerprints to the department of public safety for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. The department of public safety may exchange this fingerprint data with the federal bureau of investigation.

20-143. Rule-making power

A. The director may make reasonable rules necessary for effectuating any provision of this title.

B. The director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by one hundred or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities exchange act of 1934, as amended, and as may be amended. Such rule shall not apply to any such company having a class of equity securities which are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended. Whenever such equity securities of any such company are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended, then, no person shall solicit or permit the use of his name to solicit, in any manner whatsoever, any proxy, consent or authorization in respect of any equity security of such company without having first complied with the rules prescribed by the securities and exchange commission pursuant to section 14 of the securities exchange act of 1934, as amended, or as may be amended.

C. All rules made pursuant to this section shall be subject to title 41, chapter 6.

D. In addition to any other penalty provided, wilful violation of any rule made by the director is a violation of this title.

Specific Authority

20-1001. Definitions

In this article, unless the context otherwise requires:

1. "Member" means an individual who is enrolled in a group prepaid dental plan as a principal subscriber together with such person's dependents who are entitled to dental care services under the plan solely because of their status as dependents of the principal subscriber.

2. "Membership coverage" means any certificate or contract issued to a member setting out the dental coverage to which such member is entitled.

3. "Prepaid dental plan" means any contractual arrangement whereby any prepaid dental plan organization undertakes to provide directly or to arrange for prepaid dental services and to pay or make reimbursement for any remaining portion of such prepaid dental services on a prepaid basis through insurance or otherwise.

4. "Prepaid dental plan organization" means any person who undertakes to conduct one or more prepaid dental plans providing only dental services.

5. "Prepaid dental services" means services included in the practice of dentistry as described in section 32-1202.

6. "Provider" means any person licensed or otherwise authorized to furnish prepaid dental services in this state.

20-1002. Establishment of prepaid dental plan organizations

A. No person, unless authorized pursuant to article 3 or article 9 of this chapter, may establish or operate a prepaid dental plan organization in this state, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration in conjunction with a prepaid dental plan without obtaining and maintaining a certificate of authority pursuant to this article.

B. Within ninety days after the effective date of this article, every prepaid dental plan organization operating in this state shall submit an application for a certificate of authority to the director. Each such applicant may continue to operate as an organization until the director acts upon the application.

20-1003. Application for certificate of authority

A. An application for a certificate of authority to operate as a prepaid dental plan organization shall be filed with the director in a form prescribed by the director, shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

1. A copy of any basic organizational document of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments to the documents.

2. A copy of any bylaws, rules and regulations or similar document regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses and official positions of the persons who are responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of

trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation and the partners of members in the case of a partnership or association.

4. If the prepaid dental plan organization is a corporation, evidence that the board of directors of the corporation includes:

(a) Dentists who are duly licensed pursuant to title 32, chapter 11 and who have contracted with the corporation to render dental service to members.

(b) Members of the prepaid dental plan, who shall comprise at least one-third of the members of the board.

5. A copy of any contract made or to be made between any providers or persons listed in paragraph 3 and the applicant.

6. A statement generally describing the prepaid dental plan organization and its dental plan or plans, facilities and personnel, as approved by the director.

7. A copy of the form of membership coverage that is to be issued to the members.

8. A copy of the form of any group contract that is to be issued to employers, unions, trustees or other applicants.

9. Financial statements showing the applicant's assets, liabilities and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the director determines that additional or more recent financial information is required for the proper administration of this article.

10. A description of the proposed method of marketing the plan, a financial plan that includes a three-year projection of the initial operating results anticipated and a statement as to the sources of working capital as well as any other sources of funding.

11. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the director, the director's successors in office and duly authorized deputies as the true and lawful attorney of the applicant in and for this state, on whom all lawful process in any legal action or proceeding against the prepaid dental plan organization on a cause of action arising in this state may be served.

12. A statement reasonably describing the geographic area or areas to be served, as approved by the director.

13. The fee prescribed in section 20-167 for issuance of a certificate of authority.

14. Any other information the director may require.

B. Within ten days after any significant modification of information previously furnished pursuant to subsection A of this section, a prepaid dental plan organization shall file notice of that modification with the director.

20-1004. Issuance of certificate of authority

Issuance of a certificate of authority shall be granted by the director if the director is satisfied that the following conditions are met:

1. The persons responsible for conducting the affairs of the prepaid dental plan organization are competent and trustworthy and are professionally capable of providing or arranging for the provision of services offered.

2. The prepaid dental plan organization constitutes an appropriate mechanism to achieve an effective prepaid dental plan, in accordance with regulations issued by the director, that shall include at least the basic dental services appropriate to that plan as determined by the director.

3. The prepaid dental plan organization is financially responsible and may reasonably be expected to meet its obligations to members and prospective members. In making this determination the director shall consider at least:

(a) The financial soundness of the prepaid dental plan's arrangements for services and the schedule of charges used.

(b) Any agreement with an insurer, a hospital or a medical service corporation, a government or any other organization for insuring the payment of the cost of prepaid dental services or the provisions for automatic applicability of an alternative coverage in the event of discontinuance of the plan.

(c) The sufficiency of an agreement with providers for the provision of prepaid dental services.

4. Each officer responsible for conducting the affairs of the prepaid dental plan organization has filed with the director, subject to the director's approval, a fidelity bond in the amount of fifty thousand dollars.

20-1005. Deposit requirement; exception

A. A prepaid dental plan organization shall maintain on deposit with the state treasurer through the director's office a surety bond, guaranteeing services under the plan, or cash or securities eligible for investment of capital funds, in the following amounts depending on the number of members entitled to dental care services pursuant to contracts issued by the plan:

<u>Number of members</u>	<u>Deposit</u>
5,000 or less	\$ 25,000
5,001 - 7,500	30,000
7,501 - 10,000	50,000
10,001 - 15,000	75,000

15,001 - 20,000	100,000
20,001 - 25,000	125,000
25,001 - 30,000	150,000
30,001 - 40,000	175,000
40,001 and above	200,000

B. The deposit prescribed by subsection A shall be held by the state treasurer in trust for the benefit and protection of persons covered by a prepaid dental plan.

C. Any securities within the description of subsection A, with the approval of the director, may be exchanged for similar securities or cash of equal amount. Interest on securities deposited shall be payable to the prepaid dental plan organization depositing such securities.

D. An unpaid final judgment arising upon a membership coverage shall be a lien on the deposit prescribed by subsection A, subject to execution after thirty days from the entry of final judgment. If the deposit is reduced, it shall be replenished within ninety days by the prepaid dental plan organization.

E. Upon liquidation or dissolution of a prepaid dental plan organization and the satisfaction of all its debts and liabilities, any balance remaining of the cash or securities deposit prescribed in subsection A together with any other assets of the prepaid dental plan organization shall be returned by the director to the prepaid dental plan organization.

F. The deposit prescribed by subsection A shall not apply with respect to a prepaid dental plan organization which is funded by the federal, state or a municipal government or any political subdivision or body to the extent and for such period of time that the prepaid dental plan organization can demonstrate to the director the presence of operational commitments from such sources equivalent to such deposit.

20-1006. Reserve requirement; exception

A. A prepaid dental plan organization at all times shall maintain for protection of members a financial reserve consisting of two per cent of prepaid charges collected from members for the plan, until such reserve totals five hundred thousand dollars. Such reserve shall be in addition to the deposit prescribed by section 20-1005.

B. The reserve prescribed by subsection A of this section shall not apply with respect to a prepaid dental plan organization which is funded by the federal, state or a municipal government or any political subdivision or body and meets the requirements of section 20-1005, subsection F.

20-1006.01. Risk-based capital requirements; minimum capital and surplus

A. A prepaid dental plan organization shall comply with chapter 2, article 12 of this title.

B. A prepaid dental plan organization that is exempt from the risk-based capital requirements prescribed in section 20-488.08 shall maintain unimpaired capital or surplus, or both, in an

amount of at least twenty-five thousand dollars. 20-1007. [Membership coverage by prepaid dental plan organizations](#)

A. Every member in a prepaid dental plan shall be issued a membership coverage form by the prepaid dental plan organization.

B. Any contract applied for that provides family coverage shall, as to such coverage of individuals in the family, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the insured from the instant of such child's birth, to a child adopted by the insured, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the insured and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members in the family. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium shall be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

C. No membership coverage or amendment shall be issued or delivered to any person in this state until a copy of the form of the membership coverage or amendment has been filed with and approved by the director.

D. A membership coverage shall contain a clear and complete statement of a contract, or a reasonably complete summary if it is a certificate of contract, of:

1. The prepaid dental services or other benefits to which the member is entitled under the prepaid dental plan.
2. Any limitations of the services, kind of services or benefits to be provided, including any deductible or co-payment feature.
3. Where and in what manner information is available as to how services may be obtained.
4. The member's obligation respecting charges for the prepaid dental plan.

E. A membership coverage and advertising and sales material shall contain no provisions or statements that are unjust, unfair, inequitable, misleading or deceptive or that encourage misrepresentation or that are untrue.

F. The director shall approve any form of membership coverage if the requirements of subsections D and E are met and the prepaid dental plan is able in the judgment of the director to meet its financial obligations under the membership coverage. It is unlawful to issue such form until approved. If the director does not disapprove any such form within thirty days after the filing, it shall be deemed approved. If the director disapproves a form of membership coverage, the director shall notify the prepaid dental plan organization, specifying the reasons for

disapproval. The director shall grant a hearing on such disapproval within fifteen days after a request in writing is received from the prepaid dental plan organization.

G. As used in subsection B of this section, the term "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under the age of eighteen years.

20-1008. Examination of prepaid dental plan organization

A. The director may once in each six months for the first three years after organization and once each year thereafter, or more often if deemed necessary by the director, visit each prepaid dental plan organization organized under the laws of this state and examine its financial condition and its ability to meet its liabilities and its compliance with the laws of this state affecting the conduct of its business. The director may annually visit and examine each prepaid dental plan organization not organized under the laws of this state but authorized to transact business in this state.

B. The director may in like manner examine each prepaid dental plan organization applying for an initial certificate of authority to do business in this state.

C. In lieu of making an examination, the director may accept a full report of the most recent examination of a foreign or alien prepaid dental plan organization, certified to by the appropriate examining official of another state, territory, commonwealth or district of the United States.

D. On request by the director of the department of insurance, the director of the department of health services or another person the director of the department of insurance determines to be qualified may participate in the examinations and visits described in this section to verify the existence of an effective prepaid dental plan and to review the delivery of services by the prepaid dental plan organization.

20-1009. Annual report to director

A. Every prepaid dental plan organization annually on or before the first day of March shall file with the director a report of its financial condition, transactions and affairs as of the preceding December 31 as prescribed in sections 20-223 and 20-234 and shall pay the annual renewal fee prescribed in section 20-167.

B. The prepaid dental plan organization shall also submit any reports required by chapter 2, article 12 of this title.

C. A prepaid dental plan organization that fails to timely file the annual report required under subsection A of this section is subject to the penalties prescribed in section 20-223.

20-1010. Taxes

A. On the tax payment dates prescribed in section 20-224, each prepaid dental plan organization shall pay to the director for deposit, pursuant to sections 35-146 and 35-147, in a form prescribed by the director a tax for transacting a prepaid dental plan in the amount of 2.0 per cent of prepaid net charges received from members.

B. The failure by an organization to pay the tax imposed by this section results in a civil penalty determined pursuant to section 20-225.

C. A prepaid dental plan organization may claim a premium tax credit if the organization qualifies for a credit pursuant to section 20-224.03 or 20-224.04.

20-1011. Operational expenses

No more than thirty per cent of prepaid charges in the first year of operation, twenty-five per cent of prepaid charges in the second year of operation and twenty per cent of prepaid charges in any subsequent year shall be used for the marketing and administrative expenses of a prepaid dental plan organization, including all costs related to soliciting members and providers.

20-1012. Prohibited practices

Chapter 2, article 6 of this title, relating to unfair trade practices and frauds, shall apply to prepaid dental plan organizations, except to the extent the director determines that the nature of prepaid dental plan organizations render particular provisions inappropriate.

20-1013. Regulation of agents

The director shall, after notice and hearing, promulgate such rules and regulations as are necessary to provide for the licensing of agents which shall include provisions for examination, licensing, annual fees and disciplinary procedures similar to those provided in chapter 2, article 3 of this title.

20-1014. Examination

The director may conduct an examination of the affairs of any prepaid dental plan organization as often as the director deems it necessary for the protection of the interests of the people of this state.

20-1015. Suspension or revocation of certificate of authority; civil penalties

A. The director may suspend or revoke any certificate of authority issued to a prepaid dental plan organization pursuant to this article if the director finds that any of the following conditions exists:

1. The prepaid dental plan organization is operating significantly in contravention of its basic organizational documents or in a manner contrary to that described in, and reasonably inferred from, any other information submitted pursuant to section 20-1003.
2. The prepaid dental plan organization issued membership coverage that does not comply with the requirements of section 20-1007.
3. The prepaid dental plan does not provide or arrange for basic dental services appropriate to such plan as determined by the director.
4. The prepaid dental plan organization can no longer be expected to meet its obligations to members or prospective members.
5. The prepaid dental plan organization, or any authorized person on its behalf, has advertised or merchandised its services in a materially untrue, misleading, deceptive or unfair manner.
6. The prepaid dental plan organization has failed to substantially comply with this article or any rules adopted pursuant to this article.
7. The prepaid dental plan organization is in an unsound condition or in such a condition as to render its further transaction of business in this state hazardous to its members or to the residents of this state.

B. If the certificate of authority of a prepaid dental plan organization is suspended, the organization shall not accept, during the period of the suspension, any additional members except newborn children or other newly acquired dependents of existing members and shall not engage in any advertising or solicitation.

C. If the certificate of authority of a prepaid dental plan organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs and shall conduct no further business except as may be essential to the orderly conclusion of solicitation. The director, by written order, may permit such further operation of the organization as the director finds to be in the best interest of members to the end that members shall be afforded the greatest practical opportunity to obtain continuing prepaid dental plan coverage.

D. Notwithstanding subsections B and C of this section, a prepaid dental plan organization that has had its certificate of authority denied, suspended or revoked, or that is subject to an adverse action by the director, is entitled to a hearing pursuant to title 41, chapter 6, article 10 and, except as provided in section 41-1092.08, subsection H, is entitled to judicial review pursuant to title 12, chapter 7, article 6.

E. If, after a hearing, the director finds grounds pursuant to subsection A of this section to suspend or revoke an organization's certificate of authority, the director may impose, in lieu of or in addition to that suspension or revocation, the following civil penalties that shall be remitted to the state treasurer for deposit, pursuant to sections 35-146 and 35-147, in the state general fund:

1. For an unintentional violation, not more than one thousand dollars for each violation and not more than an aggregate of ten thousand dollars in any six month period.
2. For an intentional violation, not more than five thousand dollars for each violation and not more than an aggregate of fifty thousand dollars in any six month period.

20-1016. Rehabilitation, liquidation or conservation of prepaid dental plan organization

Any rehabilitation, liquidation or conservation of a prepaid dental plan organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurer and shall be conducted pursuant to chapter 3, article 4 of this title.

20-1018. Advertising matter or sales materials

A prepaid dental plan organization shall not issue or deliver any advertising matter or sales material to any person in this state until the prepaid dental plan organization files the advertising matter or sales material with the director. This section does not require a prepaid dental plan to have the prior approval of the director to issue or deliver the advertising matter or sale material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the prepaid dental plan organization to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At least five days before issuing an order pursuant to this section, the director shall provide the prepaid dental plan organization with a written notice of the basis of the order to provide the prepaid dental plan organization with an opportunity to cure the alleged deficiency in the advertising matter or sales material within a single five day period for the particular advertising matter or sales material at issue. The prepaid dental plan organization may appeal the director's order pursuant to title 41, chapter 6, article 10. Except as otherwise provided in this section, a prepaid dental plan organization may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

20-1019. Order of benefit determination for dental care

A. If a person receiving dental care is a member of a prepaid dental plan and is an insured or certificate holder under an indemnity health insurance policy which provides benefits for the same treatment as the person's prepaid dental plan, the indemnity health insurance policy, if

issued after the effective date of this section, shall pay benefits to its insured or certificate holder or the assignee thereof without regard to the existence of the prepaid dental plan.

B. Notwithstanding subsection A, the indemnity plan insurer is not obligated to pay any amount for a procedure covered without charge to the member of the prepaid dental plan or to pay in excess of the amount of the member's obligation under the prepaid dental plan.

C. In the event that the member's copayment obligation under the prepaid dental plan has been met, then the indemnity insurer shall remit any payments due under this section directly to its insured or certificate holder.

D. The director may adopt rules to enforce this section.

20-2510. Health care insurers requirements; medical directors

A. A health care insurer that proposes to provide coverage of inpatient hospital and medical benefits, outpatient surgical benefits or any medical, surgical or health care service for residents of this state with utilization review of those benefits shall meet at least one of the following requirements:

1. Have a certificate issued pursuant to this chapter.
2. Be accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.
3. Contract with a utilization review agent that has a certificate issued pursuant to this chapter.
4. Contract with a utilization review agent that is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.
5. Provide to the director a signed and notarized statement that the health care insurer has submitted an application for accreditation to the utilization review accreditation commission or the national committee for quality assurance and is awaiting completion of the accreditation review process. On completion of the accreditation review process, the insurer shall provide to the director adequate proof that the insurer has been accredited. If the insurer is denied accreditation, within sixty days after the denial the insurer shall meet at least one of the requirements set forth in paragraph 1, 2, 3 or 4 of this subsection.

B. Except as provided in subsections C, D and E of this section, any direct denial of prior authorization of a service requested by a health care provider on the basis of medical necessity by a health care insurer shall be made in writing by a medical director who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17. The written denial shall include an explanation of why the treatment was denied, and the medical director who made the denial shall sign the written denial. The health care insurer shall send a

copy of the written denial to the health care provider who requested the treatment. Health care insurers shall maintain copies of all written denials and shall make the copies available to the department for inspection during regular business hours. The medical director is responsible for all direct denials that are made on the basis of medical necessity. Nothing in this section prohibits a health care insurer from consulting with a licensed physician whose scope of practice may provide the health care insurer with a more thorough review of the medical necessity.

C. For determinations made pursuant to subsection B of this section, a dental service corporation as defined in section 20-822 or a prepaid dental plan organization as defined in section 20-1001 may use as a medical director either:

1. An individual who holds an active unrestricted license to practice dentistry in this state pursuant to title 32, chapter 11.
2. A physician who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17.

D. For determinations made pursuant to subsection B of this section, an optometric service corporation may use as a medical director either:

1. An individual who holds an active unrestricted license to practice optometry in this state pursuant to title 32, chapter 16.
2. A physician who holds an active unrestricted license to practice medicine in this state pursuant to title 32, chapter 13 or 17.

E. For determinations made pursuant to subsection B of this section, a health care insurer shall use a chiropractor licensed in this state pursuant to title 32, chapter 8 or by any regulatory board in another state to review any direct denial of prior authorization of a chiropractic service requested by a chiropractor on the basis of medical necessity.

Arizona Department of Insurance

5 year review – 2016

Authorizing Statutes

ARTICLE 20. CAPTIVE INSURERS

A.A.C. R20-6-2002

The Department adopted this rule under the Director's general rulemaking authority under A.R.S. § 20-143 and specific authority under A.R.S. §§ 20-167(H), 20-1098, 20-1098.01(J), 20-1098.05, 20-1098.06, 20-1098.07 and 20-1098.08.

General Authority

20-143. Rule-making power

A. The director may make reasonable rules necessary for effectuating any provision of this title.

B. The director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by one hundred or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities exchange act of 1934, as amended, and as may be amended. Such rule shall not apply to any such company having a class of equity securities which are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended. Whenever such equity securities of any such company are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended, then, no person shall solicit or permit the use of his name to solicit, in any manner whatsoever, any proxy, consent or authorization in respect of any equity security of such company without having first complied with the rules prescribed by the securities and exchange commission pursuant to section 14 of the securities exchange act of 1934, as amended, or as may be amended.

C. All rules made pursuant to this section shall be subject to title 41, chapter 6.

D. In addition to any other penalty provided, wilful violation of any rule made by the director is a violation of this title.

Specific Authority

20-167. Fees

A. The director shall collect in advance the following fees, as adjusted pursuant to subsection F of this section, which are nonrefundable on payment:

- | | | |
|----------------------------------|----------------|----------------|
| | Not Less Than: | Not More Than: |
| 1. For filing charter documents: | | |

(a) Original charter documents,
 articles of incorporation,
 bylaws, or record of
 organization of insurers,
 or certified copies thereof,
 required to be filed with
 the director and not also
 subject to filing in the
 office of the corporation

commission	\$ 40.00	\$ 115.00
(b) Amended charter documents	15.00	45.00

(c) No charge or fee shall be
 required for filing with
 the director any of such
 documents also required
 by law to be filed in the
 office of the corporation
 commission

2. Certificate of authority:

(a) Issuance:

Fraternal benefit societies	\$ 15.00	\$ 45.00
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Medical or hospital service
 corporations, health care

services organizations or

prepaid dental plan

organizations	40.00	115.00
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Mechanical

reimbursement reinsurers	150.00	450.00
All other insurers	100.00	295.00
(b) Renewal:		
Fraternal benefit societies	15.00	45.00

Medical or hospital service

corporations, health care

services organizations or

prepaid dental plan

organizations	40.00	115.00
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Domestic stock life insurers,

domestic stock disability

insurers or domestic stock

life and disability insurers	750.00	2,250.00
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Domestic life reinsurers,

domestic disability

reinsurers or domestic

life and disability

reinsurers	2,250.00	5,500.00
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Mechanical reimbursement

reinsurers	2,250.00	5,500.00
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All other insurers	70.00	205.00
3. Certificate of registration as an administrator or application for renewal under section 20-485.12	\$ 100.00	\$ 295.00
4. Authority to solicit applications for and issue policies by means of mechanical vending machines	\$ 30.00	\$ 90.00
5. Service company permit	\$ 150.00	\$ 450.00
6. Application for motor vehicle service contract program approval	\$ 150.00	\$ 450.00
7. Life care contract application or annual report	\$ 225.00	\$ 675.00
8. Filing annual statement	\$ 150.00	\$ 450.00
9. Annual statement filing for exempt insurer transacting life insurance, disability insurance or annuity business pursuant to section 20-401.05	\$ 65.00	\$ 100.00
10. Licenses and examinations:		
(a) Licenses:		
Surplus lines broker's license, quadrennially	\$ 600.00	\$1,000.00

All other licenses,

quadrennially	60.00	180.00
(b) Examinations for license:		

Examination on laws and one kind

of insurance	8.00	25.00
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Examination on laws and two or

more kinds of insurance	15.00	45.00
11. Miscellaneous:		

Fee accompanying service of

process upon director	\$ 8.00	\$ 25.00
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Certificate of director,

under seal	1.50	5.00
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Copy of document filed in

director's office, per page	0.50	0.75
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B. Except as provided in section 20-1098.18, the director shall deposit, pursuant to sections 35-146 and 35-147, all fees collected pursuant to this section in the state general fund. A refund is not allowed for any unused portion of a fee, and the director shall not prorate fees.

C. The license fees prescribed by this section shall be payment in full of all demands for all state, county, district and municipal license fees, license taxes, business privilege taxes and business privilege fees and charges of every kind.

D. Each domestic stock life or disability insurer that pays the renewal fee required under subsection A of this section is entitled to a credit in the amount of at least four hundred fifty-five dollars but not more than six hundred eighty dollars, as adjusted pursuant to subsection F of this section, to apply to the premium tax the insurer then owes pursuant to section 20-224, but the credit is not cumulative.

E. The director may contract for the examination for the licensing of adjusters, insurance producers, bail bond agents, risk management consultants and surplus lines brokers. If the director does so, the fee for examinations for licenses pursuant to this section is payable directly

to the contractor by the applicant for examination. The director may agree to a reasonable examination fee to be charged by the contractor. The fee may exceed the amounts prescribed in this section.

F. Each December 1, if the revenue collected from fees during the prior fiscal year is less than ninety-five per cent or more than one hundred ten per cent of the appropriated budget for the current fiscal year, the director shall revise all fees within the limits prescribed by subsection A of this section on a uniform percentage basis among all fee categories and shall adjust the credit prescribed by subsection D of this section as necessary in order to retain any required uniformity. The director shall revise the fees in such a manner that the revenue derived from the fees during the subsequent fiscal year equals at least ninety-five per cent but not more than one hundred ten per cent of the appropriated budget for the current fiscal year. The revised fee schedule shall be effective July 1 of the subsequent fiscal year. For the purposes of this subsection, appropriated budget does not include any appropriation for the operation of the captive insurance program established under chapter 4, article 14 of this title. Any fees collected from captive insurers pursuant to subsection H of this section shall not be counted for the purpose of meeting the requirement of this section to recover at least ninety-five but not more than one hundred ten per cent of the department's appropriated budget.

G. The director may contract with a voluntary domestic organization of surplus lines brokers to perform any transaction prescribed in chapter 2, article 5 of this title, including the acceptance or maintenance of the reports required by section 20-408. The director may allow the contractor to charge a stamping fee. The surplus lines broker shall pay the stamping fee established pursuant to this section directly to the contractor.

H. Captive insurers shall pay certificate of authority issuance and renewal fees as prescribed by the director.

I. For the purposes of subsection G of this section, "stamping fee" means a reasonable filing fee charged by a contractor for any transaction prescribed in chapter 2, article 5 of this title, including the acceptance or maintenance of the reports required by section 20-408.

20-1098. Definitions

In this article, unless the context otherwise requires:

1. "Affiliate" has the same meaning prescribed in section 20-481.
2. "Agency captive insurer" means a captive insurer that is owned by one or more business entities that are licensed in any state as insurance producers or managing general agents and that only insure risks on policies placed through their owners.
3. "Alien captive insurer" means any insurer that is formed to write insurance business for its affiliates and that is licensed pursuant to the laws of an alien jurisdiction that imposes statutory or regulatory standards that are acceptable to the director on companies transacting the business of insurance in such a jurisdiction.

4. "Association" means any lawfully formed association of individuals or business entities that has been in existence for at least one year and that is organized for a primary purpose other than procuring or providing insurance for its members.
5. "Association captive insurer" means a captive insurer that is completely under the direct or indirect voting control of an association.
6. "Branch business" means any insurance business that is transacted by a branch captive insurer in this state.
7. "Branch captive insurer" means an alien captive insurer that is licensed pursuant to this chapter to transact the business of insurance through a business unit with a principal place of business in this state.
8. "Branch operations" means any business operations of a branch captive insurer in this state.
9. "Business entity" means any legal entity other than an individual or sole proprietorship.
10. "Captive insurer" means any pure captive insurer, agency captive insurer, group captive insurer or protected cell captive insurer that is domiciled in this state and that is formed and licensed under this article.
11. "Controlled unaffiliated business" means an individual or business entity that satisfies all of the following:
 - (a) Is not an affiliate of the captive insurer providing coverage or reinsurance.
 - (b) Has a contractual relationship with an affiliate of the captive insurer providing coverage or reinsurance.
 - (c) Whose risk management function that is related to the covered risk of loss is controlled by an affiliate of the captive insurer providing coverage or reinsurance.
12. "Deductible reimbursement" means insurance coverage that reimburses the insured for the deductible it paid under a separate commercial insurance policy issued to the same insured, without other conditions related to the underlying loss.
13. "Direct or directly", when used in this article to describe the transaction of insurance business by a captive insurer, means a transaction in which the captive insurer issues an insurance policy that provides primary coverage to the insured under the policy and that does not provide reinsurance coverage to another insurer.
14. "Group captive insurer" means any of the following:
 - (a) A risk retention group.

(b) An industry group captive insurer.

(c) An association captive insurer.

15. "Industry group" means two or more business entities or persons that are engaged in businesses or activities similar or related with respect to the liability that they are exposed to by virtue of any related, similar or common business, trade, product, services, premises or operations.

16. "Industry group captive insurer" means a captive insurer that is completely under the direct or indirect voting control of an industry group.

17. "Manager" means a person who is experienced in the field of captive insurance and who maintains all documents relating to a captive insurer's operations, transactions and affairs in this state and assists the captive insurer in its management and compliance with this article.

18. "Member" means any individual or business entity that belongs to a group captive insurer.

19. "Participant" means an entity and any affiliates of the entity that are insured by a protected cell captive insurer pursuant to a participant contract.

20. "Participant contract" means a contract by which a protected cell captive insurer insures risks of one or more participants and limits losses under the contract to the assets of a protected cell.

21. "Protected cell" means a separate account that is established and maintained by a protected cell captive insurer pursuant to a participant contract.

22. "Protected cell captive insurer" means a captive insurer:

(a) In which the minimum capital and surplus required by applicable law is provided by one or more sponsors.

(b) That is formed and licensed under this article.

(c) That insures the risks of participants through participant contracts.

(d) That segregates liability under a participant contract through one or more protected cells.

23. "Pure captive insurer" means a captive insurer that insures only the risks of its affiliates and controlled unaffiliated business.

24. "Risk retention group" means a captive insurer that is organized pursuant to the liability risk retention act of 1986 (15 United States Code sections 3901 and 3902) and chapter 14 of this title.

25. "Sponsor" means an entity that meets the requirements of section 20-1098.06 and that the director has approved to provide all or part of the capital and surplus required by applicable law to operate a protected cell captive insurer.

20-1098.01. Licensing; authority

A. If allowed by its articles of incorporation, bylaws or other organizational document, an applicant may apply to the director for a license to transact captive insurance, except that:

1. A pure captive insurer shall not insure risks other than the risks of its affiliates and controlled unaffiliated business.

2. A group captive insurer, other than a risk retention group, shall not insure risks other than the risks of its group members, its affiliates and controlled unaffiliated business. A risk retention group shall insure only the risks of its group members.

3. An agency captive insurer shall not:

(a) Insure any risks other than those placed by or through its owners.

(b) Directly insure life or disability insurance risks.

4. A protected cell captive insurer shall not insure any risks other than those prescribed in its participant contracts.

B. The following apply to the transaction of insurance by a captive insurer on a direct basis:

1. A captive insurer shall not directly insure any of the following types of insurance business:

(a) Hospital service corporations, medical service corporations, dental service corporations, optometric service corporations or hospital, medical, dental and optometric service corporations as defined in section 20-822.

(b) Health care services organizations as defined in section 20-1051.

(c) Prepaid dental plan organizations as defined in section 20-1001.

(d) Prepaid legal insurance contracts as defined in section 20-1097.

(e) Business of title insurance as defined in section 20-1562.

(f) Personal motor vehicle or homeowner's insurance coverage or any component of that insurance coverage.

(g) Mortgage guaranty insurance as defined in section 20-1541.

(h) Workers' compensation or employers' liability insurance policies except in connection with a self-insurance program as prescribed in this subsection.

2. A pure captive insurer shall not provide direct coverage of workers' compensation or employers' liability in this state unless the coverage is provided under a self-insurance program that is approved by the industrial commission of Arizona pursuant to section 23-961. A captive insurance program that is authorized by section 23-961 is subject to and shall comply with all requirements of title 23, chapter 6 that are applicable to self-insurance.

3. A pure captive insurer shall not provide direct coverage of workers' compensation or employers' liability insurance in another state unless the coverage is provided under a self-insurance program that is qualified as a self-insurance program under the applicable state or federal law, as determined by the agency or other entity that has jurisdiction over the self-insurance program.

4. This subsection does not prohibit a captive insurer from directly insuring deductible reimbursement risk.

5. This subsection does not prohibit a captive insurer from directly insuring employment practices liability risk.

C. A captive insurer shall not accept or cede reinsurance except as provided in section 20-1098.11.

D. A captive insurer that writes life insurance or disability insurance shall comply with all applicable state and federal laws.

E. A captive insurer shall:

1. Hold at least one meeting of its board of directors or, for reciprocal insurers, its subscribers' advisory committee each year in this state.

2. Maintain its principal place of business in this state.

3. Appoint a resident statutory agent to accept service of process and to otherwise act on its behalf in this state and shall file the appointment with the director. In the case of a captive insurer formed as a corporation or reciprocal insurer, if the statutory agent cannot with reasonable diligence be found at the registered office of the captive insurer, the director is an agent of the captive insurer on whom any process, notice or demand may be served.

F. Before receiving a license, an applicant for a captive insurer license shall file with the director the following:

1. If formed as a corporation, a certified copy of its articles of incorporation, articles of organization or other organizational document, a copy of its duly adopted bylaws or other

governance rules, a statement under oath of its president and secretary showing its financial condition and any other statement or document required by the director.

2. If formed as a reciprocal insurer, a copy of the power of attorney of its attorney-in-fact, a copy of its subscribers' agreement, a copy of its duly adopted bylaws or other governance rules, a statement under oath of its attorney-in-fact showing its financial condition and any other statement or document required by the director.

G. In addition to the information required by subsection F of this section, each applicant for a captive insurer license shall file with the director evidence of all of the following:

1. The amount and liquidity of its assets relative to the risks to be assumed.
2. The adequacy of the expertise, experience and character of the directors and officers of the captive insurer.
3. The overall soundness of its plan of operation.
4. The adequacy of the loss prevention programs of its insureds.
5. The engagement of a competent manager that does business at a location in this state.
6. The establishment of business relationships with any accountants, banks, attorneys and other professionals that are acceptable to the department.
7. The ability of the captive insurer's owners or members to pay claims to third parties if the captive insurer is unable to pay those claims.
8. Other factors deemed relevant by the director in ascertaining whether the proposed captive insurer will be able to meet its policy obligations.

H. In addition to the information required by subsections F and G of this section, if the applicant is seeking authority as a protected cell captive insurer, the applicant shall file:

1. A business plan that demonstrates, in a manner acceptable to the director, how the applicant will account for the loss and expense experience of each protected cell and report that information to the director.
2. A statement acknowledging that all financial records of the protected cell captive insurer, including records pertaining to protected cells, shall be available for inspection or examination by the director or the director's designee.
3. Its form for all participant contracts.
4. Evidence that the protected cell captive insurer will allocate expenses fairly and equitably to each protected cell.

I. Before the issuance of a license, an applicant shall promptly notify the director of any material change in the information filed pursuant to this section.

J. An applicant for a captive insurer license shall pay to the director a nonrefundable fee for the issuance of a captive insurance license pursuant to section 20-167. The captive insurer shall pay the license renewal fee pursuant to section 20-167 when the captive insurer files the annual report prescribed in section 20-1098.07.

K. If the director is satisfied that the documents and statements that the applicant has filed comply with this article, the director may grant the applicant a captive insurer license that authorizes the captive insurer to transact captive insurance business in this state.

L. The director shall approve or deny an application for a license to transact captive insurance business within thirty days after the director deems the application complete.

20-1098.05. Protected cell captive insurers

A. One or more sponsors may form a protected cell captive insurer as prescribed in this article.

B. A protected cell captive insurer may establish and maintain one or more protected cells to insure the risks of one or more participants, subject to the following conditions:

1. A protected cell captive insurer shall not have any stockholders other than its participants and sponsors.

2. A protected cell captive insurer shall separately account for each protected cell in its books and records to reflect the financial condition and results of operations of each protected cell, net income or loss of each protected cell, dividends or other distributions to participants of each protected cell and any other factors prescribed in the participant contract or required by the director.

3. The assets of a protected cell are not chargeable with liabilities arising out of any other insurance business the protected cell captive insurer may conduct.

4. A protected cell captive insurer shall not sell, exchange or transfer assets, issue a dividend or make a distribution between or among any of its protected cells without the written consent of all its protected cells.

5. A protected cell captive insurer shall not sell, exchange or transfer assets, issue a dividend or make a distribution to a sponsor or participant unless the director approves the transaction and determines that the transaction will not cause insolvency or impairment of any protected cell.

6. At the time of filing its annual report pursuant to section 20-1098.07 a protected cell captive insurer shall annually file with the department:

(a) An accounting statement, in the form the director requires, detailing the financial experience of each protected cell.

(b) Any other financial reports prescribed by the director.

7. A protected cell captive insurer shall notify the director in writing within ten days after learning of any protected cell that is insolvent or otherwise unable to meet its claim or expense obligations.

8. A protected cell captive insurer shall obtain the director's written approval of any participant contract before the contract becomes effective.

9. The addition of a new participant or the withdrawal of a participant from an existing protected cell is deemed a change in the captive insurer's business plan and requires the director's prior approval.

10. With respect to each protected cell, the insurance business written by a protected cell captive insurer shall be any of the following:

(a) Assumed from an insurance company licensed under the laws of any state.

(b) Reinsured by a reinsurer authorized or accredited by this state.

(c) Secured by a trust fund or an irrevocable letter of credit with an evergreen clause.

20-1098.06. Protected cell captive insurers; sponsors; participants

A. A risk retention group shall not be either a sponsor or a participant in a protected cell captive insurer.

B. An association, corporation, limited liability company, partnership, trust or any other business entity may be a participant in any protected cell captive insurer formed or licensed under this article.

C. A sponsor may be a participant in a protected cell captive insurer.

D. A participant need not be a shareholder of a protected cell captive insurer or any affiliate of a protected cell captive insurer.

E. Each protected cell shall comply with the restrictions prescribed in section 20-1098.01, subsection A with respect to the risks insured through the protected cell.

20-1098.07. Annual report

A. Not later than ninety days after the end of the captive insurer's fiscal year, the captive insurer shall submit to the director a report of its financial condition that is verified by oath of two of its

executive officers and that is supplemented by additional information as required by the director. Except as provided in section 20-1098.03, a captive insurer may submit a report that uses generally accepted accounting principles unless the director requires the captive insurer to use statutory accounting principles with any useful or necessary modifications or adaptations of those principles required by the director for the type of insurance and kinds of insurers to be reported on.

B. The captive insurer's financial statements shall be audited by an independent certified public accountant and be in compliance with chapter 3, article 10 of this title, unless the director determines that an audit is not necessary. The audit shall include a reconciliation of differences, if any, between the audited financial report and the statement or form filed with the department. The audit opinion shall be filed with the director not later than six months after the end of the captive insurer's fiscal year.

C. Unless exempted by the director, the annual report shall be based on the type of risks insured by the insurer and shall meet the applicable requirements of one or more of the following:

1. Chapter 3, article 8 of this title.

2. Chapter 3, article 9 of this title.

3. The actuarial provisions of the national association of insurance commissioners health annual statement instructions.

20-1098.08. Examinations

A. Whenever the director determines it to be prudent, the director may examine the business, transactions and affairs of each captive insurer to ascertain the captive insurer's financial condition and ability to fulfill its obligations and whether the captive insurer has complied with this article.

B. Section 20-1098.23 applies to all examination reports, preliminary examination reports or results, working papers, recorded information, documents and copies of any of those reports, results, papers, information or documents produced by, obtained by or disclosed to the director in the course of an examination made under this section.

C. The director may use independent contractor examiners pursuant to sections 20-148 and 20-159 to conduct examinations pursuant to this section. All examinations and examination related expenses shall be borne by the captive insurer and shall be paid by the insurance examiners' revolving fund pursuant to section 20-159.

D. As a condition of licensure, an alien captive insurer shall consent to the examination by the director of the affairs of the alien captive insurer in the jurisdiction in which the alien captive insurer is formed. The examination of a branch captive insurer shall be of branch business and branch operations only, during the period the branch captive insurer is formed, and must

demonstrate to the director's satisfaction that the alien captive insurer is operating in a sound financial condition pursuant to all the applicable laws and regulations of the jurisdiction.

Arizona Department of Insurance

5 year review – 2016

Authorizing Statutes

Article 23. THRESHOLD RATE REVIEW – INDIVIDUAL HEALTH INSURANCE

A.A.C. R20-6-2301, R20-6-2302, R20-6-2303, R20-6-2304 and R20-6-2305

The Department adopted this rule under the Director's general rulemaking authority under A.R.S. § 20-143 and specific authority under A.R.S. § 20-238. Additionally, 45 CFR 154.301(a)(5), a rule promulgated pursuant to the Affordable Care Act, allows a state to determine the standard for effective rate review by regulation.

General Authority

20-143. Rule-making power

- A. The director may make reasonable rules necessary for effectuating any provision of this title.
- B. The director shall make rules concerning proxies, consents or authorizations in respect of securities issued by domestic stock insurance companies having a class of equity securities held of record by one hundred or more persons to conform with the requirements of section 12(g)(2)(G)(ii) of the securities exchange act of 1934, as amended, and as may be amended. Such rule shall not apply to any such company having a class of equity securities which are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended. Whenever such equity securities of any such company are registered or are required to be registered pursuant to section 12 of the securities exchange act of 1934, as amended, or as may be amended, then, no person shall solicit or permit the use of his name to solicit, in any manner whatsoever, any proxy, consent or authorization in respect of any equity security of such company without having first complied with the rules prescribed by the securities and exchange commission pursuant to section 14 of the securities exchange act of 1934, as amended, or as may be amended.
- C. All rules made pursuant to this section shall be subject to title 41, chapter 6.
- D. In addition to any other penalty provided, wilful violation of any rule made by the director is a violation of this title.

Specific Authority

20-238. Health insurance; state regulation; rating areas; definitions

(Conditionally Rpld.)

- A. The director, through the adoption of rules or other regulatory and administrative actions within the director's authority, shall ensure that this state retains its full authority to regulate

policies, certificates, evidences of coverage and contracts of insurance that are issued or delivered by health insurers taking into consideration the enactment of the act.

B. Notwithstanding any other provision of this title, a health insurer subject to the act shall not issue a contract, policy, certificate or evidence of coverage or otherwise transact insurance if the coverage and benefits provided in the contract, policy, certificate or evidence of coverage are inconsistent with the applicable provisions of the act.

C. Except for coverage under individual and small group policies, certificates, evidences of coverage and contracts that are grandfathered as prescribed by 42 United States Code section 18011, the following rating areas are established and shall be used by all health insurers issuing individual and small group policies, certificates, evidences of coverage or contracts in this state:

1. Mohave, Coconino, Apache and Navajo counties.
2. Yavapai county.
3. La Paz and Yuma counties.
4. Maricopa county.
5. Pinal and Gila counties.
6. Pima and Santa Cruz counties.
7. Graham, Greenlee and Cochise counties.

D. For the purposes of this section:

1. "Act" means the patient protection and affordable care act (P.L. 111-148) as amended by the health care and education reconciliation act (P.L. 111-152) or any rules adopted pursuant to those acts.
2. "Health insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation, dental service corporation, prepaid dental plan organization or hospital, medical, dental and optometric service corporation.
3. "Rating area" means an area within which a health insurer shall not vary rates based on geography.

§154.301 CMS's determinations of Effective Rate Review Programs.

(a) *Effective Rate Review Program.* In evaluating whether a State has an Effective Rate Review Program, CMS will apply the following criteria for the review of rates for the small group market and the individual market, and also, as applicable depending on State law, the review of rates for different types of products within those markets:

(1) The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3) of this section.

(2) The State conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase.

(3) The State's rate review process includes an examination of:

(i) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions.

(ii) The health insurance issuer's data related to past projections and actual experience.

(iii) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.

(iv) The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.

(4) The examination must take into consideration the following factors to the extent applicable to the filing under review:

(i) The impact of medical trend changes by major service categories.

(ii) The impact of utilization changes by major service categories.

(iii) The impact of cost-sharing changes by major service categories, including actuarial values.

(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.

(v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.

(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.

(vii) The impact of changes in reserve needs;

- (viii) The impact of changes in administrative costs related to programs that improve health care quality;
- (ix) The impact of changes in other administrative costs;
- (x) The impact of changes in applicable taxes, licensing or regulatory fees.
- (xi) Medical loss ratio.
- (xii) The health insurance issuer's capital and surplus.
- (xiii) The impacts of geographic factors and variations.
- (xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.
- (xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

(5) The State's determination of whether a rate increase is unreasonable is made under a standard that is set forth in State statute or regulation.

(b) *Public disclosure and input.* (1) In addition to satisfying the provisions in paragraph (a) of this section, a State with an Effective Rate Review Program must provide:

(i) For proposed rate increases subject to review, access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS's Web address for such information), and have a mechanism for receiving public comments on those proposed rate increases, no later than the date specified in guidance by the Secretary.

(ii) Beginning with rates filed for coverage effective on or after January 1, 2016, for all final rate increases (including those not subject to review), access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification (as applicable) that CMS makes available on its Web site (or provide CMS's Web address for such information), no later than the first day of the annual open enrollment period in the individual market for the applicable calendar year.

(2) If a State intends to make the information in paragraph (b)(1)(i) of this section available to the public prior to the date specified by the Secretary, or if it intends to make the information in paragraph (b)(1)(ii) of this section available to the public prior to the first day of the annual open enrollment period in the individual market for the applicable calendar year, the State must notify CMS in writing, no later than 30 days prior to the date it intends to make the information public, of its intent to do so and the date it intends to make the information public.

(3) A State with an Effective Rate Review Program must ensure the information in paragraphs (b)(1)(i) and (ii) of this section is made available to the public at a uniform time for all proposed

and final rate increases, as applicable, in the relevant market segment and without regard to whether coverage is offered through or outside an Exchange.

(c) CMS will determine whether a State has an Effective Rate Review Program for each market based on information available to CMS that a rate review program meets the criteria described in paragraphs (a) and (b) of this section.

(d) CMS reserves the right to evaluate from time to time whether, and to what extent, a State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria set forth in paragraphs (a) and (b) of this section.

[76 FR 29985, May 23, 2011, as amended at 78 FR 13441, Feb. 27, 2013; 80 FR 10864, Feb. 27, 2015]

ARIZONA STATE BOARD OF CHARTER SCHOOLS (F-16-0901)

Title 7, Chapter 5, Article 3, Charter Oversight; Article 5, Audits and Audit Contracts



**GOVERNOR'S REGULATORY REVIEW COUNCIL
ANALYSIS OF FIVE-YEAR REVIEW REPORT**

MEETING DATE: October 4, 2016

AGENDA ITEM: F-3

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: Chris Kleminich, Staff Attorney

DATE: September 16, 2016

SUBJECT: ARIZONA STATE BOARD FOR CHARTER SCHOOLS (F-16-0901)
Title 7, Chapter 5, Article 3, Charter Oversight; Article 5, Audits and Audit Contracts

This five-year-review report from the Arizona State Board for Charter Schools (Board) covers eight rules in A.A.C. Title 7, Chapter 5, Articles 3 and 5. Article 3 relates primarily to the Board's administrative responsibilities and general supervision and oversight. Article 5 relates to the Board's standards for audits. None of the rules have been amended since they first became effective in February 2006.

Proposed Action

The Board indicates that it intends to amend all of the rules reviewed to address issues described below, and intends to make new rules related to performance frameworks, in a rulemaking to be submitted to the Council by June 2017.

Substantive or Procedural Concerns

None, though staff strongly encourages the Board to continue to highly prioritize the completion of this important rulemaking.

Analysis of the agency's report pursuant to criteria in A.R.S. § 41-1056 and R1-6-301:

1. Has the agency certified that it is in compliance with A.R.S. § 41-1091?

Yes. The Board has certified its compliance with A.R.S. § 41-1091.

2. Has the agency analyzed the rules' effectiveness in achieving their objectives?

Yes. The Board indicates that the rules can be made more effective in the following ways:

- Section 304(A): Factors listed for determining an appropriate disciplinary action are not relevant to all disciplinary proceedings, and the phrase “as applicable” should be added accordingly.
- Section 502(B)(4): The standard for disapproval of an audit contract has changed, as the Board will now disapprove an audit contract if the contracted firm receives a peer review rating of “fail” or if any auditor working on the audit fails to meet required continuing education standards.
- Section 503(B): The rule should indicate that an audit is incomplete if it is submitted by an audit firm that fails to meet the requirements of Section 502(B).
- Section 503(C): The Board should provide written notice when an audit is complete to the charter holder and to the firm that prepared the complete audit.
- Section 503(F): This subsection requires a charter holder whose audit is incomplete to appear before the Board for possible disciplinary action. The rule should be changed to render this appearance unnecessary if the charter holder is able to submit a complete audit prior to the Board meeting.
- Section 504(C): This subsection requires a charter holder with a serious impact finding to appear before the Board for possible disciplinary action. The rule should be changed to render this appearance unnecessary if the charter holder is able to provide credible evidence that the charter holder will be in compliance at the time of the next audit.

3. Has the agency received any written criticisms of the rules during the last five years, including any written analysis questioning whether the rules are based on valid scientific or reliable principles or methods?

No. The Board has received no written criticisms of these rule during the last five years.

As the Board notes in its report, however, a petition was submitted to the Council in January 2016 under A.R.S. § 41-1033(C). The petitioners argued that the Board adopted several substantive policy statements for charter holders that actually constituted rules. The number of members requesting a hearing on the petition was insufficient for it to proceed. The Board, recognizing that a rulemaking was necessary, has opened a docket for the needed rulemaking. See 22 A.A.R. 823, April 15, 2016.

4. Has the agency analyzed whether the rules are authorized by statute?

Yes. The Board cites to both general and specific authority for the rules. Most notably, as general authority, the Board cites to A.R.S. § 15-182(E)(5) which requires the Board to “[a]dopt rules for its own government.”

5. **Has the agency analyzed the rules' consistency with statutes and other rules?**

Yes. The Board indicates that the rules are consistent with statutes and other rules with one exception. Section 304(B), which lists possible disciplinary actions against a charter holder, is interpreted by the Board to be inconsistent with A.R.S. § 15-185(I), which authorizes the sponsor of a charter school to impose a civil penalty for failure to comply with the fingerprinting requirement in A.R.S. §§ 15-183(C) and 15-512.

6. **Has the agency analyzed the current enforcement status of the rules?**

Yes. The Board indicates that the rules are enforced as written, with the exception of Section 304(B), as the Board imposes a civil penalty for failure to comply with the fingerprinting requirement.

7. **Has the agency analyzed whether the rules are clear, concise, and understandable?**

Yes. The Board indicates that the rules are generally understandable, but the conciseness and clarity of all of the rules will be improved in the Board's upcoming rulemaking.

8. **Stringency of the Rules:**

a. **Are the rules more stringent than corresponding federal law?**

No. No federal laws directly correspond to the rules.

b. **If so, is there statutory authority to exceed the requirements of federal law?**

Not applicable.

9. **For rules adopted after July 29, 2010:**

Not applicable, as all of the rules were adopted prior to July 29, 2010.

a. **Do the rules require issuance of a regulatory permit, license or agency authorization?**

Not applicable.

b. **If so, are the general permit requirements of A.R.S. § 41-1037 met or does an exception apply?**

Not applicable.

10. Has the agency indicated whether it completed the course of action identified in the previous five-year-review report?

Yes. The Board indicates that, in its 2011 five-year-review report, it planned to amend Sections 303, 501, and 503. In the report, the Board provides many reasons as to why it failed to complete the proposed course of action.

Conclusion

The report meets the requirements of A.R.S. § 41-1056 and R1-6-301. As noted above, the Board indicates that it intends to amend all of the rules reviewed to address issues described below, and intends to make new rules related to performance frameworks, in a rulemaking to be submitted to the Council by June 2017. This analyst recommends that the report be approved.



**GOVERNOR'S REGULATORY REVIEW COUNCIL
M E M O R A N D U M**

MEETING DATE: October 4, 2016

AGENDA ITEM: F-3

TO: Members of the Governor's Regulatory Review Council ("Council")

FROM: GRRC Economic Team

DATE: September 16, 2016

SUBJECT: **ARIZONA STATE BOARD FOR CHARTER SCHOOLS (F-16-0901)**
Title 7, Chapter 5, Article 3, Charter Oversight; Article 5, Audits and Audit Contracts

I reviewed the five-year-review report's economic, small business, and consumer impact comparison for compliance with A.R.S. § 41-1056 and make the following comments.

1. Economic Impact Comparison

The Board details the responsibilities allocated to them via Articles 3 and 5 and reviews the economic impacts of the rules. Article 3 establishes supervision and oversight responsibilities for the Board to the charter schools and their auditing process. This includes outlining corrective action plans and site visits. Article 5 details the Board's process for approving audit contracts, audit completeness, and reviewing completed audits.

According to the Board, there are currently 556 charter schools in Arizona with a total of 170,700 students enrolled. The Board sponsors all but 21 of these schools.

In the 2006 EIS, the Board indicated that it rejected "only 1 contract for...failure of the supervising certified public accountant to maintain good standing with an accounting industry regulatory board (2006 EIS, 10)." In FY 2015, no audited contracts were disapproved. If the Board decided to withhold funding to a charter school for noncompliance with its charter or applicable laws, the charter could face temporary costs ranging from \$1,000 to \$40,000 per month. The Board continues to believe that the rules have a minimal overall economic impact.

2. Has the agency determined that the rules impose the least burden and costs to persons regulated by the rules?

The Board states that they believe the "benefits of the rules reviewed outweigh their probable costs, and impose the least burden and costs on charter holders (09)."

3. Was an analysis submitted to the agency under A.R.S. § 41-1056(A)(7)?

The Board did not report any analysis submitted to the agency by another person that compares the rules' impact on this state's business competitiveness to the impact on businesses in other states.

4. Conclusion

After review, staff concludes that the report complies with A.R.S. § 41-1056 and recommends approval.

Arizona State Board for Charter Schools

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June 21, 2016



Nicole A. Ong, Chair
Governor's Regulatory Review Council
100 North 15th Avenue, Ste. 402
Phoenix, AZ 85007

RE: Five-year-review Report on 7 A.A.C. 5, Articles 3 and 5

Dear Ms. Ong:

As required by A.R.S. § 41-1056, the State Board for Charter rules submits for your approval a report on a review of its rules. The Board reviewed all the referenced rules.

As required under A.R.S. § 41-1056(A), the Board certifies that it is in compliance with A.R.S. § 41-1091 regarding a substantive policy directory.

If you have questions regarding this report, please contact me at (602) 364-3091. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Whitney Chapa".

Whitney Chapa
Executive Director

STATE BOARD FOR CHARTER SCHOOLS

Five-year-review Report: A.A.C. Title 7, Chapter 5, Articles 3 and 5

June 2016

Five-year-review Report

A.A.C. Title 7. Education

Chapter 5. State Board for Charter Schools

INTRODUCTION

Charter schools are public schools originally authorized by the legislature in 1994. Under A.R.S. § 15-181(A), charter schools provide academic choice for parents and pupils and a learning environment that improves pupil achievement. In exchange for greater accountability for improved student performance, charter holders are provided greater autonomy in operation. In the 2015-16 school year, more than 170,700 pupils attended 556 charter schools in Arizona. Approximately one in three of Arizona's public schools is a charter school and approximately 17 percent of pupils attend a charter school.

A person seeking to establish a charter school is required to have a sponsor (See A.R.S. § 15-183(A)). Almost all of Arizona's charter schools are sponsored by the State Board for Charter Schools (Board). An initial charter is issued for 15 years and can be renewed for 20 years. The sponsor of a charter school is required to review compliance with the charter every five years.

The Board's responsibilities include approving charter applications and renewals, overseeing charter school performance and accountability, and taking corrective action when necessary. The Board's oversight focuses on compliance with financial, legal, and contractual requirements, and academic performance and operational expectations.

In this report, the Board reviews its rules dealing with charter oversight and audit guidelines and contracts.

Statute that generally authorizes the agency to make rules: A.R.S. § 15-182(E)(5)

1. Specific statute authorizing the rule:

R7-5-301: A.R.S. § 15-183(R)

R7-5-302: A.R.S. § 15-183(R)

R7-5-303: A.R.S. § 15-183(R)

R7-5-304: A.R.S. §§ 15-183(I)(3) and (R) and 15-185

R7-5-501: A.R.S. §§ 15-183(E)(6) and 914 and Laws 1999, 1st S.S., Ch. 4, § 15

R7-5-502: A.R.S. §§ 15-183(E)(6) and 914 and Laws 1999, 1st S.S., Ch. 4, § 15

R7-5-503: A.R.S. §§ 15-183(E)(6) and 914 and Laws 1999, 1st S.S., Ch. 4, § 15

R7-5-504: A.R.S. §§ 15-183(E)(6) and 914 and Laws 1999, 1st S.S., Ch. 4, § 15

2. Objective of the rule including the purpose for the existence of the rule:

R7-5-301. General Supervision, Oversight, and Administrative Responsibility:

The objective of the rule is to provide notice to charter holders regarding the means by which the Board performs its administrative responsibilities and general supervision and oversight. This provides efficiency in the Board's ability to fulfill its statutory responsibilities.

R7-5-302. Corrective Action Plan:

The objective of the rule is to provide notice to charter holders of the factors considered when determining to require a corrective action plan (CAP), the requirements for preparing a CAP, and the consequences of failing to prepare or implement a CAP. This provides efficiency in the Board's supervision and oversight responsibilities.

R7-5-303. Site Visits; Records; Notice of Violation:

The objective of the rule is to provide notice to charter holders that the Board uses site visits to fulfill its supervision and oversight responsibilities, identify charter holders' responsibilities during a site visit, and possible consequences of a site visit. This provides efficiency in the Board's ability to fulfill its statutory responsibilities.

R7-5-304. Disciplinary Action:

The objective of the rule is to provide notice to charter holders regarding the factors considered by the Board when deciding on disciplinary action for a charter violation and the disciplinary options the Board may use. This provides efficiency in the Board's ability to fulfill its statutory responsibilities.

R7-5-501. Audit Guidelines:

The objective of the rule is to provide notice to charter holders of when and how the Board will make available audit guidelines. This provides efficiency in the Board’s supervision and oversight responsibilities by enabling charter holders to comply timely with the audit requirement.

R7-5-502. Approval of Audit Contracts:

The objective of the rule is to provide notice to charter holders that the Board is required to approve all audit contracts (See Laws 1999, 1st SS, Chap 4, § 15), the standards the Board uses to decide whether to approve an audit contract, and if an audit contract is disapproved, the audit firm’s ability to correct the issue causing disapproval. This provides efficiency in the Board’s ability to fulfill its statutory responsibilities by enabling charter holders to enter audit contract that meet Board standards.

R7-5-503. Audit Completeness Determinations:

The objective of the rule is to provide notice to charter holders regarding the standards the Board uses to determine whether an audit is complete and consequences of failing to submit a complete audit. This provides efficiency in the Board’s ability to fulfill its statutory responsibilities by enabling charter holders to submit complete audits.

R7-5-504. Review of Complete Audits:

The objective of the rule is to provide notice to charter holders regarding options the Board has for responding to a complete audit and expectations of charter holders following an audit. This provides efficiency in the Board’s ability to fulfill its statutory responsibilities.

3. Effectiveness of the rule in achieving the objective including a summary of any available data supporting the conclusion:

Although the rules are generally effective enabling the Board to fulfill its statutory responsibilities, the Board determined the rules could be more effective as follows:

R7-5-304(A): This subsection requires the Board to consider certain factors when determining an appropriate disciplinary action. However, all factors listed are not relevant to all disciplinary proceedings. The Board believes the rule would be more effective if the phrase “as applicable” is added to this subsection.

R7-4-502(B)(4): This standard for disapproval of an audit contract has changed. The Board will now disapprove an audit contract if the contracted audit firm receives a peer review rating of “fail” or if any auditor who will work on the audit has failed to meet required continuing education standards.

R7-5-503(B): This subsection indicates the Board will find an audit is incomplete if it does not include all items listed in the audit guidelines. The Board has determined the rule should also indicate an audit is incomplete if the audit is submitted by an audit firm that fails to meet the requirements of R7-5-502(B)(1) – (4).

R7-5-503(C): This subsection requires the Board to provide written notice to the charter holder when an audit is complete. The Board has determined the rule would be more effective if notice is also provided to the firm that prepared the complete audit.

R7-5-503(F): This subsection requires a charter holder whose audit is incomplete to appear before the Board for possible disciplinary action. However, the Board has found this is unnecessary when the charter holder is able to submit a complete audit before the Board meeting.

R7-5-504(C): This subsection requires a charter holder with a serious impact finding to appear before the Board for possible disciplinary action. However, the Board has found this is unnecessary when the charter holder is able to provide credible evidence that the charter holder will be in compliance at the time of the next audit.

4. Consistency of the rule with state and federal statutes and other rules made by the agency, and a listing of the statutes or rules used in determining the consistency:

Except as indicated below, the rules reviewed are consistent with A.R.S. Title 15, Chapter 1, Article 8, A.R.S. § 15-914, and Laws 1999, 1st S.S., Ch. 4, § 15:

R7-5-304(B), which lists possible disciplinary actions against a charter holder, is not consistent with A.R.S. § 15-185(I), which authorizes the sponsor of a charter school to impose a civil penalty for failure to comply with the fingerprinting requirement in A.R.S. §§ 15-183(C) and 15-512.

5. Agency enforcement policy including whether the rule is currently being enforced and, if so, whether there are any problems with enforcement:

The Board enforces all of the rules in a manner that is consistent with statute and in the best interest of the state. As authorized under A.R.S. § 15-185(I), the Board imposes a civil penalty for failure to comply with the fingerprinting requirement.

6. Clarity, conciseness, and understandability of the rule:

The rules are generally understandable but the conciseness and clarity of the rules could be improved. As indicated in item 7, there are important issues not addressed in the rules.

7. Summary of written criticisms of the rule received by the agency with the past five years, including letters, memoranda, reports, written analyses submitted to the agency questioning whether the rule is based on valid scientific or reliable principles or methods, and, written allegations made in litigation or administrative proceedings in which the agency was a party that the rule is discriminatory, unfair, unclear, inconsistent with statute or beyond the authority of the agency to enact, and the result of the litigation of administrative proceedings:

On January 21, 2016, two attorneys submitted a petition to the Governor's Regulatory Review Council under the provisions of A.R.S. § 41-1033(C) asserting that the Board has adopted several policy statements as "guidance" for charter holders that are actually rules as defined at A.R.S. § 41-1001. The attorneys requested that the Council consider the policy statements and find that they are void because they were not enacted in accordance with the Arizona Administrative Procedure Act. The Council decided not to hear the petition after receiving assurances from the Board that it would begin a rulemaking immediately to address

this issue. The Board opened a docket for the needed rulemaking on March 24, 2016 (See 22 A.A.R. 823, April 15, 2016).

8. A comparison of the estimated economic, small business, and consumer impact of the rule with the economic, small business, and consumer impact statement prepared on the last making of the rule or, if no economic, small business, and consumer impact statement was prepared on the last making of the rule, an assessment of the actual economic, small business, and consumer impact of the rule:

All of the rules reviewed were newly made in a rulemaking that went into effect on February 7, 2006. The economic, small business, and consumer impact statement prepared with the rulemaking is available. When the rules were made, the Board estimated the economic impact of the rules on charter holders would be minimal. This is because it is within the control of a charter holder to determine whether and to what extent the disciplinary oversight rules in Article 3 apply to the charter holder. If the disciplinary rules do apply to a charter holder, the cost of coming into compliance is minimal. Similarly, the rules in Article 5, which establish standards for statutorily required audits, impose minimal cost on qualified audit firms and charter holders. The Board believes it correctly estimated the rules would have minimal economic impact.

There are currently 556 charter schools in Arizona (443 charter holders) with an enrollment of 170,700 students. The Board sponsors 535 of the 556 charter schools. The remaining charter schools are sponsored by the Arizona State University and several school district governing boards. Beginning in FY2017, there will no longer be charter schools sponsored by school district governing boards because the authority of school district governing boards to sponsor charter schools is being phased out. In addition to the Board and ASU, the Department of Education and universities under the jurisdiction of the Arizona Board of Regents and community college districts are eligible to sponsor charter schools.

The Board fulfills its statutory responsibility to supervise charter holders by conducting site visits (76 were conducted in FY2016) and reviewing annual audit and Department of Education's performance data. As a result of supervising charter holders, the Board may determine a charter holder is not in compliance with its charter, other contractual agreements

with the Board, and statutory requirements or is not making sufficient progress towards performance expectations. When this happens, the Board may take several disciplinary steps.

The Board may require a charter holder to submit a correction action plan. During FY2016, 58 charter holders were required to submit a CAP. Issues giving rise to the need for a CAP are identified through the required audit or site visits. Frequent reasons for a CAP include failing to comply with the statutory fingerprinting requirement, failing to comply with federal or state payroll tax requirements, and failing to follow standard financial internal control procedures. A charter holder can generally prepare and complete a CAP within a month or two. However, for cases involving payroll taxes, for example, the time for completion may be longer because the charter holder's compliance cannot be determined until certain reports are submitted to taxing authorities.

Under A.R.S. § 15-185(H), the Board may ask the Department of Education to withhold funds from a charter holder. Funds were withheld from five charter holders in FY2016. The primary reason for withholding funds is failure to submit the required audit. When funds are withheld, the charter holder is required to prepare a CAP.

A charter holder that fails to meet academic performance expectations may be required to demonstrate it is making sufficient progress towards meeting the performance expectations. During FY2016, 144 charter schools (27 percent of those sponsored by the Board) were required to demonstrate sufficient progress.

A charter holder that has repeated issues of noncompliance may be required to enter a consent agreement that includes terms for compliance. During the last year, the Board determined three charter holders had serious impact findings due to repeat issues of noncompliance identified through audit. The Board has not, however, required them to enter into a consent agreement because it is continuing to gather data regarding compliance by two of the charter holders. The third charter will expire at the end of the fiscal year.

During FY2015, the Board entered consent agreements with two charter holders. If the charter holder fails to comply with a consent agreement, the Board can move to a hearing with the intent of revoking the charter. In FY2015, the Board voted to revoke two charters. One of the charter holders is still in process of appealing the revocation order.

The Board currently has 11 FTE positions filled but has 14 FTE authorized positions. During FY2016, the Board was appropriated \$990,200. Under A.R.S. § 15-183(CC), the Board charges applicants the full cost of application review and technical assistance.

9. Any analysis submitted to the agency by another person regarding the rule's impact on this state's business competitiveness as compared to the competitiveness of businesses in other states:

No analysis has been submitted.

10. How the agency completed the course of action indicated in the agency's previous 5YRR:

In a 5YRR approved by the Council on May 3, 2011, the Board indicated it would amend R7-5-303, R7-5-501, and R7-5-503. The Board did not complete the planned action because of staff shortages and a change in position for the individual who was working on revising the rules.

11. A determination after analysis that the probable benefits of the rule outweigh within this state the probable costs of the rule and the rule imposes the least burden and costs to persons regulated by the rule, including paperwork and other compliance costs necessary to achieve the underlying regulatory objective:

The Board believes the benefits of the rules reviewed outweigh their probable costs and impose the least burden and costs on charter holders. The rules in Article 3 are designed to protect the public by having the Board supervise charter holders to ensure they comply with their charters, other contractual agreements with the Board, and statutory requirements, and meet performance expectations. A charter holder that meets these expectations will incur no

costs. A charter holder that fails to meet the expectations will incur the cost of taking corrective actions.

The rules in Article 5 provide standards for the annual audit required by statute (See A.R.S. § 15-914). The rules impose minimal cost on charter holders. Charter holders are required by statute to submit the contract with an audit firm to the Board for approval before the audit is conducted. During FY2015, no audit contracts were disapproved by the Board.

12. A determination after analysis that the rule is not more stringent than a corresponding federal law unless there is statutory authority to exceed the requirements of that federal law:

There are numerous federal laws applicable to all schools including charter schools. These include the Every Student Succeeds Act, Family Educational Rights and Privacy Act, Individuals with Disabilities Education Act, and various civil rights statutes. All charters require that the holder comply with federal law. However, no federal law is specifically applicable to the rules reviewed so the rules are not more stringent than federal law.

13. For a rule made after July 29, 2010, that require issuance of a regulatory permit, license, or agency authorization, whether the rule complies with A.R.S. § 41-1037:

None of the rules was made after July 29, 2010.

14. Course of action the agency proposes to take regarding each rule, including the month and year in which the agency anticipates submitting the rules to the Council if the agency determines it is necessary to amend or repeal an existing rule or to make a new rule. If no issues are identified for a rule in the report, the agency may indicate that no action is necessary for the rule:

The Board intends to amend all the rules reviewed and make new rules to address the issue raised in the A.R.S. § 41-1033 petition submitted to the Governor's Regulatory Review Council in January 2016. The Board intends to complete the rulemaking by June 2017.

TITLE 7. EDUCATION
CHAPTER 5. STATE BOARD FOR CHARTER SCHOOLS

Authority: A.R.S. § 15-182

ARTICLE 1. GENERAL PROVISIONS

Section
R7-5-101. Definitions

ARTICLE 2. NEW CHARTERS

Section
R7-5-201. Application for a New Charter
R7-5-202. New Charter Application Processing Fee
R7-5-203. Time-frames for Granting or Denying a New Charter
R7-5-204. Review of Administratively Complete Application Package, Technical Assistance, and In-Person Interview
R7-5-205. Execution of a Charter
R7-5-206. Good Cause Extension to Execute a Charter
R7-5-207. Good Cause Suspension of a Charter

ARTICLE 3. CHARTER OVERSIGHT

Section
R7-5-301. General Supervision, Oversight, and Administrative Responsibility
R7-5-302. Corrective Action Plan
R7-5-303. Site Visits; Records; Notice of Violation
R7-5-304. Disciplinary Action

ARTICLE 4. AMENDMENT TO A CHARTER

Section
R7-5-401. Amendment to a Charter

ARTICLE 5. AUDITS AND AUDIT CONTRACTS

Section
R7-5-501. Audit Guidelines
R7-5-502. Approval of Audit Contracts
R7-5-503. Audit Completeness Determinations
R7-5-504. Review of Complete Audits

ARTICLE 1. GENERAL PROVISIONS

R7-5-101. Definitions

For the purpose of this Chapter, the following definitions apply:

“Accounting industry regulatory body”

“Administrative completeness review time-frame” means the number of days from the Board's receipt of a submission for Board consideration until the Board staff determines whether the submission contains all components and is formatted as required by statute and rule. The administrative completeness review time-frame does not include the period during which the Board performs a substantive review of the submission.

“Annual application cycle” means a new charter application process which is conducted each year to grant charters for the operation of new charter schools and is based on the earliest fiscal year in which a new charter school may begin operation.

“Applicant” means a person that applies to the Board for a new charter, a person who applies to transfer a charter from another charter school sponsor, a charter holder who applies to renew or replicate a charter sponsored by the Board, or a charter holder who applies to transfer an existing charter school site operated under a charter sponsored by the Board to a separate Board-sponsored charter held by the same charter holder.

“Application” means the Board-approved forms and instructions used by an applicant to apply for a new charter, transfer a charter, or renew or replicate a charter sponsored by the Board.

“Application package” means an application, narratives, and documents including exhibits and attachments as submitted by an applicant.

“ASBCS Online” means the Board's web-based interface accessible through the Arizona State Board for Charter Schools' website.

“Audit” means a charter holder's annual audit, as required by A.R.S. § 15-914.

“Audit contract” means an engagement letter provided by an audit firm that describes the terms of a contract between a charter holder and the audit firm.

“Audit firm” means a business that conducts an independent audit for a charter school.

“Audit guidelines” means the Board-approved general guidance on charter school audit requirements, which is available online.

“Authorized representative” means an individual with the power to bind an applicant contractually according to the applicant’s Articles of Incorporation, operating agreement, or by-laws.

“Board” means the Arizona State Board for Charter Schools.

“Charter” means a contract between a person and the Board to operate a charter school under A.R.S. § 15-181 et seq.

“Charter holder” means a person that enters into a charter with the Board.

“Charter representative” means an individual with the power to bind a charter holder contractually according to the charter holder’s Articles of Incorporation, operating agreement, or by-laws and is the point of contact for the Board for the purposes of communication and accountability to contract terms and conditions.

“Charter school” means a public school operated under a charter granted under A.R.S. § 15-181 et seq.

“Date of notice” means the date on which an electronic notification is sent by the Board to an applicant or charter holder through the authorized representative or charter representative.

“Day” means a business day.

“Department” means the Arizona Department of Education.

“Fiscal year” means the 12-month period beginning July 1 and ending June 30.

“Good standing” means that a supervising certified public accountant or audit firm has no current or pending disciplinary action or any regulatory action that requires the supervising certified public accountant or audit firm to complete conditions specified by an accounting industry regulatory body.

“Overall time-frame” means the number of days after receipt of a submission for Board consideration until the Board decides whether to grant or deny the request contained within the submission. The overall time-frame consists of both the administrative completeness review time-frame and the substantive review time-frame.

“Peer review” means an external quality control review as required by generally accepted government auditing standards that determines whether an audit firm’s internal quality control system is in place and operating effectively, and provides assurance that established policies and procedures and applicable auditing standards are being followed.

“Person” means an individual, partnership, corporation, association, or public or private organization of any kind.

“Preliminary application package” means an administratively complete application package that is forwarded to the Technical Review Panel for scoring.

“Principals” means the officers, members, partners, or board of an applicant.

“Revised application package” means an application package including revisions submitted by an applicant after receiving written notification that the applicant’s preliminary application package failed to meet the scoring requirements of R7-5-204.

“Serious impact finding” means an issue identified by the Board that in the opinion of the Board has or potentially has a significant impact on the operation of the charter school or students, such as threat to the health and safety of children, failure to meet the academic needs of the children, gross violation of generally accepted accounting principles that increases the opportunity for fraud or theft, or repeat issues of non-compliance.

“Submission deadline” means a date and time established each year by the Board and identified in the application for a new charter by which a new charter application package shall be submitted to the Board to be considered in a specified annual application cycle.

“Substantive review time-frame” means the number of days after a submission for Board consideration is determined to be administratively complete until the Board decides whether to grant or deny the request contained within the submission.

“Sufficiently qualified” means the Board’s determination that an applicant’s application package, knowledge and understanding of the application package, experience, qualifications, current and prior charter compliance, capacity, personal and professional background, and creditworthiness indicate an ability to implement a charter or operate a charter school in accordance with the performance frameworks adopted by the Board and requirements of statute and rule.

“Supervising certified public accountant” means the certified public accountant responsible for leading the audit work or signing the final audit.

“Technical Review Panel” means individuals approved by the Executive Director of the Board who use their expertise in charter school development, curriculum, and finance to assist in the evaluation of a preliminary or revised application package.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1141, effective March 2, 2004 (Supp. 04-1). Amended by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1). Amended by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

ARTICLE 2. NEW CHARTERS

R7-5-201. Application for a New Charter

- A. By March 31 of each year, the Board shall approve and make available online at its web site an application for a new charter for a specified annual application cycle.
- B. A person desiring to establish a charter school shall submit an application package online through the web-based application wizard on ASBCS Online by the submission deadline identified in the application. A person may utilize an alternate submission process:
 - 1. A person utilizing the alternate submission process shall submit by hand delivery or mail a signed, notarized waiver request to the Board in the form and by the waiver deadline set out in the application.
 - 2. The Board shall send an acknowledgment of timely receipt of a waiver request within 10 days of receipt of a waiver request.
 - 3. Any person who submits a timely waiver request waives the right to have the Board consider any application package submitted through ASBCS Online in the same annual application cycle. Instead, such a person shall only submit an application package according to the alternate submission process instructions and by the alternate submission process submission deadline identified in the application.
 - 4. An application package shall not be accepted through the alternative submission process unless a waiver request has been received by the waiver deadline and acknowledged as timely by the Board.
- C. An applicant for a new charter shall ensure that the submitted application package contains all the information, materials, documents, and attachments identified in the application for a new charter for the current annual application cycle and in the format specified in that application, which shall together constitute:
 - 1. A detailed educational plan,
 - 2. A detailed business plan,
 - 3. A detailed operational plan, and
 - 4. Any other materials the Board requires.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1141, effective March 2, 2004 (Supp. 04-1). Amended by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

R7-5-202. New Charter Application Processing Fee

Each applicant shall pay a new charter application processing fee, in accordance with A.R.S. § 15-183(CC).

- 1. The new charter application processing fee is \$6,500 for each application package an applicant submits to the Board.
- 2. Each applicant shall pay the new charter application processing fee in the form of a single personal check or cashier's check with the applicant's name clearly identified on the front of the check made payable to Arizona State Board for Charter Schools. The check shall be delivered by mail or hand delivery to the Board office during regular business hours by the submission deadline.
- 3. Failure to timely submit the new charter application processing fee shall result in the application package being deemed administratively incomplete under R7-5-203(B).
- 4. All checks shall be deposited within five days of submission. If an applicant's new charter application processing fee payment to the Board is dishonored for any reason including an insufficient funds check:
 - a. The application package shall be deemed administratively incomplete under R7-5-203(B), and
 - b. The applicant shall use a cashier's check to pay the new charter application processing fee for any application package submitted to the Board by the applicant at any later date.
- 5. If an application package is found to be administratively incomplete, under R7-5-203(B), and the applicant paid the new charter application processing fee, the fee shall be refunded to the applicant. The fee refund shall be mailed by U.S. Postal Service regular mail to the authorized representative at the address provided in the application package.
- 6. If an application package is found to be administratively complete under R7-5-203(B), the new charter application processing fee shall become non-refundable.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1141, effective March 2, 2004 (Supp. 04-1). Section R7-5-202 renumbered to Section R7-5-203; new Section R7-5-202 made by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

R7-5-203. Time-frames for Granting or Denying a New Charter

- A. For granting or denying a charter, the time-frames required are:
 - 1. Administrative completeness review time-frame: 25 days;
 - 2. Substantive review time-frame: 175 days; and
 - 3. Overall time-frame: 200 days.
- B. An application package for a charter school shall be administratively complete if:
 - 1. The application package contains all the information, materials, documents, attachments, signatures, and notarizations identified in the application for a new charter for the current annual application cycle;
 - 2. All the application package's components are formatted as required by that application;
 - 3. All curriculum samples address the required standard;
 - 4. All templates are unmodified, completely filled out, and from the current annual application cycle; and
 - 5. The application processing fee has been paid according to R7-5-202(1), (2), and (4).
- C. The administrative completeness review time-frame, as listed in subsection (A)(1), begins the day after the Board receives an application package.

1. If the application package is administratively incomplete when received, the Board staff shall provide to the applicant a notice of deficiency that states the reasons the application package was found to be administratively incomplete.
 2. Upon written notice to the applicant that the application package is administratively incomplete, the Board staff shall close the applicant's file.
 - a. If the submission deadline has not yet passed, an applicant may correct deficiencies in an administratively incomplete application package and submit a new application package in the same annual application cycle, under R7-5-201; the applicant shall pay a new application processing fee, under R7-5-202.
 - b. An applicant who believes their application was erroneously designated as administratively incomplete may submit a written request for reconsideration to the Board within 10 days of the date of notice.
 - i. The request for reconsideration shall contain a clear statement indicating how the previously submitted application package fulfilled each of the requirements that were identified as having been deficient. The request for reconsideration shall not provide any new or additional information, documents, or materials.
 - ii. A request for reconsideration that does not address each deficiency identified in the notice or that contains new or additional information, documents, or materials shall not be considered and the applicant shall be notified that the request was not submitted according to subsection (i) and the applicant's file is closed.
 - iii. The Board staff shall review a request for reconsideration that is submitted according to subsection (i) and provide a decision on the request for reconsideration within 10 days of receipt.
 - iv. If the Board staff determines the application package was erroneously designated as administratively incomplete, the Board staff shall reopen the applicant's file and send a written notice of administrative completeness to the applicant. If the Board staff determines the application package was correctly designated as administratively incomplete, the applicant's file shall remain closed.
 3. If the application package is administratively complete, the Board shall send a written notice of administrative completeness to the applicant.
 4. If the Board does not provide a notice of deficiency or administrative completeness to the applicant within the administrative completeness review time-frame, the application package is deemed administratively complete.
- D.** A substantive review time-frame, as listed in subsection (A)(2), begins when an application package is determined to be administratively complete. The substantive review is conducted according to R7-5-204.
- E.** Within the time provided in subsection (A)(3), the Board shall provide the applicant with written notice of its decision to grant or deny a charter.
1. The Board shall deny a charter if it determines that the application package does not meet the requirements of statute or rule or the applicant is not sufficiently qualified to operate a charter school. The written notice shall include the basis for the denial. The applicant may:
 - a. Submit a new application package under R7-5-201 for consideration by the Board in any later annual application cycle; or
 - b. Appeal the Board's decision.
 2. The Board shall grant a charter if it determines that the application package meets the requirements of statute and rule and the applicant is sufficiently qualified to operate a charter school.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1141, effective March 2, 2004 (Supp. 04-1). Section R7-5-203 renumbered to Section R7-5-204; new Section R7-5-203 renumbered from R7-5-202 and amended by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

R7-5-204. Review of Administratively Complete Application Package, Technical Assistance, and In-Person Interview

The review of an administratively complete application package is as follows:

1. The Technical Review panel shall score the preliminary application package using the evaluation criteria identified in the application to determine whether an application package meets the Board's scoring requirements.
 - a. An application package shall be assigned a score of "Meets the Criteria," "Approaches the Criteria," or "Falls Below the Criteria" for each evaluation criterion.
 - i. An evaluation criterion shall be scored "Meets the Criteria" when the section within which that evaluation criterion is identified by the application:
 - (1) Addresses the evaluation criterion fully with specific and accurate information;
 - (2) Reflects a thorough understanding of the evaluation criterion; and
 - (3) Is clear and coherent.
 - ii. An evaluation criterion shall be assigned a score of "Approaches the Criteria" when the section within which that evaluation criterion is identified by the application:
 - (1) Addresses the evaluation criterion partially and lacks specific and accurate information for some aspect of the evaluation criterion;
 - (2) Presents a partial understanding of the evaluation criterion; or
 - (3) Is not clear and coherent.
 - iii. An evaluation criterion shall be assigned a score of "Falls Below the Criteria" when the section within which that evaluation criterion is identified by the application does not address the evaluation criterion.
 - b. An application package meets the Board's scoring requirements if:
 - i. No evaluation criterion receives a score of Falls Below the Criteria;
 - ii. No more than one evaluation criterion in each section is scored as Approaching the Criteria; and

- iii. The application package receives a score of Meets the Criteria for at least 95% of the evaluation criteria in each plan (educational plan, operational plan, and business plan).
- 2. The Board staff shall conduct a background and credit check of each principal of the applicant and confirm each principal possesses a valid fingerprint clearance card.
 - a. If issues arise from the information obtained during the background and credit checks of any principal, the Board staff shall provide the pertinent principal written notice of the issues and the principal will have the opportunity to provide a written response clarifying the information.
 - b. Information obtained and communications conducted during this process shall be considered by the Board in making its decision on whether to grant or deny a charter.
- 3. The Board staff shall notify the applicant if the preliminary application package fails to meet the scoring requirements as evaluated by the Technical Review Panel. The Board staff shall provide reasons the application package fails to meet the scoring requirements and include the comments of the Technical Review Panel, which will serve as technical assistance and suggestions for improving the application package.
- 4. An applicant who receives notification that a preliminary application package fails to meet the scoring requirements as evaluated by the Technical Review Panel may, within 20 days of the date of notice, submit a revised application package or a written request that the preliminary application package be forwarded to the Board.
- 5. If a revised application package or written request is not submitted to the Board within 20 days of the date of notice that a preliminary application package fails to meet the scoring requirements, the Board staff shall close the applicant's file. An applicant whose file is closed and who wants to obtain a charter shall apply again under R7-5-201 in any later annual application cycle.
- 6. If a revised application package is submitted, the Technical Review Panel shall score the revised application package using the scores and scoring requirements described in subsection (1).
- 7. If a revised application package fails to meet the scoring requirements as evaluated by the Technical Review Panel, the Board staff shall notify the applicant of the intent to close the file. The Board staff shall include with the notice the comments of the Technical Review Panel.
- 8. An applicant who receives notification of the Board staff's intent to close the file may, within 20 days of the date of notice, submit a written request that the revised application package be forwarded to the Board.
- 9. If a written request is not submitted to the Board within 20 days of the date of notice that a revised application package fails to meet the scoring requirements, the Board staff shall close the applicant's file. An applicant whose file is closed and who wants to obtain a charter shall apply again under R7-5-201 in any later annual application cycle.
- 10. At least 30 days prior to the last Board meeting before the substantive review time-frame expires, and within 90 days of the determination that a preliminary or revised application package meets the scoring requirements as evaluated by the Technical Review Panel, or the receipt of an applicant's request under subsection (4) or (8) that the Board consider an application package that fails to meet the scoring requirements as evaluated by the Technical Review Panel, the principals of the applicant shall make themselves available for an in-person interview with two or more members of the Technical Review Panel. In the interview, the members of the Technical Review Panel shall assess:
 - a. The applicant's understanding of the components presented in the written application package;
 - b. The applicant's capacity to implement a plan to operate a charter school in accordance with the performance frameworks adopted by the Board;
 - c. The applicant's clarification of any issues that arise in the course of the due diligence process for any applicant, principal, or Education Service Provider; and
 - d. Any other factors relevant to determining whether the applicant is sufficiently qualified to operate a charter school.
- 11. The Board shall consider an application package to determine whether to approve or deny the application package and whether to grant or deny the charter if the Technical Review Panel determines that the application package meets or exceeds the scoring requirements or if the applicant requests under subsection (4) or (8) that the Board consider an application package that fails to meet the scoring requirements as evaluated by the Technical Review Panel.
 - a. For the purpose of deciding whether to approve or deny the application package, the Board shall consider:
 - i. The application package; and
 - ii. A copy of the scoring rubric completed by the Technical Review Panel.
 - b. For the purpose of deciding whether to grant or deny a new charter, the Board shall determine whether the applicant is sufficiently qualified by considering the following:
 - i. The application package;
 - ii. A copy of the scoring rubric completed by the Technical Review Panel;
 - iii. The results of the in-person interview of the applicant's principals;
 - iv. Information obtained through verification and investigation of the backgrounds including employment, experience, education, fingerprint clearance card, and assessment of creditworthiness for each of the principals of the applicant;
 - v. Information concerning any current or former charter operations for any Education Service Provider or principal of the applicant;
 - vi. A Board staff report; and
 - vii. Testimony presented at the Board meeting.
- 12. The Board shall provide an applicant, with at least seven days written notice of the date, time, and place of the meeting at which the Board will consider the applicant's application package.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1141, effective March 2, 2004 (Supp. 04-1). Amended by final rulemaking at 12

A.A.R. 577, effective February 7, 2006 (Supp. 06-1). Section R7-5-204 renumbered to Section R7-5-205; new Section R7-5-204 renumbered from R7-5-203 and amended by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

R7-5-205. Execution of a Charter

- A.** After the Board's decision to grant a new charter, and before the charter is signed, the applicant shall submit to the Board the following:
1. No change
 2. Charter school site location information including:
 - a. Certificate of occupancy for each charter school site approved for educational use, and
 - b. Fire marshal report for each charter school site approved for educational use, or
 - c. If the certificate of occupancy and fire marshal report are not available, a completed Occupancy Compliance Assurance form;
 3. General Statement of Assurances form obtained from the Department;
 4. A statement indicating where all public notices of meetings will be posted as required by the Secretary of State under A.R.S. § 38-431.02; and
 5. Copy of the lease agreement or other documentation of a secured charter school facility for each charter school site.
- B.** A charter shall be signed by the Board President or designee and authorized representative of the applicant within 12 months after the Board's decision to grant the charter.
1. If a charter is not timely signed, the Board's decision to grant the new charter expires, unless the applicant applies for and is granted a good cause extension to execute the charter under R7-5-206.
 2. If an applicant who is granted a new charter but does not timely sign the charter and does not obtain a good cause extension wants to obtain a new charter, the applicant shall apply again under R7-5-201 in any later annual application cycle.
- C.** A charter holder shall begin providing educational instruction no later than the second fiscal year after the Board's decision to grant the charter, unless the charter holder is granted a good cause extension to execute a charter under R7-5-206 or good cause suspension of a charter under R7-5-207.
1. A charter holder who is granted a good cause extension to execute a charter under R7-5-206 or good cause suspension of a charter under R7-5-207 shall begin providing educational instruction no later than the third fiscal year after the Board's decision to grant the charter.
 2. If a charter holder does not begin providing educational instruction as required by subsections (C) and (C)(1) the Board shall issue the charter holder a notice of intent to revoke the charter in accordance with A.R.S. § 15-183(I).
- D.** A charter holder shall submit to the Board written proof that the charter school is in compliance with federal, state, and local rules, regulations, and statutes relating to health, safety, civil rights and insurance at least 10 days before the first day it will begin providing educational instruction by submitting:
1. Charter school site contact information;
 2. Insurance policy binder issued by an insurance company licensed to do business in Arizona;
 3. County health certificate for each site at which students will be taught;
 4. Evidence of a public meeting, required by A.R.S. § 15-183(C)(7), at least 30 days before the charter holder opens a site for the charter school;
 5. Certificate of attendance of the charter representative or principal at the special education training for new charters offered by the Department's Exceptional Student Services Division; and
 6. Any other documents required to demonstrate compliance with federal, state, and local rules, regulations, and statutes relating to health, safety, civil rights and insurance.
- E.** If a charter holder has completed an Occupancy Compliance Assurance form, state aid funding shall not initiate until the Board has determined that the required certificate of occupancy and fire marshal report submissions are complete and sufficient.
- F.** A new charter is effective upon the signing of both parties for a term of 15 years commencing on the date stated in the charter, unless revoked under A.R.S. § 15-183(I).

Historical Note

New Section R7-5-205 renumbered from R7-5-204 and amended by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

R7-5-206. Good Cause Extension to Execute a Charter

Before the Board's decision to grant a new charter expires, an applicant who has not yet executed the charter may submit to the Board a written request for a good cause extension to execute a charter.

1. The written request for a good cause extension to execute a charter shall:
 - a. Explain and provide evidence of why the applicant is unable to implement the plans contained in the application package and execute the charter within the allotted 12 months;
 - b. Explain the applicant's new timeline for implementing the plans contained in the application package, and why the timeline is viable and adequate for achieving the proposed start-up date of the school and appropriate for operating a charter school in accordance with the performance frameworks adopted by the Board and requirements of statute and rule.
 - c. Provide clear and specific action steps with target completion dates that will enable the applicant to implement the plans contained in the application package in accordance with the timeline provided and the requirements of R7-5-205(C)(1).
2. The Board may grant a good cause extension to execute a charter if an applicant demonstrates good cause. When considering a request for a good cause extension to execute a charter, the Board shall consider:
 - a. The timeliness of the submission of the request and the proposed extension date;

- b. The viability of the applicant's new timeline for implementing the plans contained in the application package;
 - c. Whether the new timeline provided by the applicant is adequate to begin providing educational instruction as required under R7-5-205(C)(1) and complies with the plans contained in the application package;
 - d. Unforeseen circumstances affecting the applicant's ability to execute the charter within the allotted 12 months;
 - e. Whether there have been changes in the principals of the applicant; and
 - f. The status of compliance with all applicable federal, State and local laws, and with all of the terms of a charter.
3. The Board shall not grant more than one good cause extension to execute a charter to any applicant for the same charter.
 4. If the Board grants a good cause extension to execute a charter, the Board shall specify the date by which the applicant shall execute the charter and begin providing educational instruction based on the timeline provided by the applicant and the requirements of R7-5-205(C)(1). If the applicant does not execute the charter by the specified date, the Board's decision to grant the charter shall expire.

Historical Note

Section R7-5-206 made by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

R7-5-207. Good Cause Suspension of a Charter

Prior to the first day of the fiscal year that a charter holder must begin providing educational instruction, the charter holder of a not-yet-operational charter may submit to the Board a written request for a good cause suspension of a charter.

1. A charter holder is eligible to apply for a good cause suspension of a charter if:
 - a. The charter holder has not been granted a good cause extension to execute a charter,
 - b. The charter holder has not begun providing educational instruction under the charter, and
 - c. The charter holder has not received or has returned state equalization or other state or federal funding for which provision of instruction is a requirement of receipt.
2. The written request for a good cause suspension of a charter shall:
 - a. Explain and provide evidence for why the charter holder is unable to implement the plans contained in the application package and begin providing educational instruction as required under R7-5-205(C);
 - b. Explain the charter holder's new timeline for implementing the plans contained in the application package, and why the new timeline is viable and adequate for achieving the proposed start-up date of the school and appropriate for operating a charter school in accordance with the performance frameworks adopted by the Board and requirements of statute and rule.
 - c. Provide clear and specific action steps with target completion dates that will enable the charter holder to implement the plans contained in the application package in accordance with the timeline provided and the requirements of R7-5-205(C)(1).
3. The Board may grant a good cause suspension of a charter if the charter holder demonstrates good cause. When considering a request for a good cause suspension of a charter, the Board shall consider:
 - a. The timeliness of the submission of the request and the proposed extension date;
 - b. The viability of the charter holder's new timeline for implementing the plans contained in the application package;
 - c. Whether the new timeline provided by the charter holder is adequate to begin providing educational instruction as required under R7-5-205(C)(1) and complies with the plans contained in the application package;
 - d. Unforeseen circumstances affecting the charter holder's ability to begin providing educational instruction as required under R7-5-205(C);
 - e. Whether there have been changes in the principals of the charter holder; and
 - f. The status of compliance with all applicable federal, State and local laws, and with all of the terms of the charter.
4. The Board shall not grant more than one good cause suspension of a charter to any charter holder for the same charter and shall not grant a good cause suspension of a charter to any charter holder who previously received a good cause extension to execute a charter for the same charter.
5. A charter holder who is granted a good cause suspension may execute and submit an amendment to the charter indicating a new effective date which shall conform to the date on which the charter holder shall begin providing educational instruction.
6. A charter holder who is granted a good cause suspension of a charter shall not apply to receive any state equalization or other state or federal funding for which provision of instruction is a requirement of receipt until the fiscal year in which the charter holder plans to begin providing educational instruction and shall promptly return any such funding it receives prior to the fiscal year in which it begins providing educational instruction.
7. A charter holder granted a good cause suspension of a charter shall begin providing educational instruction as required by R7-5-205(C). If a charter holder does not begin providing educational instruction as required, the Board shall issue the charter holder a notice of intent to revoke the charter in accordance with A.R.S. § 15-183(I).

Historical Note

Section R7-5-207 made by final rulemaking at 20 A.A.R. 437, effective April 5, 2014 (Supp. 14-1).

ARTICLE 3. CHARTER OVERSIGHT

R7-5-301. General Supervision, Oversight, and Administrative Responsibility

- A.** A charter holder shall comply with the provisions of its charter and with federal and state laws at all times.
- B.** The Board may use any of the following means in performing its administrative responsibilities to and general supervision and oversight of a charter holder:
 1. Oral, written, and electronic communication with the authorized representative or charter school personnel;

2. Oral, written, and electronic communication with representatives of federal, state, and local agencies having jurisdiction over the operation of the charter school or having the authority to investigate or adjudicate allegations of misconduct by any member of the charter school's staff;
3. Oral, written, and electronic communication with students, parents, or outside parties regarding any activity or program conducted by or for the charter school or regarding allegations of misconduct by any member of the charter school's staff;
4. Collection and review of reports, audits, data, records, documents, files, and communication from any source relating to any activity or program conducted by or for the charter school;
5. A corrective action plan as described in R7-5-302; and
6. A site visit as described in R7-5-303.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

R7-5-302. Corrective Action Plan

- A. Upon receipt of information under R7-5-301(B) that a charter holder is not in compliance with the provisions of its charter or federal or state laws, the Board shall consider the following factors in determining whether a corrective action plan (CAP) is required:
 1. The seriousness of the offense;
 2. The charter holder's history of compliance with the provisions of its charter and federal and state laws;
 3. The length of time the offense has been occurring; and
 4. Any other factors relating to the charter holder's compliance with the provisions of its charter and federal or state laws.
- B. If the Board requires a CAP, it shall make a written request to the charter holder for the submission of a CAP to be implemented to remedy the offense. The request shall include:
 1. A description of the offense,
 2. A list of the specific criteria to be included in the CAP,
 3. A deadline for the submission of the CAP,
 4. A timeline for the implementation of the CAP, and
 5. The consequences for failure to submit or implement the CAP.
- C. The Board shall decide to accept the CAP based on whether the specified criteria stated in the request are included in the CAP.
 1. The Board shall provide written notification to the authorized representative regarding the acceptance or rejection of the CAP.
 2. Written notification that the Board rejected the CAP shall include the reason for the rejection, the deadline for submission of the revised CAP, and the consequences for failure to submit a CAP that meets the specified criteria.
- D. The Board shall monitor the charter holder's implementation of the approved CAP to ensure the offense is rectified.
 1. The charter holder shall demonstrate to the Board through documentation or a site visit that steps have been taken to correct the offense or, in the case of a serious impact finding, that the charter holder is currently in compliance.
 2. The Board shall consider possible disciplinary action under R7-5-304 against the charter holder if the charter holder fails to implement the CAP and rectify the offense.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

R7-5-303. Site Visits; Records; Notice of Violation

- A. A designee of the Board or Department may conduct a site visit of a charter school to a review or evaluate the charter school's financial operations, academic program, or compliance with the provisions of its charter and federal and state laws.
- B. A designee of the Board or Department may conduct a site visit to corroborate information submitted to the Board and to gather information, documentation, and testimony that permit the Board to fulfill its oversight function under the law and ensure the charter school is in compliance with the provisions of its charter and federal and state laws.
- C. A designee of the Board or Department shall conduct a site visit during regular operational hours of a charter school or at any other reasonable time.
- D. A designee of the Board or Department may conduct either an announced or unannounced site visit.
- E. A designee of the Board or Department may conduct an investigation of a charter school in response to concerns raised by students, parents, employees, members of the community or other individuals or groups regarding any activity or program conducted by or for the charter school or regarding allegations of misconduct by any member of the charter school's staff.
- F. Upon request by a designee of the Board or Department, a charter holder shall open for inspection all records, documents, and files relating to any activity or program conducted by or for the charter school or the charter holder relating to the charter school.
- G. Upon request by a designee of the Board or Department, a charter holder shall provide access to all school facilities.
 1. During a site visit, a charter holder shall provide access to classrooms for the purpose of counting students, observing a program of instruction, or documenting individuals providing instruction.
 2. In conducting a site visit, the designee of the Board or the Department shall make every effort not to disrupt the classroom environment.
- H. The Board or Department shall inform a charter holder in writing of any offense identified during a site visit and shall specify any further action that must be taken by the charter holder. In determining the appropriate action to take, the Board shall consider the items in R7-5-304(A).
- I. The Board shall require a charter holder with a serious impact finding to appear before the Board for possible disciplinary action under R7-5-304.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

R7-5-304. Disciplinary Action

- A.** The Board may discipline a charter holder for violation of its charter or federal or state laws. In determining the appropriate disciplinary action to take, the Board shall consider the following:
1. Threat to the health or safety of children;
 2. Whether the charter holder's historical compliance record indicates repeated or multiple breaches of the provisions of its charter or federal or state laws;
 3. Whether the charter holder has failed to meet the academic needs of the children;
 4. Length of time the offense has been occurring;
 5. The charter holder's compliance with and response to staff investigation in providing necessary information and documentation within requested time-frames;
 6. Whether there has been a misuse of funds; and
 7. Any other factor that has a bearing on the charter holder's ability and willingness to operate in compliance with the provisions its charter and federal and state laws.
- B.** The Board shall take disciplinary action against a charter holder based on the Board's assessment of the factors listed in subsection (A). Disciplinary action may include any of the following:
1. Requiring a corrective action plan as described in R7-5-302;
 2. Requesting the Department to withhold up to 10 percent of the charter school's monthly state aid in accordance with A.R.S. § 15-185(H). Upon proof of corrected deficiencies and that the charter holder is in compliance, the Board shall request the Department to restore the full amount of state aid payments to the charter school;
 3. Entering into a consent agreement with the charter holder for the resolution of the non-compliance. The Board shall ensure that the consent agreement:
 - a. Describes each offense;
 - b. Stipulates the facts agreed to by the Board and the charter holder;
 - c. Specifies the actions the charter holder must take to demonstrate compliance and avoid further disciplinary action;
 - d. Provides a timeline for the charter holder to complete the actions specified in the consent agreement;
 - e. Stipulates that if the charter holder fails to comply with the terms and conditions of the consent agreement, the Board may, after giving the number of days notice specified in the consent agreement, hold a hearing at which the Board receives information to determine whether evidence exists that the charter holder has failed to comply with the consent agreement. If the Board determines that the charter holder has breached the consent agreement, the Board may revoke the charter holder's charter; and
 - f. Is approved by the Board and the charter holder and signed by the Board president or designee and the authorized representative;
 4. Issuing a notice of intent to revoke the charter in accordance with A.R.S. § 15-183(I) if the Board determines there is cause to believe that the charter holder may have breached one or more provisions of its charter; and
 5. Revoking the charter in accordance with A.R.S. § 15-183(I).

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

ARTICLE 4. AMENDMENT TO A CHARTER

R7-5-401. Amendment to a Charter

- A.** A charter holder that wishes to amend its charter shall submit to the Board:
1. A completed charter amendment form approved by the Board,
 2. The support documentation indicated on the charter amendment form, and
 3. Evidence that the proposed charter amendment has been approved by the charter school's governing body.
- B.** For approving or disapproving an amendment, the time-frames required by A.R.S. § 41-1072 et seq. are:
1. Administrative completeness review time-frame: 20 days.
 2. Substantive review time-frame: 40 days.
 3. Overall time-frame: 60 days.
- C.** A charter holder shall conform to the terms of the charter until an amendment is approved by the Board.

Historical Note

New Section made by final rulemaking at 10 A.A.R. 1141, effective March 2, 2004 (Supp. 04-1).

ARTICLE 5. AUDITS AND AUDIT CONTRACTS

R7-5-501. Audit Guidelines

By July 1 of each year, the Board shall make available to the public at its office and online at its web site, written audit guidelines that provide general guidance on charter school audit requirements, including the deadline for submitting the completed audit to the Board and information that must be included for the audit to be deemed complete.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

R7-5-502. Approval of Audit Contracts

- A. In accordance with A.R.S. § 15-914 and Laws 1999, 1st S.S., Ch. 4, § 15, a charter holder shall submit to the Board for approval an audit contract for each audit before the audit begins.
- B. The Board shall disapprove an audit contract only for the following reasons:
 - 1. Board knowledge that a person employed by the audit firm has been convicted under a federal or state statute for embezzlement, theft, fraudulent schemes and artifices, fraudulent schemes and practices, bid rigging, perjury, forgery, bribery, falsification or destruction of records, receiving stolen property, or any other offense indicating a lack of business integrity or business honesty;
 - 2. Failure of the audit firm or supervising certified public accountant to maintain good standing with an accounting industry regulatory body;
 - 3. Violation of or failure of the audit firm to meet generally accepted auditing standards or generally accepted government auditing standards as identified by an accounting industry regulatory body;
 - 4. Failure of the audit firm to receive an unmodified opinion during the audit firm's most recent peer review or failure of any auditor working on the audit to meet the continuing professional education requirements prescribed by generally accepted government auditing standards; or
 - 5. Failure to acknowledge that the audit firm shall adhere to the audit requirements listed in the Board's audit guidelines.
- C. The Board shall provide written notification of approval or disapproval of an audit contract to the charter holder and the audit firm within 10 days of receipt of the audit contract.
- D. The Board shall include the cause for disapproval in a notice of disapproval.
- E. If the charter holder or audit firm provides documentation that demonstrates the cause for disapproval no longer exists, the Board shall approve the audit contract and notify all parties of the approval.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

R7-5-503. Audit Completeness Determinations

- A. In accordance with A.R.S. § 15-914 and Laws 1999, 1st S.S., Ch. 4, § 15, a charter holder shall submit an audit to the Board for a determination regarding the audit's completeness.
- B. The Board shall find that an audit is incomplete if it does not include all of the items listed in the Board's audit guidelines.
- C. The Board shall provide written notification of a complete audit to the charter holder within five days of the receipt of the audit. The Board shall provide written notification of an incomplete audit to the charter holder and the audit firm within five days of receipt of the audit.
- D. The Board shall include the cause for the determination in a notice of an incomplete audit.
- E. If the charter holder or audit firm provides documentation that demonstrates the cause for an incomplete audit no longer exists, the Board shall deem the audit complete and notify the charter holder.
- F. The Board shall require that a charter holder whose audit does not include the items stated in the audit guidelines appear before the Board for possible disciplinary action under R7-5-304.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

R7-5-504. Review of Complete Audits

- A. The Board staff shall review each audit deemed complete.
- B. The Board shall send a letter to a charter holder after the audit is reviewed. If the Board identifies an issue in the audit, the Board shall direct the charter holder to address the issue and based on an assessment of the factors in R7-5-302(A), may require the charter holder to submit a corrective action plan.
- C. The Board shall require that a charter holder with a serious impact finding appear before the Board for possible disciplinary action under R7-5-304.

Historical Note

New Section made by final rulemaking at 12 A.A.R. 577, effective February 7, 2006 (Supp. 06-1).

15-181. Charter schools; purpose; scope

A. Charter schools may be established pursuant to this article to provide a learning environment that will improve pupil achievement. Charter schools provide additional academic choices for parents and pupils. Charter schools may consist of new schools or all or any portion of an existing school. Charter schools are public schools that serve as alternatives to traditional public schools and charter schools are not subject to the requirements of article XI, section 1, Constitution of Arizona, or chapter 16 of this title.

B. Charter schools shall comply with all provisions of this article in order to receive state funding as prescribed in section 15-185.

15-182. State board for charter schools; membership; terms; compensation; duties

A. The state board for charter schools is established consisting of the following members:

1. The superintendent of public instruction or the superintendent's designee.
2. Six members of the general public, at least two of whom shall reside in a school district where at least sixty per cent of the children who attend school in the district meet the eligibility requirements established under the national school lunch and child nutrition acts (42 United States Code sections 1751 through 1785) for free lunches, and at least one of whom shall reside on an Indian reservation, who are appointed by the governor pursuant to section 38-211.
3. Two members of the business community who are appointed by the governor pursuant to section 38-211.
4. A teacher who provides classroom instruction at a charter school and who is appointed by the governor pursuant to section 38-211.
5. An operator of a charter school who is appointed by the governor pursuant to section 38-211.
6. Three members of the legislature who shall serve as advisory members and who are appointed jointly by the president of the senate and the speaker of the house of representatives.

B. The superintendent of public instruction shall serve a term on the state board for charter schools that runs concurrently with the superintendent's term of office. The members appointed pursuant to subsection A, paragraph 6 of this section shall serve two year terms on the state board for charter schools that begin and end on the third Monday in January and that run concurrently with their respective terms of office. Members appointed pursuant to subsection A, paragraphs 2, 3, 4 and 5 of this section shall serve staggered four year terms that begin and end on the third Monday in January.

C. The state board for charter schools shall annually elect a president and such other officers as it deems necessary from among its membership.

D. Members of the state board for charter schools are not eligible to receive compensation but are eligible for reimbursement of expenses pursuant to title 38, chapter 4, article 2.

E. The state board for charter schools shall:

1. Exercise general supervision over charter schools sponsored by the board and recommend legislation pertaining to charter schools to the legislature.

2. Grant charter status to qualifying applicants for charter schools pursuant to section 15-183.
 3. Adopt and use an official seal in the authentication of its acts.
 4. Keep a record of its proceedings.
 5. Adopt rules for its own government.
 6. Determine the policy of the board and the work undertaken by it.
 7. Delegate to the superintendent of public instruction the execution of board policies.
 8. Prepare a budget for expenditures necessary for the proper maintenance of the board and the accomplishment of its purpose.
- F. The state board for charter schools may:
1. Contract.
 2. Sue and be sued.
 3. Use the services of the auditor general.
 4. Subject to title 41, chapter 4, article 4 and legislative appropriation, employ staff.
- G. The state board for charter schools may accept gifts or grants of monies or real or personal property from public and private organizations, if the purpose of the gift or grant specified by the donor is approved by the board and is within the scope of the board's powers and duties. The board shall establish and administer a gift and grant fund for the deposit of monies received pursuant to this subsection.

15-183. Charter schools; application; requirements; immunity; exemptions; renewal of application; reprisal; fee; funds; annual reports

A. An applicant seeking to establish a charter school shall submit a written application to a proposed sponsor as prescribed in subsection C of this section. The application, application process and application time frames shall be posted on the sponsor's website and shall include the following, as specified in the application adopted by the sponsor:

1. A detailed educational plan.
2. A detailed business plan.
3. A detailed operational plan.
4. Any other materials required by the sponsor.

B. The sponsor of a charter school may contract with a public body, private person or private organization for the purpose of establishing a charter school pursuant to this article.

C. The sponsor of a charter school may be either a school district governing board, the state board of education, the state board for charter schools, a university under the jurisdiction of the Arizona board of regents, a community college district with enrollment of more than fifteen thousand full-time equivalent students or a group of community college districts with a combined enrollment of more than fifteen thousand full-time equivalent students, subject to the following requirements:

1. For charter schools that submit an application for sponsorship to a school district governing board:

- (a) An applicant for a charter school may submit its application to a school district governing board, which shall either accept or reject sponsorship of the charter school within ninety days. An applicant may submit a revised application for

reconsideration by the governing board. If the governing board rejects the application, the governing board shall notify the applicant in writing of the reasons for the rejection. The applicant may request, and the governing board may provide, technical assistance to improve the application.

(b) In the first year that a school district is determined to be out of compliance with the uniform system of financial records, within fifteen days of the determination of noncompliance, the school district shall notify by certified mail each charter school sponsored by the school district that the school district is out of compliance with the uniform system of financial records. The notification shall include a statement that if the school district is determined to be out of compliance for a second consecutive year, the charter school will be required to transfer sponsorship to another entity pursuant to subdivision (c) of this paragraph.

(c) In the second consecutive year that a school district is determined to be out of compliance with the uniform system of financial records, within fifteen days of the determination of noncompliance, the school district shall notify by certified mail each charter school sponsored by the school district that the school district is out of compliance with the uniform system of financial records. A charter school that receives a notification of school district noncompliance pursuant to this subdivision shall file a written sponsorship transfer application within forty-five days with the state board of education, the state board for charter schools or the school district governing board if the charter school is located within the geographic boundaries of that school district. A charter school that receives a notification of school district noncompliance may request an extension of time to file a sponsorship transfer application, and the state board of education, the state board for charter schools or a school district governing board may grant an extension of not more than an additional thirty days if good cause exists for the extension. The state board of education and the state board for charter schools shall approve a sponsorship transfer application pursuant to this paragraph.

(d) A school district governing board shall not grant a charter to a charter school that is located outside the geographic boundaries of that school district.

(e) A school district that has been determined to be out of compliance with the uniform system of financial records during either of the previous two fiscal years shall not sponsor a new or transferring charter school.

(f) Notwithstanding any other law, a school district governing board shall not grant a charter to a new charter school that begins initial operations after June 30, 2013 or convert an existing district public school to a charter school that begins initial operations after June 30, 2013.

2. The applicant may submit the application to the state board of education or the state board for charter schools. Notwithstanding any other law, neither the state board for charter schools nor the state board of education shall grant a charter to a school district governing board for a new charter school that begins initial operations after June 30, 2013 or for the conversion of an existing district public school to a charter school that begins initial operations after June 30, 2013. The state board of education or the state board for charter schools may approve the application if the application meets the requirements of this article and may approve the charter if the proposed sponsor determines, within its sole discretion, that the applicant is sufficiently qualified to operate a charter school and that the

applicant is applying to operate as a separate charter holder by considering factors such as whether:

(a) The schools have separate governing bodies, governing body membership, staff, facilities and student population.

(b) Daily operations are carried out by different administrators.

(c) The applicant intends to have an affiliation agreement for the purpose of providing enrollment preferences.

(d) The applicant's charter management organization has multiple charter holders serving varied grade configurations on one physical site or nearby sites serving one community.

(e) It is reconstituting an existing school site population at the same or new site.

(f) It is reconstituting an existing grade configuration from a prior charter holder with at least one grade remaining on the original site with the other grade or grades moving to a new site. The state board of education or the state board for charter schools may approve any charter schools transferring charters. The state board of education and the state board for charter schools shall approve any charter schools transferring charters from a school district that is determined to be out of compliance with the uniform system of financial records pursuant to this section, but may require the charter school to sign a new charter that is equivalent to the charter awarded by the former sponsor. If the state board of education or the state board for charter schools rejects the preliminary application, the state board of education or the state board for charter schools shall notify the applicant in writing of the reasons for the rejection and of suggestions for improving the application. An applicant may submit a revised application for reconsideration by the state board of education or the state board for charter schools. The applicant may request, and the state board of education or the state board for charter schools may provide, technical assistance to improve the application.

3. The applicant may submit the application to a university under the jurisdiction of the Arizona board of regents, a community college district or a group of community college districts. A university, a community college district or a group of community college districts shall not grant a charter to a school district governing board for a new charter school that begins initial operations after June 30, 2013 or for the conversion of an existing district public school to a charter school that begins initial operations after June 30, 2013. A university, a community college district or a group of community college districts may approve the application if it meets the requirements of this article and if the proposed sponsor determines, in its sole discretion, that the applicant is sufficiently qualified to operate a charter school.

4. Each applicant seeking to establish a charter school shall submit a full set of fingerprints to the approving agency for the purpose of obtaining a state and federal criminal records check pursuant to section 41-1750 and Public Law 92-544. If an applicant will have direct contact with students, the applicant shall possess a valid fingerprint clearance card that is issued pursuant to title 41, chapter 12, article 3.1. The department of public safety may exchange this fingerprint data with the federal bureau of investigation. The criminal records check shall be completed before the issuance of a charter.

5. All persons engaged in instructional work directly as a classroom, laboratory or other teacher or indirectly as a supervisory teacher, speech therapist or principal shall have a valid fingerprint clearance card that is issued pursuant to title 41,

chapter 12, article 3.1, unless the person is a volunteer or guest speaker who is accompanied in the classroom by a person with a valid fingerprint clearance card. A charter school shall not employ a teacher whose certificate has been surrendered or revoked, unless the teacher's certificate has been subsequently reinstated by the state board of education. All other personnel shall be fingerprint checked pursuant to section 15-512, or the charter school may require those personnel to obtain a fingerprint clearance card issued pursuant to title 41, chapter 12, article 3.1. Before employment, the charter school shall make documented, good faith efforts to contact previous employers of a person to obtain information and recommendations that may be relevant to a person's fitness for employment as prescribed in section 15-512, subsection F. The charter school shall notify the department of public safety if the charter school or sponsor receives credible evidence that a person who possesses a valid fingerprint clearance card is arrested for or is charged with an offense listed in section 41-1758.03, subsection B. Charter schools may hire personnel that have not yet received a fingerprint clearance card if proof is provided of the submission of an application to the department of public safety for a fingerprint clearance card and if the charter school that is seeking to hire the applicant does all of the following:

- (a) Documents in the applicant's file the necessity for hiring and placement of the applicant before receiving a fingerprint clearance card.
- (b) Ensures that the department of public safety completes a statewide criminal records check on the applicant. A statewide criminal records check shall be completed by the department of public safety every one hundred twenty days until the date that the fingerprint check is completed or the fingerprint clearance card is issued or denied.
- (c) Obtains references from the applicant's current employer and the two most recent previous employers except for applicants who have been employed for at least five years by the applicant's most recent employer.
- (d) Provides general supervision of the applicant until the date that the fingerprint card is obtained.
- (e) Completes a search of criminal records in all local jurisdictions outside of this state in which the applicant has lived in the previous five years.
- (f) Verifies the fingerprint status of the applicant with the department of public safety.

6. A charter school that complies with the fingerprinting requirements of this section shall be deemed to have complied with section 15-512 and is entitled to the same rights and protections provided to school districts by section 15-512.

7. If a charter school operator is not already subject to a public meeting or hearing by the municipality in which the charter school is located, the operator of a charter school shall conduct a public meeting at least thirty days before the charter school operator opens a site or sites for the charter school. The charter school operator shall post notices of the public meeting in at least three different locations that are within three hundred feet of the proposed charter school site.

8. A person who is employed by a charter school or who is an applicant for employment with a charter school, who is arrested for or charged with a nonappealable offense listed in section 41-1758.03, subsection B and who does not immediately report the arrest or charge to the person's supervisor or potential employer is guilty of unprofessional conduct and the person shall be immediately

dismissed from employment with the charter school or immediately excluded from potential employment with the charter school.

9. A person who is employed by a charter school and who is convicted of any nonappealable offense listed in section 41-1758.03, subsection B or is convicted of any nonappealable offense that amounts to unprofessional conduct under section 15-550 shall immediately do all of the following:

- (a) Surrender any certificates issued by the department of education.
- (b) Notify the person's employer or potential employer of the conviction.
- (c) Notify the department of public safety of the conviction.
- (d) Surrender the person's fingerprint clearance card.

D. An entity that is authorized to sponsor charter schools pursuant to this article has no legal authority over or responsibility for a charter school sponsored by a different entity. This subsection does not apply to the state board of education's duty to exercise general supervision over the public school system pursuant to section 15-203, subsection A, paragraph 1.

E. The charter of a charter school shall do all of the following:

1. Ensure compliance with federal, state and local rules, regulations and statutes relating to health, safety, civil rights and insurance. The department of education shall publish a list of relevant rules, regulations and statutes to notify charter schools of their responsibilities under this paragraph.
2. Ensure that it is nonsectarian in its programs, admission policies and employment practices and all other operations.
3. Ensure that it provides a comprehensive program of instruction for at least a kindergarten program or any grade between grades one and twelve, except that a school may offer this curriculum with an emphasis on a specific learning philosophy or style or certain subject areas such as mathematics, science, fine arts, performance arts or foreign language.
4. Ensure that it designs a method to measure pupil progress toward the pupil outcomes adopted by the state board of education pursuant to section 15-741.01, including participation in the Arizona instrument to measure standards test and the nationally standardized norm-referenced achievement test as designated by the state board and the completion and distribution of an annual report card as prescribed in chapter 7, article 3 of this title.
5. Ensure that, except as provided in this article and in its charter, it is exempt from all statutes and rules relating to schools, governing boards and school districts.
6. Ensure that, except as provided in this article, it is subject to the same financial and electronic data submission requirements as a school district, including the uniform system of financial records as prescribed in chapter 2, article 4 of this title, procurement rules as prescribed in section 15-213 and audit requirements. The auditor general shall conduct a comprehensive review and revision of the uniform system of financial records to ensure that the provisions of the uniform system of financial records that relate to charter schools are in accordance with commonly accepted accounting principles used by private business. A school's charter may include exceptions to the requirements of this paragraph that are necessary as determined by the district governing board, the university, the community college district, the group of community college districts, the state board of education or

the state board for charter schools. The department of education or the office of the auditor general may conduct financial, program or compliance audits.

7. Ensure compliance with all federal and state laws relating to the education of children with disabilities in the same manner as a school district.

8. Ensure that it provides for a governing body for the charter school that is responsible for the policy decisions of the charter school. Notwithstanding section 1-216, if there is a vacancy or vacancies on the governing body, a majority of the remaining members of the governing body constitute a quorum for the transaction of business, unless that quorum is prohibited by the charter school's operating agreement.

9. Ensure that it provides a minimum of one hundred eighty instructional days before June 30 of each fiscal year unless it is operating on an alternative calendar approved by its sponsor. The superintendent of public instruction shall adjust the apportionment schedule accordingly to accommodate a charter school utilizing an alternative calendar.

F. A charter school shall keep on file the resumes of all current and former employees who provide instruction to pupils at the charter school. Resumes shall include an individual's educational and teaching background and experience in a particular academic content subject area. A charter school shall inform parents and guardians of the availability of the resume information and shall make the resume information available for inspection on request of parents and guardians of pupils enrolled at the charter school. This subsection does not require any charter school to release personally identifiable information in relation to any teacher or employee, including the teacher's or employee's address, salary, social security number or telephone number.

G. The charter of a charter school may be amended at the request of the governing body of the charter school and on the approval of the sponsor.

H. Charter schools may contract, sue and be sued.

I. The charter is effective for fifteen years from the first day of the fiscal year as specified in the charter, subject to the following:

1. At least eighteen months before the expiration of the charter, the sponsor shall notify the charter school that the charter school may apply for renewal and shall make the renewal application available to the charter school. A charter school that elects to apply for renewal shall file a complete renewal application at least fifteen months before the expiration of the charter. A sponsor shall give written notice of its intent not to renew the charter school's request for renewal to the charter school at least twelve months before the expiration of the charter. The sponsor shall make data used in making renewal decisions available to the school and the public and shall provide a public report summarizing the evidence basis for each decision. The sponsor may deny the request for renewal if, in its judgment, the charter holder has failed to do any of the following:

(a) Meet or make sufficient progress toward the academic performance expectations set forth in the performance framework.

(b) Meet the operational performance expectations set forth in the performance framework or any improvement plans.

(c) Complete the obligations of the contract.

(d) Comply with this article or any provision of law from which the charter school is not exempt.

2. A charter operator may apply for early renewal. At least nine months before the charter school's intended renewal consideration, the operator of the charter school shall submit a letter of intent to the sponsor to apply for early renewal. The sponsor shall review fiscal audits and academic performance data for the charter school that are annually collected by the sponsor, review the current contract between the sponsor and the charter school and provide the qualifying charter school with a renewal application. On submission of a complete application, the sponsor shall give written notice of its consideration of the renewal application. The sponsor may deny the request for early renewal if, in the sponsor's judgment, the charter holder has failed to do any of the following:

- (a) Meet or make sufficient progress toward the academic performance expectations set forth in the performance framework.
- (b) Meet the operational performance expectations set forth in the performance framework or any improvement plans.
- (c) Complete the obligations of the contract.
- (d) Comply with this article or any provision of law from which the charter school is not exempt.

3. A sponsor shall review a charter at five-year intervals using a performance framework adopted by the sponsor and may revoke a charter at any time if the charter school breaches one or more provisions of its charter or if the sponsor determines that the charter holder has failed to do any of the following:

- (a) Meet or make sufficient progress toward the academic performance expectations set forth in the performance framework.
- (b) Meet the operational performance expectations set forth in the performance framework or any improvement plans.
- (c) Comply with this article or any provision of law from which the charter school is not exempt.

4. In determining whether to renew or revoke a charter holder, the sponsor must consider making sufficient progress toward the academic performance expectations set forth in the sponsor's performance framework as one of the most important factors.

5. At least sixty days before the effective date of the proposed revocation, the sponsor shall give written notice to the operator of the charter school of its intent to revoke the charter. Notice of the sponsor's intent to revoke the charter shall be delivered personally to the operator of the charter school or sent by certified mail, return receipt requested, to the address of the charter school. The notice shall incorporate a statement of reasons for the proposed revocation of the charter. The sponsor shall allow the charter school at least sixty days to correct the problems associated with the reasons for the proposed revocation of the charter. The final determination of whether to revoke the charter shall be made at a public hearing called for such purpose.

J. The charter may be renewed for successive periods of twenty years.

K. A charter school that is sponsored by the state board of education, the state board for charter schools, a university, a community college district or a group of community college districts may not be located on the property of a school district unless the district governing board grants this authority.

L. A governing board or a school district employee who has control over personnel actions shall not take unlawful reprisal against another employee of the school

district because the employee is directly or indirectly involved in an application to establish a charter school. A governing board or a school district employee shall not take unlawful reprisal against an educational program of the school or the school district because an application to establish a charter school proposes the conversion of all or a portion of the educational program to a charter school. For the purposes of this subsection, "unlawful reprisal" means an action that is taken by a governing board or a school district employee as a direct result of a lawful application to establish a charter school and that is adverse to another employee or an education program and:

1. With respect to a school district employee, results in one or more of the following:

- (a) Disciplinary or corrective action.
- (b) Detail, transfer or reassignment.
- (c) Suspension, demotion or dismissal.
- (d) An unfavorable performance evaluation.
- (e) A reduction in pay, benefits or awards.
- (f) Elimination of the employee's position without a reduction in force by reason of lack of monies or work.
- (g) Other significant changes in duties or responsibilities that are inconsistent with the employee's salary or employment classification.

2. With respect to an educational program, results in one or more of the following:

- (a) Suspension or termination of the program.
- (b) Transfer or reassignment of the program to a less favorable department.
- (c) Relocation of the program to a less favorable site within the school or school district.
- (d) Significant reduction or termination of funding for the program.

M. Charter schools shall secure insurance for liability and property loss. The governing body of a charter school that is sponsored by the state board of education or the state board for charter schools may enter into an intergovernmental agreement or otherwise contract to participate in an insurance program offered by a risk retention pool established pursuant to section 11-952.01 or 41-621.01 or the charter school may secure its own insurance coverage. The pool may charge the requesting charter school reasonable fees for any services it performs in connection with the insurance program.

N. Charter schools do not have the authority to acquire property by eminent domain.

O. A sponsor, including members, officers and employees of the sponsor, is immune from personal liability for all acts done and actions taken in good faith within the scope of its authority.

P. Charter school sponsors and this state are not liable for the debts or financial obligations of a charter school or persons who operate charter schools.

Q. The sponsor of a charter school shall establish procedures to conduct administrative hearings on determination by the sponsor that grounds exist to revoke a charter. Procedures for administrative hearings shall be similar to procedures prescribed for adjudicative proceedings in title 41, chapter 6, article 10. Except as provided in section 41-1092.08, subsection H, final decisions of the state board of education and the state board for charter schools from hearings conducted

pursuant to this subsection are subject to judicial review pursuant to title 12, chapter 7, article 6.

R. The sponsoring entity of a charter school shall have oversight and administrative responsibility for the charter schools that it sponsors. In implementing its oversight and administrative responsibilities, the sponsor shall ground its actions in evidence of the charter holder's performance in accordance with the performance framework adopted by the sponsor. The performance framework shall be publicly available, shall be placed on the sponsoring entity's website and shall include:

1. The academic performance expectations of the charter school and the measurement of sufficient progress toward the academic performance expectations.
2. The operational expectations of the charter school, including adherence to all applicable laws and obligations of the charter contract.
3. Intervention and improvement policies.

S. Charter schools may pledge, assign or encumber their assets to be used as collateral for loans or extensions of credit.

T. All property accumulated by a charter school shall remain the property of the charter school.

U. Charter schools may not locate a school on property that is less than one-fourth mile from agricultural land regulated pursuant to section 3-365, except that the owner of the agricultural land may agree to comply with the buffer zone requirements of section 3-365. If the owner agrees in writing to comply with the buffer zone requirements and records the agreement in the office of the county recorder as a restrictive covenant running with the title to the land, the charter school may locate a school within the affected buffer zone. The agreement may include any stipulations regarding the charter school, including conditions for future expansion of the school and changes in the operational status of the school that will result in a breach of the agreement.

V. A transfer of a charter to another sponsor, a transfer of a charter school site to another sponsor or a transfer of a charter school site to a different charter shall be completed before the beginning of the fiscal year that the transfer is scheduled to become effective. An entity that sponsors charter schools may accept a transferring school after the beginning of the fiscal year if the transfer is approved by the superintendent of public instruction. The superintendent of public instruction shall have the discretion to consider each transfer during the fiscal year on a case by case basis. If a charter school is sponsored by a school district that is determined to be out of compliance with this title, the uniform system of financial records or any other state or federal law, the charter school may transfer to another sponsoring entity at any time during the fiscal year. A charter holder seeking to transfer sponsors shall comply with the current charter terms regarding assignment of the charter. A charter holder transferring sponsors shall notify the current sponsor that the transfer has been approved by the new sponsor.

W. Notwithstanding subsection V of this section, a charter holder on an improvement plan must notify parents or guardians of registered students of the intent to transfer the charter and the timing of the proposed transfer. On the approved transfer, the new sponsor shall enforce the improvement plan but may modify the plan based on performance.

X. Notwithstanding subsection Y of this section, the state board for charter schools shall charge a processing fee to any charter school that amends its contract to

participate in Arizona online instruction pursuant to section 15-808. The charter Arizona online instruction processing fund is established consisting of fees collected and administered by the state board for charter schools. The state board for charter schools shall use monies in the fund only for the processing of contract amendments for charter schools participating in Arizona online instruction. Monies in the fund are continuously appropriated.

Y. The sponsoring entity may not charge any fees to a charter school that it sponsors unless the sponsor has provided services to the charter school and the fees represent the full value of those services provided by the sponsor. On request, the value of the services provided by the sponsor to the charter school shall be demonstrated to the department of education.

Z. Charter schools may enter into an intergovernmental agreement with a presiding judge of the juvenile court to implement a law related education program as defined in section 15-154. The presiding judge of the juvenile court may assign juvenile probation officers to participate in a law related education program in any charter school in the county. The cost of juvenile probation officers who participate in the program implemented pursuant to this subsection shall be funded by the charter school.

AA. The sponsor of a charter school shall modify previously approved curriculum requirements for a charter school that wishes to participate in the board examination system prescribed in chapter 7, article 6 of this title.

BB. If a charter school decides not to participate in the board examination system prescribed in chapter 7, article 6 of this title, pupils enrolled at that charter school may earn a Grand Canyon diploma by obtaining a passing score on the same board examinations.

CC. Notwithstanding subsection Y of this section, a sponsor of charter schools may charge a new charter application processing fee to any applicant. The application fee shall fully cover the cost of application review and any needed technical assistance. Authorizers may approve policies that allow a portion of the fee to be returned to the applicant whose charter is approved.

DD. A charter school may choose to provide a preschool program for children with disabilities pursuant to section 15-771.

EE. Pursuant to the prescribed graduation requirements adopted by the state board of education, the governing body of a charter school operating a high school may approve a rigorous computer science course that would fulfill a mathematics course required for graduation from high school. The governing body may approve a rigorous computer science course only if the rigorous computer science course includes significant mathematics content and the governing body determines the high school where the rigorous computer science course is offered has sufficient capacity, infrastructure and qualified staff, including competent teachers of computer science.

FF. A charter school may permit the use of school property, including school buildings, grounds, buses and equipment, by any person, group or organization for any lawful purpose, including a recreational, educational, political, economic, artistic, moral, scientific, social, religious or other civic or governmental purpose. The charter school may charge a reasonable fee for the use of the school property.

GG. A charter school and its employees, including the governing body, or chief administrative officer, are immune from civil liability with respect to all decisions

made and actions taken to allow the use of school property, unless the charter school or its employees are guilty of gross negligence or intentional misconduct. This subsection does not limit any other immunity provisions that are prescribed by law.

HH. Sponsors authorized pursuant to this section shall submit an annual report to the auditor general on or before October 1 of each year. The report shall include:

1. The current number of charters authorized and the number of schools operated by authorized charter holders.
2. The academic and operational performance of the sponsor's charter portfolio as measured by the sponsor's adopted performance framework.
3. The number of new charters approved and the number of charter schools closed and reason for the closure in the prior year.
4. The sponsor's application, amendment, renewal and revocation processes, charter contract template and current performance framework as required by this section.

II. The auditor general shall prescribe the format for the annual report required by subsection HH of this section and may require that the annual report be submitted electronically. The auditor general shall review the submitted annual reports to ensure that the reports include the required items in subsection HH of this section and shall make the annual reports available upon request. If the auditor general finds significant noncompliance or a sponsor's failure to submit the annual report required by subsection HH of this section, on or before December 31 of each year the auditor general shall report to the governor, the president of the senate, the speaker of the house of representatives and the chairs of the senate and house education committees or their successor committees, and the legislature shall consider revoking the sponsor's authority to sponsor charter schools.

15-183.01. New charter application processing fund

The new charter application processing fund is established consisting of fees collected by the state board for charter schools. The state board for charter schools shall administer the fund. The state board for charter schools shall use monies in the fund only for the processing of applications submitted for new charters. Monies in the fund are continuously appropriated.

15-184. Charter schools: admissions requirements

- A. A charter school shall enroll all eligible pupils who submit a timely application, unless the number of applications exceeds the capacity of a program, class, grade level or building.
- B. A charter school shall give enrollment preference to pupils returning to the charter school in the second or any subsequent year of its operation and to siblings of pupils already enrolled in the charter school.
- C. A charter school that is sponsored by a school district governing board shall give enrollment preference to eligible pupils who reside within the boundaries of the school district where the charter school is physically located.
- D. A charter school may give enrollment preference to and reserve capacity for pupils who either:

1. Are children, grandchildren or legal wards of any of the following:
 - (a) Employees of the school.
 - (b) Employees of the charter holder.
 - (c) Members of the governing body of the school.
 - (d) Directors, officers, partners or board members of the charter holder.
2. Attended another charter school or are the siblings of that pupil if the charter school previously attended by the pupil has the identical charter holder, board and governing board membership as the enrolling charter school or is managed by the same educational management organization, charter management organization or educational service provider as determined by the charter authorizer.
- E. If remaining capacity is insufficient to enroll all pupils who submit a timely application, the charter school shall select pupils through an equitable selection process such as a lottery except that preference shall be given to siblings of a pupil selected through an equitable selection process such as a lottery.
- F. Except as provided in subsections A through D of this section, a charter school shall not limit admission based on ethnicity, national origin, gender, income level, disabling condition, proficiency in the English language or athletic ability.
- G. A charter school may limit admission to pupils within a given age group or grade level.
- H. A charter school may provide instruction to pupils of a single gender with the approval of the sponsor of the charter school. An existing charter school may amend its charter to provide instruction to pupils of a single gender, and if approved by the sponsor of the charter school, may provide instruction to pupils of a single gender at the beginning of the next school year.
- I. A charter school shall admit pupils who reside in the attendance area of a school or who reside in a school district that is under a court order of desegregation or that is a party to an agreement with the United States department of education office for civil rights directed toward remediating alleged or proven racial discrimination unless notice is received from the resident school that the admission would violate the court order or agreement. If a charter school admits a pupil after notice is received that the admission would constitute such a violation, the charter school is not allowed to include in its student count the pupils wrongfully admitted.
- J. A charter school may refuse to admit any pupil who has been expelled from another educational institution or who is in the process of being expelled from another educational institution.

15-185. Charter schools; financing; civil penalty; transportation; definitions

A. Financial provisions for a charter school that is sponsored by a school district governing board are as follows:

1. The charter school shall be included in the district's budget and financial assistance calculations pursuant to paragraph 3 of this subsection and chapter 9 of this title, except for chapter 9, article 4 of this title. The charter of the charter school shall include a description of the methods of funding the charter school by the school district. The school district shall send a copy of the charter and application, including a description of how the school district plans to fund the school, to the state board of education before the start of the first fiscal year of operation of the charter school. The charter or application shall include an estimate

of the student count for the charter school for its first fiscal year of operation. This estimate shall be computed pursuant to the requirements of paragraph 3 of this subsection.

2. A school district is not financially responsible for any charter school that is sponsored by the state board of education, the state board for charter schools, a university under the jurisdiction of the Arizona board of regents, a community college district or a group of community college districts.

3. A school district that sponsors a charter school may:

(a) Increase its student count as provided in subsection B, paragraph 2 of this section during the first year of the charter school's operation to include those charter school pupils who were not previously enrolled in the school district. A charter school sponsored by a school district governing board is eligible for the charter additional assistance prescribed in subsection B, paragraph 4 of this section. The district additional assistance allocation as provided in section 15-961 for the school district sponsoring the charter school shall be increased by the amount of the charter additional assistance. The school district shall include the full amount of the charter additional assistance in the funding provided to the charter school.

(b) Compute separate weighted student counts pursuant to section 15-943, paragraph 2, subdivision (a) for its noncharter school versus charter school pupils in order to maintain eligibility for small school district support level weights authorized in section 15-943, paragraph 1 for its noncharter school pupils only. The portion of a district's student count that is attributable to charter school pupils is not eligible for small school district support level weights.

4. If a school district uses the provisions of paragraph 3 of this subsection, the school district is not eligible to include those pupils in its student count for the purposes of computing an increase in its revenue control limit and district support level as provided in section 15-948.

5. A school district that sponsors a charter school is not eligible to include the charter school pupils in its student count for the purpose of computing an increase in its district additional assistance as provided in section 15-961, subsection B, except that if the charter school was previously a school in the district, the district may include in its student count any charter school pupils who were enrolled in the school district in the prior year.

6. A school district that sponsors a charter school is not eligible to include the charter school pupils in its student count for the purpose of computing the revenue control limit which is used to determine the maximum budget increase as provided in chapter 4, article 4 of this title unless the charter school is located within the boundaries of the school district.

7. If a school district converts one or more of its district public schools to a charter school and receives assistance as prescribed in subsection B, paragraph 4 of this section, and subsequently converts the charter school back to a district public school, the school district shall repay the state the total charter additional assistance received for the charter school for all years that the charter school was in operation. The repayment shall be in one lump sum and shall be reduced from the school district's current year equalization assistance. The school district's general budget limit shall be reduced by the same lump sum amount in the current year.

B. Financial provisions for a charter school that is sponsored by the state board of education, the state board for charter schools, a university, a community college district or a group of community college districts are as follows:

1. The charter school shall calculate a base support level as prescribed in section 15-943, except that:

(a) Section 15-941 does not apply to these charter schools.

(b) The small school weights prescribed in section 15-943, paragraph 1 apply if a charter holder, as defined in section 15-101, holds one charter for one or more school sites and the average daily membership for the school sites are combined for the calculation of the small school weight. The small school weight shall not be applied individually to a charter holder if one or more of the following conditions exists and the combined average daily membership derived from the following conditions is greater than six hundred:

(i) The organizational structure or management agreement of the charter holder requires the charter holder or charter school to contract with a specific management company.

(ii) The governing body of the charter holder has identical membership to another charter holder in this state.

(iii) The charter holder is a subsidiary of a corporation that has other subsidiaries that are charter holders in this state.

(iv) The charter holder holds more than one charter in this state.

(c) Notwithstanding subdivision (b) of this paragraph, for fiscal year 2015-2016 the department of education shall reduce by thirty-three percent the amount provided by the small school weight for charter schools prescribed in subdivision (b) of this paragraph.

(d) Notwithstanding subdivision (b) of this paragraph, for fiscal year 2016-2017 the department of education shall reduce by sixty-seven percent the amount provided by the small school weight for affiliated charter schools prescribed in subdivision (b) of this paragraph.

2. Notwithstanding paragraph 1 of this subsection, the student count shall be determined initially using an estimated student count based on actual registration of pupils before the beginning of the school year. Notwithstanding section 15-1042, subsection F, student level data submitted to the department may be used to determine estimated student counts. After the first forty days, one hundred days or two hundred days in session, as applicable, the charter school shall revise the student count to be equal to the actual average daily membership, as defined in section 15-901, of the charter school. Before the fortieth day, one hundredth day or two hundredth day in session, as applicable, the state board of education, the state board for charter schools, the sponsoring university, the sponsoring community college district or the sponsoring group of community college districts may require a charter school to report periodically regarding pupil enrollment and attendance, and the department of education may revise its computation of equalization assistance based on the report. A charter school shall revise its student count, base support level and charter additional assistance before May 15. A charter school that overestimated its student count shall revise its budget before May 15. A charter school that underestimated its student count may revise its budget before May 15.

3. A charter school may utilize section 15-855 for the purposes of this section. The charter school and the department of education shall prescribe procedures for determining average daily membership.

4. Equalization assistance for the charter school shall be determined by adding the amount of the base support level and charter additional assistance. The amount of the charter additional assistance is one thousand seven hundred thirty-four dollars ninety-two cents per student count in preschool programs for children with disabilities, kindergarten programs and grades one through eight and two thousand twenty-two dollars two cents per student count in grades nine through twelve.

5. The state board of education shall apportion state aid from the appropriations made for such purposes to the state treasurer for disbursement to the charter schools in each county in an amount as determined by this paragraph. The apportionments shall be made as prescribed in section 15-973, subsection B.

6. The charter school shall not charge tuition for pupils who reside in this state, levy taxes or issue bonds. A charter school may admit pupils who are not residents of this state and shall charge tuition for those pupils in the same manner prescribed in section 15-823.

7. Not later than noon on the day preceding each apportionment date established by paragraph 5 of this subsection, the superintendent of public instruction shall furnish to the state treasurer an abstract of the apportionment and shall certify the apportionment to the department of administration, which shall draw its warrant in favor of the charter schools for the amount apportioned.

C. If a pupil is enrolled in both a charter school and a public school that is not a charter school, the sum of the daily membership, which includes enrollment as prescribed in section 15-901, subsection A, paragraph 1, subdivisions (a) and (b) and daily attendance as prescribed in section 15-901, subsection A, paragraph 5, for that pupil in the school district and the charter school shall not exceed 1.0. If a pupil is enrolled in both a charter school and a public school that is not a charter school, the department of education shall direct the average daily membership to the school with the most recent enrollment date. On validation of actual enrollment in both a charter school and a public school that is not a charter school and if the sum of the daily membership or daily attendance for that pupil is greater than 1.0, the sum shall be reduced to 1.0 and shall be apportioned between the public school and the charter school based on the percentage of total time that the pupil is enrolled or in attendance in the public school and the charter school. The uniform system of financial records shall include guidelines for the apportionment of the pupil enrollment and attendance as provided in this section.

D. Charter schools are allowed to accept grants and gifts to supplement their state funding, but it is not the intent of the charter school law to require taxpayers to pay twice to educate the same pupils. The base support level for a charter school or for a school district sponsoring a charter school shall be reduced by an amount equal to the total amount of monies received by a charter school from a federal or state agency if the federal or state monies are intended for the basic maintenance and operations of the school. The superintendent of public instruction shall estimate the amount of the reduction for the budget year and shall revise the reduction to reflect the actual amount before May 15 of the current year. If the reduction results in a negative amount, the negative amount shall be used in computing all budget limits and equalization assistance, except that:

1. Equalization assistance shall not be less than zero.
 2. For a charter school sponsored by the state board of education, the state board for charter schools, a university, a community college district or a group of community college districts, the total of the base support level and the charter additional assistance shall not be less than zero.
 3. For a charter school sponsored by a school district, the base support level for the school district shall not be reduced by more than the amount that the charter school increased the district's base support level and district additional assistance allocation.
- E. If a charter school was a district public school in the prior year and is now being operated for or by the same school district and sponsored by the state board of education, the state board for charter schools, a university, a community college district, a group of community college districts or a school district governing board, the reduction in subsection D of this section applies. The reduction to the base support level of the charter school or the sponsoring district of the charter school shall equal the sum of the base support level and the charter additional assistance received in the current year for those pupils who were enrolled in the traditional public school in the prior year and are now enrolled in the charter school in the current year.
- F. Equalization assistance for charter schools shall be provided as a single amount based on average daily membership without categorical distinctions between maintenance and operations or capital.
- G. At the request of a charter school, the county school superintendent of the county where the charter school is located may provide the same educational services to the charter school as prescribed in section 15-308, subsection A. The county school superintendent may charge a fee to recover costs for providing educational services to charter schools.
- H. If the sponsor of the charter school determines at a public meeting that the charter school is not in compliance with federal law, with the laws of this state or with its charter, the sponsor of a charter school may submit a request to the department of education to withhold up to ten percent of the monthly apportionment of state aid that would otherwise be due the charter school. The department of education shall adjust the charter school's apportionment accordingly. The sponsor shall provide written notice to the charter school at least seventy-two hours before the meeting and shall allow the charter school to respond to the allegations of noncompliance at the meeting before the sponsor makes a final determination to notify the department of education of noncompliance. The charter school shall submit a corrective action plan to the sponsor on a date specified by the sponsor at the meeting. The corrective action plan shall be designed to correct deficiencies at the charter school and to ensure that the charter school promptly returns to compliance. When the sponsor determines that the charter school is in compliance, the department of education shall restore the full amount of state aid payments to the charter school.
- I. In addition to the withholding of state aid payments pursuant to subsection H of this section, the sponsor of a charter school may impose a civil penalty of one thousand dollars per occurrence if a charter school fails to comply with the fingerprinting requirements prescribed in section 15-183, subsection C or section 15-512. The sponsor of a charter school shall not impose a civil penalty if it is the

first time that a charter school is out of compliance with the fingerprinting requirements and if the charter school provides proof within forty-eight hours of written notification that an application for the appropriate fingerprint check has been received by the department of public safety. The sponsor of the charter school shall obtain proof that the charter school has been notified, and the notification shall identify the date of the deadline and shall be signed by both parties. The sponsor of a charter school shall automatically impose a civil penalty of one thousand dollars per occurrence if the sponsor determines that the charter school subsequently violates the fingerprinting requirements. Civil penalties pursuant to this subsection shall be assessed by requesting the department of education to reduce the amount of state aid that the charter school would otherwise receive by an amount equal to the civil penalty. The amount of state aid withheld shall revert to the state general fund at the end of the fiscal year.

J. A charter school may receive and spend monies distributed by the department of education pursuant to section 42-5029, subsection E and section 37-521, subsection B.

K. If a school district transports or contracts to transport pupils to the Arizona state schools for the deaf and the blind during any fiscal year, the school district may transport or contract with a charter school to transport sensory impaired pupils during that same fiscal year to a charter school if requested by the parent of the pupil and if the distance from the pupil's place of actual residence within the school district to the charter school is less than the distance from the pupil's place of actual residence within the school district to the campus of the Arizona state schools for the deaf and the blind.

L. Notwithstanding any other law, a university under the jurisdiction of the Arizona board of regents, a community college district or a group of community college districts shall not include any student in the student count of the university, community college district or group of community college districts for state funding purposes if that student is enrolled in and attending a charter school sponsored by the university, community college district or group of community college districts.

M. The governing body of a charter school shall transmit a copy of its proposed budget or the summary of the proposed budget and a notice of the public hearing to the department of education for posting on the department of education's website no later than ten days before the hearing and meeting. If the charter school maintains a website, the charter school governing body shall post on its website a copy of its proposed budget or the summary of the proposed budget and a notice of the public hearing.

N. The governing body of a charter school shall collaborate with the private organization that is approved by the state board of education pursuant to section 15-792.02 to provide approved board examination systems for the charter school.

O. If permitted by federal law, a charter school may opt out of federal grant opportunities if the charter holder or the appropriate governing body of the charter school determines that the federal requirements impose unduly burdensome reporting requirements.

P. For the purposes of this section:

1. "Monies intended for the basic maintenance and operations of the school" means monies intended to provide support for the educational program of the school, except that it does not include supplemental assistance for a specific purpose or

title VIII of the elementary and secondary education act of 1965 monies. The auditor general shall determine which federal or state monies meet the definition in this paragraph.

2. "Operated for or by the same school district" means the charter school is either governed by the same district governing board or operated by the district in the same manner as other traditional schools in the district or is operated by an independent party that has a contract with the school district. The auditor general and the department of education shall determine which charter schools meet the definition in this subsection.

15-185.01. Charter school pupils attending joint technical education districts; average daily membership calculation

Notwithstanding section 15-185, subsection C, if a pupil is enrolled in both a charter school and a joint technical education district and resides within the boundaries of a school district participating in the joint technical education district, the average daily membership for that pupil shall be calculated in the same manner prescribed for a pupil who is enrolled in both the member school district and a joint technological education district pursuant to section 15-393.

15-187. Charter schools; teachers; employment benefits

A. A teacher who is employed by or teaching at a charter school and who was previously employed as a teacher at a school district shall not lose any right of certification, retirement or salary status or any other benefit provided by law, by the rules of the governing board of the school district or by the rules of the board of directors of the charter school due to teaching at a charter school on the teacher's return to the school district.

B. A teacher who is employed by or teaching at a charter school and who submits an employment application to the school district where the teacher was employed immediately before employment by or at a charter school shall be given employment preference by the school district if both of the following conditions are met:

1. The teacher submits an employment application to the school district no later than three years after ceasing employment with the school district.

2. A suitable position is available at the school district.

C. A charter school that is sponsored by a school district governing board, a university, a community college district, a group of community college districts, the state board of education or the state board for charter schools is eligible to participate in the Arizona state retirement system pursuant to title 38, chapter 5, article 2. The charter school is a political subdivision of this state for purposes of title 38, chapter 5, article 2.

D. Notwithstanding any other law, a charter school shall not adopt policies that provide employment retention priority for teachers based on tenure or seniority.

15-187.01. Optional inclusion of charter school employees in state health and accident coverage; payment of premiums; advance notice; minimum period of participation; definition

A. If a governing body of a charter school determines that state health and accident insurance coverage is necessary or desirable and in the best interest of the charter school, it may provide for inclusion of the charter school's employees and spouses and dependents of the charter school's employees in state health and accident insurance coverage pursuant to section 38-651.

B. If the charter school elects to participate in the state health and accident insurance coverage, it shall be the only health and accident insurance coverage offered to charter school employees.

C. A charter school governing body that elects to include its employees in the state health and accident insurance coverage shall notify the department of administration of its intention to do so by January 15 of the calendar year prior to the school year starting after June 30 in which the charter school's employees would be eligible to receive state health and accident insurance coverage.

D. A charter school governing body that elects to include its employees in the state health and accident insurance coverage shall participate in state health and accident insurance coverage for at least two years.

E. Charter schools that opt to participate in the state health and accident insurance coverage shall agree to accept the benefit level, plan design, insurance providers, premium level and other terms and conditions determined by the department of administration and shall accept such other contractual arrangements made by the department of administration with health and accident insurance providers.

F. Charter schools shall reimburse the department of administration for administrative and operational costs associated with charter schools participating in the state health and accident insurance coverage determined pursuant to section 38-651, subsection K.

G. As used in this section, "state health and accident insurance coverage" means the health and accident coverage procured by the department of administration under section 38-651.

15-188. Charter schools stimulus fund

A. The charter schools stimulus fund is established for the purpose of providing financial support to charter school applicants and charter schools for start-up costs and costs associated with renovating or remodeling existing buildings and structures. The fund consists of monies appropriated by the legislature and grants, gifts, devises and donations from any public or private source. The department of education shall administer the fund.

B. The state board of education shall adopt rules to implement the provisions of this section, including application and notification requirements. If sufficient monies are appropriated for this purpose, monies from the charter schools stimulus fund shall be distributed to qualifying charter school applicants and charter schools in the following manner:

1. Each qualifying charter school applicant or charter school shall be awarded an initial grant of up to one hundred thousand dollars during or before the first year of the charter school's operation. If an applicant for a charter school receives an initial

grant pursuant to this paragraph and fails to begin operating a charter school within the next eighteen months, the applicant shall reimburse the department of education for the amount of the initial grant plus interest calculated at a rate of ten per cent a year.

2. Applicants for charter schools and charter schools that received initial grants pursuant to paragraph 1 may apply to the department of education for an additional grant of up to one hundred thousand dollars. If an applicant for a charter school receives an additional grant pursuant to this paragraph and fails to begin operating a charter school within the next eighteen months, the applicant shall reimburse the department of education for the amount of the additional grant plus interest calculated at a rate of ten per cent a year. A reimbursement required by this paragraph is in addition to any reimbursement required by paragraph 1.

C. Monies in the charter schools stimulus fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

15-189. Charter schools; vacant buildings; list; used equipment

A. The school facilities board, in conjunction with the department of administration, shall annually publish a list of vacant and unused buildings and vacant and unused portions of buildings that are owned by this state or by school districts in this state and that may be suitable for the operation of a charter school. The school facilities board shall make the list available to applicants for charter schools and to existing charter schools. The list shall include the address of each building, a short description of the building, the name of the owner of the building and any other pertinent information related to the vacancy of the building. The school facilities board shall annually submit the list to the governor, the president of the senate and the speaker of the house of representatives and provide a copy of the list to the secretary of state. If a school district decides to sell or lease a vacant and unused building or a vacant and unused portion of a building, the school district may not prohibit a charter school from negotiating to buy or lease the property in the same manner as other potential buyers or lessees. A school district shall attempt to obtain the highest possible value under current market conditions for the sale or lease of the vacant and unused building or the vacant and unused portion of a building. Nothing in this section requires the owner of a building on the list to sell or lease the building or a portion of the building to a charter school or to any other school or to any other prospective buyer or tenant.

B. A school district may sell used equipment to a charter school before the school district attempts to sell or dispose of the equipment by other means.

15-189.01. Charter schools; zoning; development fees

A. Charter schools shall be classified the same as public schools that are operated by a school district for the purposes of zoning and the assessment of zoning fees, site plan fees and development fees, including any required hearings or applications. Municipalities and counties shall allow a charter school to be established and operate at a location or in a facility for which the zoning regulations of the county or municipality cannot legally prohibit schools operated by school districts, except that a county or municipality may adopt zoning regulations that

prohibit a charter school from operating on property that is less than an acre in size and that is located within an existing single family residence zoning district.

B. Except as provided in subsection D of this section, a charter school is subject to the same level of oversight and the same rules, hearing requirements, application requirements, ordinances, limitations and other requirements, if any, that would be applied to and enforced against a school that is operated by a school district. A municipality or county shall not enforce, or attempt to enforce, any ordinance, procedure or process against a charter school that cannot be legally enforced against a school district. Voluntary compliance of a school district in the zoning regulations of a municipality or a county does not result in the application of those zoning regulations to a charter school.

C. The construction and development of the charter school facility shall be subject to the building codes, including life and safety building codes, of the municipality, county or state in which the charter school facility is located.

D. Municipalities and counties shall adopt procedures to ensure that hearings and administrative reviews involving charter schools are scheduled and conducted on an expedited basis and that charter schools receive a final determination from the municipality or county within thirty days after the beginning of processes requiring only an administrative review and within ninety days after the beginning of processes requiring a public hearing and allowing an appeal to a board of adjustment, city or town governing body or board of supervisors.

E. Except as provided in subsection F of this section, no political subdivision of this state may enact or interpret any law, rule or ordinance in a manner that conflicts with this section.

F. Notwithstanding subsections A and B of this section, a charter school shall not be established or operated on commercial or residential property in an age restricted community that is located in unorganized territory.

G. A charter school may authorize a third party to apply to a municipality or county as the representative of that charter school for any application or action prescribed in subsections A through D of this section.

15-189.02. Charter schools; public bidding requirements

A. A charter school's procurement is exempt from public bidding requirements if the aggregate dollar amount of the procurement does not exceed the maximum amount of the exemption authorized by title 41, chapter 23 or pursuant to rules adopted by the director of the department of administration.

B. Notwithstanding subsection A, the state board for charter schools may authorize an exemption from public bidding requirements that exceeds the maximum exemption prescribed in subsection A of this section for any charter school sponsored by the state board for charter schools.

15-189.03. Academic credits; transfer

A. If a pupil who was previously enrolled in a charter school or school district enrolls in a charter school in this state, the charter school shall accept credits earned by the pupil in courses or instructional programs at the charter school or school district. A charter school governing board may adopt a policy concerning the

application of transfer credits for the purpose of determining whether a credit earned by a pupil who was previously enrolled in a school district or charter school will be assigned as an elective or core credit.

B. A pupil who transfers from a charter school or school district shall be provided with a list that indicates which credits have been accepted as an elective credit and which credits have been accepted as a core credit by the charter school. Within ten school days after receiving the list, a pupil may request to take an examination in each particular course in which core credit has been denied. The charter school shall accept the credit as a core credit for each particular course in which the pupil takes an examination and receives a passing score on a test designed and evaluated by a teacher in the charter school who teaches the subject matter on which the examination is based.

15-189.04. Policies and procedures for the emergency administration of epinephrine

The governing body of each charter school shall prescribe and enforce policies and procedures for the emergency administration of auto-injectable epinephrine by a trained employee of the charter school pursuant to section 15-157.

Laws 1999, 1st SS, Chapter 4, Sec. 15. Charter school financial and compliance audits; financial statement audits; oversight responsibility

A. Notwithstanding section 15-271, subsection D, Arizona Revised Statutes, or any other law, the state board of education and the state board for charter schools, rather than the auditor general, are responsible for notifying a charter school under the board's jurisdiction if the school has failed to establish and maintain the uniform system of financial records.

B. Notwithstanding section 15-271, subsection E, Arizona Revised Statutes, or any other law, the state board of education and the state board for charter schools, rather than the auditor general, are responsible for reporting to the department of education any charter school under the board's jurisdiction that either fails to establish and maintain the uniform system of financial records that is prescribed by the auditor general or fails to correct deficiencies in the system within ninety days after receiving notice of the deficiencies.

C. Notwithstanding section 15-914, subsection D, Arizona Revised Statutes, or any other law, an independent certified public accountant who conducts an audit pursuant to section 15-914, subsections A, B and C, Arizona Revised Statutes, shall submit a uniform system of financial records compliance questionnaire to the state board that sponsors the audited charter school, rather than to the auditor general.

D. Notwithstanding section 15-914, subsection E, Arizona Revised Statutes, or any other law, contracts for all financial and compliance audits and financial statement audits for charter schools that are sponsored by the state board of education or the state board for charter schools, and the completed audits for those schools, shall be approved by the state board that sponsors the charter school affected rather than by the auditor general.

E. The requirements in subsections A and B of this section do not pertain to exceptions to requirements of the uniform system of financial records that the state

board of education or the state board for charter schools include in the charter of a charter school pursuant to section 15-183, subsection E, paragraph 6, Arizona Revised Statutes.