SOUTH CAROLINA STATE REGISTER DISCLAIMER

SOUTH CAROLINA STATE REGISTER

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SOUTH CAROLINA STATE REGISTER

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

STYLE AND FORMAT

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

Notices are documents considered by the agency to have general public interest.
Notices of Drafting Regulations give interested persons the opportunity to comment during the initial drafting period before regulations are submitted as proposed.
Proposed Regulations are those regulations pending permanent adoption by an agency.
Pending Regulations Submitted to the General Assembly are regulations adopted by the agency pending approval by the General Assembly.
Final Regulations have been permanently adopted by the agency and approved by the General Assembly.
Emergency Regulations have been adopted on an emergency basis by the agency.
Executive Orders are actions issued and taken by the Governor.

2003 PUBLICATION SCHEDULE

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

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

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

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

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

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

EFFECTIVE DATE OF REGULATIONS

Final Regulations take effect on the date of publication in the *State Register* unless otherwise noted within the text of the regulation.
Emergency Regulations take effect upon filing with the Legislative Council and remain effective for ninety days. If the original ninety-day period begins and expires during legislative interim, the regulation may be refiled for one additional ninety-day period.

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South Carolina General Assembly Home Page: www.scstatehouse.net

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2801	2-19-03	Individual Sewage Treatment and Disposal Systems	5-29-03	Department of Health and Envir Control
2800	4-02-03	Environmental Protection Fees	5-20-03	Department of Health and Envir Control
2753	5-08-03	LIFE Scholarship Program	5-13-03	Commission on Higher Education

WITHDRAWN:

DOC No.	DATE	SUBJECT		AGENCY
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DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

In accordance with Section 44-7-200(C), Code of Laws of South Carolina, the public is hereby notified that a Certificate of Need application has been accepted for filing and publication October 24, 2003, for the following project(s). After the application is deemed complete, affected persons will be notified that the review cycle has begun. For further information, please contact Mr. Albert N. Whiteside, Director, Division of Planning and Certification of Need, 2600 Bull St., Columbia, SC 29201 at (803) 545-4200.

Affecting Anderson County

Replacement of the existing Single-Slice Computed Tomography (CT) scanner with a Multi-Slice CT scanner.
Anderson Area Medical Center
Anderson, South Carolina
Project Cost: $1,650,690

Affecting Florence County

Construction of a four (4)-floor addition to the existing facility, and renovation of the emergency department, with no change in the licensed bed capacity.
Carolinas Hospital System
Florence, South Carolina
Project Cost: $28,210,000

Establish an outpatient narcotic treatment program (Methadone Treatment Center).
Center of Hope of Florence, LLC
Florence, South Carolina
Project Cost: $174,966

Conversion of 12 existing psychiatric beds to 12 general acute care beds at McLeod Regional Medical Center (MRMC) and the transfer of the remaining 23 psychiatric beds from MRMC to Wilson Medical Center for a total of 453 general acute care beds at MRMC and 49 general acute care beds and 23 psychiatric beds at Wilson Medical Center.
McLeod Regional Medical Center
Florence, South Carolina
Project Cost: $4,947,500

Affecting Lexington County

Construction of a 5-story bed tower and the addition of 54 inpatient acute care beds.
Lexington Medical Center
West Columbia, South Carolina
Project Cost: $36,097,582

Affecting Spartanburg County

Construction of three (3) additional Operating Rooms and renovation of existing space for an 18-bed orthopedic medical/surgical unit, with no change in the existing licensed beds.
Mary Black Memorial Hospital
Spartanburg, South Carolina
Project Cost: $16,787,000

Affecting Spartanburg County

Replacement of a Single-Slice Computed Tomography (CT) scanner with a Multi-Slice CT scanner.
Spartanburg Regional Medical Center
Spartanburg, South Carolina
Project Cost: $1,222,482

Affecting Sumter County

Provide mobile Positron Emission Tomography (PET) imaging services to Toumey for one (1) day per week.
Tuomey
Sumter, South Carolina
Project Cost: $299,000

Affecting Union County

Replacement of the existing Single-Slice Computed Tomography (CT) scanner with a Multi-Slice CT scanner.
Wallace Thomson Hospital
Union, South Carolina
Project Cost: $1,242,199

In accordance with S.C. DHEC Regulation 61-15, the public and affected persons are hereby notified that the review cycle has begun for the following project(s) and a proposed decision will be made within 60 days beginning October, 24, 2003. "Affected persons" have 30 days from the above date to submit comments or requests for a public hearing to Mr. Albert N. Whiteside, Director, Division of Planning and Certification of Need, 2600 Bull Street, Columbia, S.C. 29201. For further information call (803) 545-4200.

Affecting Charleston County

Addition of four (4) rehabilitation beds for a total of forty-six (46) rehabilitation beds.
HEALTHSOUTH Rehabilitation Hospital of Charleston
Charleston, South Carolina
Project Cost: $22,130

Affecting Florence County

Establish an outpatient narcotic treatment program (Methadone Treatment Center).
Center of Hope of Florence, LLC
Florence, South Carolina
Project Cost: $174,966

Affecting Greenville County

Addition of one (1) operating room to the existing ambulatory surgery center, resulting in a total of three (3) operating rooms.
Jervey Eye Center, LLC
Greenville, South Carolina
Project Cost: $755,109

Affecting Horry County

Addition of twenty (20) psychiatric beds for a total of twenty-eight (28) licensed psychiatric beds.
Lighthouse of Conway – Acute Care
Conway, South Carolina
Project Cost: $1,034,746

Affecting Lexington County

Construction of a 5-story bed tower and the addition of 54 inpatient acute care beds.
Lexington Medical Center
West Columbia, South Carolina
Project Cost: $36,097,582

Affecting Union County

Replacement of the existing Single-Slice Computed Tomography (CT) scanner with a Multi-Slice CT scanner.
Wallace Thomson Hospital
Union, South Carolina
Project Cost: $1,242,199

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

NOTICE OF AMENDMENT TO THE SOUTH CAROLINA AIR QUALITY IMPLEMENTATION PLAN

CHAPTER 61

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

SOUTH CAROLINA TRANSPORTATION CONFORMITY MEMORANDUM OF AGREEMENT

The purpose of this Memorandum of Agreement (MOA) is to implement Section 176 of the Clean Air Act (CAA), as amended (42 U.S.C. 7401 et seq.), the related requirements of 23 U.S.C. 109(j), and regulations under 40 Code of Federal Regulations (CFR) Part 93, Subpart A with respect to the conformity of transportation plans, programs, and projects that are developed, funded, or approved by the United States Department of Transportation (USDOT) and by metropolitan planning organizations (MPOs), the South Carolina Department of Transportation (SCDOT) or other recipients of funds under title 23 U.S.C. or the Federal Transit Laws (49 U.S.C Chapter 53). This MOA sets forth policy, criteria, and procedures for demonstrating and assuring conformity of such activities to applicable implementation plans developed according to Part A, Section 110 and Part D of the CAA.

This is a Memorandum of Agreement (MOA) concerning the criteria and procedures for the determination of the conformity of transportation plans, programs and projects in South Carolina areas designated as non-attainment or maintenance for National Ambient Air Quality Standards (NAAQS), pursuant to the Clean Air Act Amendments of 1990.

The Parties to this MOA are as follows: each of the Metropolitan Planning Organizations (MPO) as described in Exhibit 1, South Carolina Department of Health and Environmental Control (DHEC), the South Carolina Department of Transportation (SCDOT), Federal Highway Administration South Carolina Division Office (FHWA), the Federal Transit Administration (FTA), the United States Environmental Protection Agency Region 4 (EPA), and local publicly-owned transit agencies, not represented by aforementioned MPOs, in non-attainment and maintenance areas.

WHEREAS, the Clean Air Act Amendments of 1990 (CAAA) require the State of South Carolina to submit a revision to the *South Carolina Air Quality Implementation Plan,* also known as the State Implementation Plan (SIP) containing the criteria and procedures for determining the conformity of transportation plans, programs and projects in areas designated as air quality non-attainment or maintenance in order to conform to the purpose of the SIP to meet national ambient air quality standards; and,

WHEREAS, the CAAA (specifically Sections 121, 174, and 176), 40 Code of Federal Regulations (CFR), Part 93, Subpart A, Title 23 United States Code (U.S.C.) 134, and 23 CFR Part 450 Subpart C, require intergovernmental consultation before findings of conformity for the plans, programs and projects are made, and for the development and submittal of applicable implementation plan revisions; and,

WHEREAS, the CAAA in Section 110(a)(2)(A) and (E) requires SIP revisions to be enforceable under state law, and 40 CFR § 51.390(d) requires that, "in order for EPA to approve the implementation plan revision submitted to EPA and DOT under this Subpart, the plan must address all requirements of Part 93, Subpart A of this chapter in a manner which gives them full legal effect"; and,

WHEREAS, the MPOs were created by federal highway and transit statutes for the spending of federal highway or transit funds within the MPO boundaries and have the authority for planning, programming, and coordination of federal highway and transit investments; and,

WHEREAS, the DHEC has been designated pursuant to South Carolina law and by the EPA as the state air quality planning agency and as the state administrator of the approved Air Quality Program for the State of South Carolina; and,

WHEREAS, the SCDOT has been designated as the State transportation planning agency under South Carolina law to carry out the statewide transportation planning process required by Title 23 U.S.C. 135, and has the authority for planning, programming, and coordination of federal highway and transit investments in areas that are not within the MPO boundaries; and,

WHEREAS, the FHWA and FTA are agencies of the United States Department of Transportation and are responsible for review and approval of the conformity determinations prepared for compliance with 23 U.S.C. and 49 U.S.C., respectively; and,

WHEREAS, the EPA is responsible for providing comment on conformity determinations; and,

WHEREAS, the local publicly-owned transit agencies in non-attainment or maintenance areas shall be responsible for providing support on transportation planning activities to the other Parties of this MOA.

NOW, THEREFORE, it is hereby agreed:

The Parties shall cooperatively support and implement the conformity criteria and procedures contained herein in order to ensure that the plans, programs and projects adopted by the Parties conform to the purpose of the SIP to meet national ambient air quality standards.

It is further agreed and understood by each Party that:

1. The conformity of plans, programs, and projects funded under Title 23 United States Code and the Federal Transit Act shall be determined pursuant to the CAAA and as provided in 40 CFR Part 93 Subpart A, as amended, and pursuant to the "South Carolina Criteria and Interagency Consultation Procedures for the Determination of the Conformity of Transportation Plans, Programs, and Projects", a copy of which is attached as Exhibit 2.

2. This MOA including Exhibit 1 and Exhibit 2 will constitute a revision to the South Carolina SIP required by Section 176 of the CAAA and will govern conformity determinations in the State of South Carolina.

3. Execution of this MOA by each Party shall be by signature of each Party's representative.

4. The provisions of this MOA shall be implemented through appropriate procedures, resolutions, or other means, in order to comply with the requirements of all Federal and State laws and regulations relating to the determination of conformity and the development of applicable implementation plan revisions. This MOA defines and delineates the roles, processes, and responsibilities of each signatory as provided in Exhibits 1 and 2 made part of this MOA.

Agreed to this 25th day of April , 2002:

The Columbia Area Transportation Study
Metropolitan Planning Organization

Signed by Walton J. McLeod, III .
Walton J. McLeod, III, Chairman
Board of Directors
Central Midlands Council of Governments

Agreed to this 4th day of April, 2002:

Greenville Area Transportation Study
Metropolitan Planning Organization

Signed by F. James Forbes .
F. James Forbes, Director
Greenville County Planning Commission

Agreed to this 8th day of April, 2002:

The Spartanburg Area Transportation Study
Metropolitan Planning Organization

Signed by Karen Floyd .
Karen Floyd, Chair
Spartanburg Area Transportation Study Policy Committee

Agreed to this 5th day of April, 2002:

Augusta Regional Transportation Study
Metropolitan Planning Organization

Signed by G A Patty .
George A. Patty, Executive Director
Augusta-Richmond County Planning Commission

Agreed to this _____ day of _____, 2002:

Augusta Regional Transportation Study
Metropolitan Planning Organization

Signed by Ronnie Young .
Ronnie Young, Chairman
Aiken County Council

APPROVED
AS TO FORM AND CONTENT
BELL, SURASKY & BROWN, P.A.
AIKEN COUNTY
BY x 6/19 x

Agreed to this 3rd day of June, 2002:

Rock Hill/Fort Mill Area Transportation Study
Metropolitan Planning Organization

Signed by C. Michael Short .
C. Michael Short, Chairman
Rock Hill/Fort Mill Area Transportation Study Policy Committee

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Agreed to this 23rd day of April, 2002:

Florence Area Transportation Study
Metropolitan Planning Organization

Signed by Elizabeth M. Matthews .
Elizabeth Matthews, Planning Director
Florence County

Agreed to this 7th day of April, 200~~2~~:**3**

Anderson Area Transportation Study
Metropolitan Planning Organization

Signed by Richard A. Shirley .
Mayor Richard A. Shirley, Chairman
Anderson Area Transportation Study

Agreed to this 2nd day of April, 2002:

Charleston Area Transportation Study
Metropolitan Planning Organization

Signed by R. Keith Summey .
R. Keith Summey, Chairman,
Charleston Area Transportation Study Policy Committee

Agreed to this 8th day of April, 2002:

Grand Strand Area Transportation Study
Metropolitan Planning Organization

Signed by Tomas G. Keegan.
Representative Tomas G. Keegan, Chairman
Grand Strand Area Transportation Study Policy Committee

Agreed to this 6 day of June, 2002:

Sumter Area Transportation Study
Metropolitan Planning Organization

Signed by Joseph T. McElveen.
Mayor Joseph T. McElveen, Jr., Chairman
Sumter Area Transportation Study

Agreed to this 26 day of March, 2002:

The South Carolina Department of Health and Environmental Control

Signed by R. Lewis Shaw.
R. Lewis Shaw, P.E., Deputy Commissioner
Environmental Quality Control

Agreed to this 13 day of February, 200~~2~~:**3**

Recommended By

Signed by D. H. Freeman.
D. H. Freeman, State Highway Engineer

The South Carolina Department of Transportation

Signed by Elizabeth Mabry.
Elizabeth Mabry, Executive Director

Agreed to this 9th day of April, 2002:

Federal Highway Administration South Carolina Division Office

Signed by Robert L. Lee.
Robert L. Lee, Division Administrator

Agreed to this 29th day of April, 2002:

The Federal Transit Administration

Signed by Jerry A. Franklin .
Jerry Franklin, Region Administrator

Agreed to this 31st day of May, 2002:

The United States Environmental Protection Agency
Region 4 Office

Signed by A. Stanley Meiburg for .
James I. Palmer, Jr., Administrator
EPA Region 4

EXHIBIT 1

Description of Metropolitan Planning Organizations

Columbia MPO - That portion of Lexington, Richland, and Calhoun counties distinctly defined and known as the Columbia Area Transportation Study (COATS).

Greenville MPO - That portion of Greenville, Laurens, Pickens, and Spartanburg counties distinctly defined and known as the Greenville Area Transportation Study (GRATS).

Spartanburg MPO - That portion of Spartanburg County distinctly defined and known as the Spartanburg Area Transportation Study (SPATS).

Augusta-Aiken MPO - That portion of Richmond and Columbia counties in the State of Georgia and that portion of Aiken County in the State of South Carolina distinctly defined and known as the Augusta Regional Transportation Study (ARTS).

Rock Hill/Fort Mill MPO - That portion of York County distinctly defined and known as the Rock Hill/Fort Mill Area Transportation Study (RFATS).

Florence MPO - That portion of Florence and Darlington counties distinctly defined and known as the Florence Area Transportation Study (FLATS).

Anderson MPO - That portion of Anderson County distinctly defined and known as the Anderson Area Transportation Study (ANATS).

Charleston MPO - That portion of Berkeley, Charleston and Dorchester counties distinctly defined and known as the Charleston Area Transportation Study (CHATS).

Grand Strand MPO - That portion of Horry and Georgetown counties distinctly defined and known as the Grand Strand Area Transportation Study (GSATS).

Sumter MPO - That portion of Sumter County distinctly defined and known as the Sumter Area Transportation Study (SUATS).

The above descriptions are intended to distinguish legal boundaries only. The MOA and associated exhibits are not valid for any portions outside of South Carolina.

EXHIBIT 2

South Carolina Criteria and Interagency Consultation Procedures for the Determination of the Conformity of Transportation Plans, Programs, and Projects

A. General

Pursuant to 40 CFR § 93.105, this document provides for interagency consultation (federal, state, and local), resolution of conflicts and public consultation procedures. Consultation procedures shall be undertaken prior to making transportation conformity determinations and prior to adopting applicable *South Carolina Air Quality Implementation Plan*, also known as the State Implementation Plan (SIP) revisions.

B. Interagency Consultation Procedures: General Procedures Factors

1. Representatives of the MPOs, the South Carolina Department of Health and Environmental Control (DHEC), the South Carolina Department of Transportation (SCDOT), and local publicly-owned transit agencies, not associated with the MPOs, shall collectively undertake an interagency consultation process in accordance with the procedures outlined herein with regional representatives of the United States Environmental Protection Agency (EPA), the Federal Highway Administration (FHWA), and the Federal Transit Administration (FTA) on the development of the applicable implementation plan, the list of transportation control measures (TCM) in the applicable implementation plan under Title 23 CFR § 450.314, the transportation plan (TP), the Transportation Improvement Program (TIP), any revisions to the preceding documents, and associated conformity determinations.

2. For the purposes of regular consultation, the affected agencies shall include:
   a. MPOs (Metropolitan Planning Organizations) in non-attainment or maintenance areas;
   b. DHEC (South Carolina Department of Health and Environmental Control);
   c. SCDOT (South Carolina Department of Transportation);
   d. FHWA (Federal Highway Administration South Carolina Division Office);
   e. FTA (Federal Transit Administration);
   f. EPA Region 4 (Environmental Protection Agency); and,
   g. Local publicly-owned transit agencies, not associated with the MPOs, in non-attainment or maintenance areas.

3. The MPO, as the lead transportation planning agency, shall have the primary responsibility in its designated non-attainment or maintenance area for developing the TP, the TIP, and project-level technical analyses by employing travel-demand modeling techniques, acquiring all necessary data, and coordinating these activities with agencies specified in Subsection B.2. The MPO shall work in consultation with SCDOT and local publicly-owned transit agencies, not associated with the MPOs, in developing these documents. The MPO shall be responsible for providing written notification of all scheduled meetings concerning transportation and related air quality issues to each of the affected agencies. Notification shall not be less than seven (7) calendar days prior to the meeting and any scheduling changes shall be coordinated in a timely manner. When the MPO is not the lead transportation planning agency, SCDOT shall have the same responsibilities as the MPO in fulfilling all applicable provisions of the consultative process and transportation conformity determinations.

4. The MPO shall notify each affected agency of all transportation planning activities for all federal and nonfederal projects that are regionally significant and therefore need to be included in regional emissions analysis when estimating emissions from mobile sources in non-attainment and maintenance areas.

5. DHEC, as the state air quality lead agency, shall have primary responsibility for developing transportation-related state implementation plans (SIP), air quality modeling demonstrations, emissions inventories, and related activities. Transportation-related SIPs shall be prepared by DHEC with the assistance of the affected agencies. DHEC shall distribute documents to all affected agencies for review and comment. DHEC shall schedule public hearings to receive public comment on transportation-related SIPs. Comments and responses to comments shall be included in applicable SIP submittals to EPA.

6. For purposes of regular consultation, organizational representation shall be defined as follows:
   a. MPO, Executive Director or designee;
   b. DHEC, Environmental Quality Control Deputy Commissioner or designee;
   c. SCDOT, Executive Director or designee;
   d. FWHA, Division Administrator or designee;
   e. FTA, Director of Office of Program Development or designee;
   f. EPA, Regional Administrator or designee; and,
   g. Local publicly-owned transit agencies.

7. Other specific roles and responsibilities of various participants in the interagency consultation process shall be as follows:

   a. The MPO, or SCDOT if there is no MPO for the area, shall be responsible for:
      i. developing transportation plans, projects, and TIPs;
      ii. evaluating the transportation impacts of TCMs;
      iii. developing transportation and socioeconomic data and planning assumptions and providing such data and planning assumptions to DHEC for use in air quality analysis to determine conformity of transportation plans, TIPs, and projects;
      iv. monitoring of regionally significant projects;
      v. developing system- or facility- based or other programmatic (non-regulatory) TCMs;
      vi. providing technical and policy input on emissions budgets;
      vii. performing transportation modeling for the purposes of generating the TIP or projects, regional emissions analyses and documentation of timely implementation of TCMs needed for conformity assessments; and,
      viii. developing draft and final conformity determination documents for all transportation plans, programs, and projects.

   b. DHEC shall be responsible for:
      i. developing emissions inventories;
      ii. developing emissions budgets;
      iii. air quality modeling;
      iv. attainment demonstrations;
      v. control strategy implementation plan revisions;
      vi. regulatory TCMs; and,
      vii. motor vehicle emissions factors.

   c. The SCDOT shall be responsible for:
      i. developing statewide transportation plans and Statewide Transportation Improvement Programs (STIPs);
      ii. providing technical input on proposed revisions to motor vehicle emissions factors;
      iii. distributing draft and final project environmental documents to other agencies;

iv. convening air quality technical review meetings on specific projects when requested by other agencies, or as needed;

v. developing updated motor vehicle emissions estimates and projections; and,

vi. choosing and evaluating transportation models and associated methods and assumptions to be used in hot spot and regional emissions analyses.

d. The FHWA and FTA shall be responsible for:

i. assuring timely action on final findings of conformity, after consultation with other agencies as provided in this paragraph and 40 CFR § 93.105;

ii. providing guidance on conformity and the transportation planning process to agencies in interagency consultation; and,

iii. review, comment, and approval of conformity determinations.

e. The EPA shall be responsible for:

i. reviewing and approving updated motor vehicle emissions factors;

ii. providing guidance on conformity criteria and procedures to agencies in interagency consultation;

iii. approving emission budgets and state implementation revisions (including TCMs);

iv. providing modeling and emission inventory development assistance to the SCDOT, DHEC, and MPO; and,

v. providing comments on the regional emissions analyses and conformity determinations of transportation plans and TIPs.

f. The local publicly-owned transit agencies, not associated with the MPOs, in non-attainment or maintenance areas shall be responsible for:

i. supporting and conducting, as necessary, the transportation planning activities for public transportation service including transit operations; and,

ii. providing the MPO with the information necessary for annual endorsement of Federal Transit Administration programs.

8. Before adoption and approval of conformity analyses prepared for plans, TIPs, and projects, the MPO and/or SCDOT, as the lead transportation planning agency, shall distribute a final draft of the documents, including supporting technical materials, to the affected agencies for review and comments. Affected agencies shall review and submit written comments to the lead agency within thirty (30) calendar days. The lead agency shall respond to written comments made by the affected agencies on plans, TIPs, projects, or SIPs in writing within thirty (30) calendar days. Comments and responses to comments shall be distributed for review by all affected agencies. Following resolution of all significant issues, final documents shall be revised accordingly and submitted to the designated lead agency for formal adoption and approval.

9. Meetings of the group of affected agencies shall convene for the specific purpose of considering issues with regard to the conformity of transportation plans, TIPs, and projects with the transportation conformity SIP. The frequency of these meetings shall be determined jointly by the specified transportation and air quality lead agencies. Affected agencies shall meet on a regular basis, at least quarterly, unless the lead agencies determine there is a need for an earlier meeting or, alternatively, that there is no need for the regularly scheduled meeting. Based upon comments received, the lead agency may schedule a meeting where consultation with all affected agencies concerned can be accomplished simultaneously for the resolution of comments and issues. Meeting agendas are the responsibility of the designated lead agency.

10. Where TCMs are to be included in applicable SIPs in urbanized non-attainment or maintenance areas, a list of TCMs shall be selected and developed by the MPO in cooperation with other affected agencies. This list of TCMs shall be distributed to all cooperating agencies by DHEC after its review and consultation with the MPO. The list of TCMs shall be made available for inspection or copying for all interested persons and agencies.

C. Interagency Consultation Procedures: Specific Processes

1. An interagency consultation process in accordance with Subsection B involving the MPO, DHEC, SCDOT, EPA, and FHWA/FTA shall be undertaken for the following:

a. evaluating and choosing a model(s) and associated methods and assumptions to be used in hot-spot analyses and regional emissions analyses;

b. for purposes of regional emissions analysis, the MPO shall actively consult with the affected agencies to determine which minor arterials and other transportation projects should be considered "regionally significant" projects (in addition to those functionally classified as principal arterial or higher or fixed guideway systems or extensions that offer an alternative to regional highway travel) and which projects should be considered to have a significant change in design concept and scope from the transportation plan or TIP. The MPO shall consider the views of each agency that comments or responds in writing prior to any final action on these issues. If the MPO receives no comments within thirty (30) calendar days, the MPO may assume consensus by the affected agencies;

c. the MPO shall submit a list of exempt projects to affected agencies to evaluate whether projects otherwise exempted from meeting the requirements of 40 CFR Part 93 Subpart A (see Sections 93.126 and 127) should be treated as nonexempt in cases where potential adverse emissions impacts may exist for any reason. The MPO shall allow thirty (30) calendar days for comments;

d. the MPO and/or SCDOT, in consultation with the affected agencies shall make a determination, as required by 40 CFR § 93.113(c)(1), whether past obstacles to implementation of TCMs that are behind the schedule established in the applicable implementation plan have been identified and are being overcome and whether state and local agencies with influence over approvals or funding for TCMs are giving maximum priority to approval or funding for TCMs. This process shall also consider whether delays in TCM implementation necessitate revisions to the applicable implementation plan to remove TCMs or substitute TCMs or other emission reduction measures;

e. the MPO and/or SCDOT, in consultation with the affected agencies, shall identify, as required by 40 CFR § 93.123(b), projects located at sites in PM_{10} non-attainment areas that have vehicle and roadway emission and dispersion characteristics that are essentially identical to those at sites which have violations verified by monitoring and, therefore, require quantitative PM_{10} hot-spot analysis;

f. the MPO shall notify the affected agencies of transportation plan or TIP revisions or amendments which merely add or delete exempt projects listed in 40 CFR § 93.126 or 93.127 and allow a thirty (30) day comment period; and,

g. the SCDOT, in consultation with the affected agencies, shall cooperatively choose the appropriate conformity test(s) and methodologies for use in isolated rural non-attainment and maintenance areas, as required by 40 CFR § 93.109(g)(2)(iii) and for any non-attainment or maintenance area for which an emissions budget has not been developed and approved.

2. An interagency consultation process in accordance with Subsection B, involving the MPO, DHEC and SCDOT shall be undertaken for the following:

a. DHEC, in cooperation with the MPO and SCDOT, shall evaluate events that will trigger new conformity determinations in addition to those triggering events established in 40 CFR § 93.104. DHEC may require a new conformity determination in the event of any unforeseen circumstances; and,

b. the MPOs shall share cooperatively the responsibilities of conducting conformity determinations on transportation activities which cross the borders of two or more MPOs' non-attainment or maintenance areas.

The MPOs will enter into a memorandum of agreement which will define the effective boundary and the respective responsibilities for each MPO for regional emissions analysis. Adjacent MPOs of non-attainment or maintenance areas shall share information concerning air quality modeling assumptions and emission rates that affect both areas.

3. For the purposes of determining the conformity of all projects outside the metropolitan planning area, but within the non-attainment or maintenance area, the MPO shall enter into a memorandum of agreement involving the MPO and SCDOT for cooperative planning and analysis of projects.

4. a. An interagency consultation process in accordance with Subsection B involving the MPO, DHEC, SCDOT, and recipients of funds designated under title 23 U.S.C. or the Federal Transit Act shall be undertaken to ensure that plans for construction of regionally significant projects which are not FHWA/FTA projects (including projects for which alternative locations, design concept and scope, or the no-build option are still being considered), including all those by recipients of funds designated under Title 23 U.S.C. or the Federal Transit Act, are disclosed to the MPO on a regular basis, and to ensure that any changes to those plans are immediately disclosed.

b. The sponsor of any such regionally significant project, and any agency that becomes aware of any such project through applications for approval, permitting or funding or otherwise, shall disclose such project to the MPO in a timely manner. Such disclosure shall be made not later than the first occasion on which any of the following actions is sought: any policy board action necessary for the project to proceed, the issuance of administrative permits for the facility or for construction of the facility, the execution of a contract to design or construct the facility, the execution of any indebtedness for the facility, any final action of a board, commission or administrator authorizing or directing employees to proceed with design, permitting or construction of the project, or the execution of any contract to design or construct or any approval needed for any facility that is dependent on the completion of the regionally significant project. To help assure timely disclosure, the sponsor of any potential regionally significant project shall disclose to the MPO within thirty (30) calendar days of acknowledgment of each project for which alternatives have been identified through the National Environmental Policy Act (NEPA) process, and in particular, any preferred alternative that may be a regionally significant project.

c. In the case of any such regionally significant project that has not been disclosed to the MPO and other interested agencies participating in the consultation process in a timely manner, such regionally significant project shall be deemed not to be included in the regional emissions analysis supporting the currently conforming plan and TIP's conformity determination and not to be consistent with the motor vehicle emissions budget in the applicable implementation plan, for the purposes of 40 CFR § 93.121.

d. For the purposes of the procedures outlined herein and 40 CFR § 93.121, the phrase "adopt or approve of a regionally significant project" means the first time any action necessary to authorizing a project occurs, such as any policy board action necessary for the project to proceed, the issuance of administrative permits for the facility or for construction of the facility, the execution of a contract to construct the facility, any final action of a board, commission or administrator authorizing or directing employees to proceed with construction of the project, or any written decision or authorization from the MPO that the project may be adopted or approved.

5. The MPO, in accordance with Subsections B and C.4, and other recipients of funds designated under title 23 U.S.C. or the Federal Transit Laws, shall cooperatively assume the location and design concept and scope of projects that are disclosed to the MPO as required by Subsection C.4, but whose sponsors have not yet decided these features in sufficient detail to perform the regional emissions analysis according to the requirements of 40 CFR § 93.122.

6. The MPO, in accordance with Subsection B, shall notify DHEC, SCDOT, and local transportation agencies not associated with the MPOs, and shall seek their input for the design, schedule, and funding of

research and data collection efforts and regional transportation model development by the MPO (e.g., household/travel transportation surveys).

7. Within fifteen (15) calendar days subsequent to approval and adoption of final documents, including transportation plans, TIPs, conformity approvals, applicable implementation plans and implementation plan revisions, the lead agency; that is, either DHEC, the MPO, or SCDOT, shall provide copies of such documents and supporting information to all affected agencies.

D. Resolving Conflicts

1. Any conflicts among state agencies or between state agencies and an MPO shall be escalated to the Governor of South Carolina (Governor) if the conflict cannot be resolved by the heads of the involved agencies.

2. In the event that the MPO or SCDOT determines that every effort has been made to address DHEC concerns and no further progress is possible, the MPO or SCDOT shall notify the representative of DHEC, as defined in Subsection B.6., in writing to this effect. Section 93.105(d) of 40 CFR shall be cited by the MPO or SCDOT in any notification of a conflict which may require action by the Governor.

3. DHEC has fourteen (14) calendar days to appeal a proposed determination of conformity (or other policy decision under this agreement) to the Governor after the MPO or SCDOT has notified DHEC of the resolution of all comments on such proposed determination of conformity or policy decision. Such fourteen (14) day period shall commence when the MPO or SCDOT has confirmed receipt by DHEC of the resolution of DHEC's comments. If DHEC appeals to the Governor, the final conformity determination must have the concurrence of the Governor. DHEC must provide notice of any appeal under this Subsection to the MPO and SCDOT. If DHEC does not appeal to the Governor within fourteen (14) calendar days, the MPO or SCDOT may proceed with the final conformity determination.

4. The Governor may delegate the role of hearing any such appeal under this Subsection, but not to the head or staff of DHEC, SCDOT, a state transportation commission or board, or an MPO.

E. Public Consultation Procedures

Consistent with the requirements of 23 CFR § 450.316(b), relating to public involvement, affected agencies making conformity determinations on transportation plans, programs, and projects shall establish and continuously implement a proactive public involvement process that provides opportunity for public review and comment prior to taking formal action on a conformity determination for all transportation plans and TIPs. This process shall, at a minimum, provide reasonable public access to technical and policy information considered by the agency at the beginning of the public comment period and before taking formal action on conformity determinations for all transportation plans and TIPs. Any charges imposed for public inspection and copying of conformity-related materials shall be consistent with South Carolina Title 30 Chapter 4 Freedom of Information Act. In addition, any such agency must specifically address in writing any public comments claiming that known plans for a regionally significant project that is not receiving FHWA or FTA funding or approval have not been properly reflected in the emissions analysis supporting a proposed conformity finding for a transportation plan or TIP. Any such agency shall also provide opportunity for public involvement in conformity determinations for projects where otherwise required by law. The opportunity for public involvement provided under this Subsection shall include access to information, emissions data, analyses, models and modeling assumptions used to perform a conformity determination, and the obligation of any such agency to consider and respond to significant comments. No transportation plan, TIP, or project may be found to conform unless the determination of conformity has been subject to a public involvement process in accordance with this Subsection, without regard to whether the DOT has certified any process under 23 CFR 450.

EXHIBIT 3

Incorporating into the *South Carolina Air Quality Implementation Plan*
as Criteria and Procedures for the Determination of Conformity

The Parties to the MOA are as follows: each of the Metropolitan Planning Organizations (MPO) as described in Exhibit 1, South Carolina Department of Health and Environmental Control (DHEC), the South Carolina Department of Transportation (SCDOT), Federal Highway Administration South Carolina Division Office (FHWA), the Federal Transit Administration (FTA), the United States Environmental Protection Agency Region 4 (EPA), and local publicly-owned transit agencies, not represented by aforementioned MPOs, in non-attainment and maintenance areas.

The Parties to the MOA agree that: "The conformity of plans, programs, and projects funded under Title 23 United States Code and the Federal Transit Act shall be determined pursuant to the CAAA and as provided in 40 CFR Part 93 Subpart A, as amended, and pursuant to the "South Carolina Criteria and Interagency Consultation Procedures for the Determination of the Conformity of Transportation Plans, Programs, and Projects," a copy of which is attached as Exhibit 2."

The Parties to the MOA agree to conduct transportation conformity determinations in accordance with the provisions of the following sections of 40 CFR Part 93 Subpart A, as amended:

93.101 - Definitions.
93.102 - Applicability.
93.103 - Priority.
93.104 - Frequency Of Conformity Determinations.
93.106 - Content Of Transportation Plans.
93.109 - Criteria And Procedures For Determining Conformity Of Transportation Plans, Programs, And Projects: General.
93.110 - Criteria And Procedures: Latest Planning Assumptions.
93.111 - Criteria And Procedures: Latest Emissions Model.
93.112 - Criteria And Procedures: Consultation.
93.113 - Criteria And Procedures: Timely Implementation Of TCMs.
93.114 - Criteria And Procedures: Currently Conforming Transportation Plan And TIP.
93.115 - Criteria And Procedures: Projects From A Plan And TIP.
93.116 - Criteria And Procedures: Localized CO And PM_{10} Violations (Hot Spots).
93.117 - Criteria And Procedures: Compliance With PM_{10} Control Measures.
93.118 - Criteria And Procedures: Motor Vehicle Emissions Budget.
93.119 - Criteria And Procedures: Emission Reductions In Areas Without Motor Vehicle Emissions Budgets.
93.120 - Consequences Of Control Strategy Implementation Plan Failures.
93.121 - Requirements For Adoption Or Approval Of Projects By Other Recipients Of Funds Designated Under Title 23 U.S.C. Or The Federal Transit Laws.
93.126 - Exempt Projects.
93.127 - Projects Exempt From Regional Emissions Analyses.

Title 40 Code Of Federal Regulations (CFR)
Chapter I - Environmental Protection Agency
Part 93 - Determining Conformity of Federal Actions to State or Federal Implementation Plans

Subpart A - Conformity to State or Federal Implementation Plans of Transportation Plans, Programs, and Projects Developed, Funded or Approved Under Title 23 U.S.C. or the Federal Transit Laws

40 CFR § 93.101 Definitions.

Terms used but not defined in this subpart shall have the meaning given them by the CAA, titles 23 and 49 U.S.C., other Environmental Protection Agency (EPA) regulations, or other DOT regulations, in that order of priority.

Applicable implementation plan is defined in section 302(q) of the CAA and means the portion (or portions) of the implementation plan, or most recent revision thereof, which has been approved under section 110, or promulgated under section 110(c), or promulgated or approved pursuant to regulations promulgated under section 301(d) and which implements the relevant requirements of the CAA.

CAA means the Clean Air Act, as amended (42 U.S.C. 7401 et seq.).

Cause or contribute to a new violation for a project means:

(1) To cause or contribute to a new violation of a standard in the area substantially affected by the project or over a region which would otherwise not be in violation of the standard during the future period in question, if the project were not implemented; or

(2) To contribute to a new violation in a manner that would increase the frequency or severity of a new violation of a standard in such area.

Clean data means air quality monitoring data determined by EPA to meet the requirements of 40 CFR part 58 that indicate attainment of the national ambient air quality standard.

Control strategy implementation plan revision is the implementation plan which contains specific strategies for controlling the emissions of and reducing ambient levels of pollutants in order to satisfy CAA requirements for demonstrations of reasonable further progress and attainment (CAA sections 182(b)(1), 182(c)(2)(A), 182(c)(2)(B), 187(a)(7), 189(a)(1)(B), and 189(b)(1)(A); and sections 192(a) and 192(b), for nitrogen dioxide).

Design concept means the type of facility identified by the project, e.g., freeway, expressway, arterial highway, grade-separated highway, reserved right-of-way rail transit, mixed-traffic rail transit, exclusive busway, etc.

Design scope means the design aspects which will affect the proposed facility's impact on regional emissions, usually as they relate to vehicle or person carrying capacity and control, e.g., number of lanes or tracks to be constructed or added, length of project, signalization, access control including approximate number and location of interchanges, preferential treatment for high-occupancy vehicles, etc.

DOT means the United States Department of Transportation.

EPA means the Environmental Protection Agency.

FHWA means the Federal Highway Administration of DOT.

FHWA/FTA project, for the purpose of this subpart, is any highway or transit project which is proposed to receive funding assistance and approval through the Federal-Aid Highway program or the Federal mass transit program, or requires Federal Highway Administration (FHWA) or Federal Transit Administration (FTA) approval for some aspect of the project, such as connection to an interstate highway or deviation from applicable design standards on the interstate system.

Forecast period with respect to a transportation plan is the period covered by the transportation plan pursuant to 23 CFR part 450.

FTA means the Federal Transit Administration of DOT.

Highway project is an undertaking to implement or modify a highway facility or highway-related program. Such an undertaking consists of all required phases necessary for implementation. For analytical purposes, it must be defined sufficiently to:

(1) Connect logical termini and be of sufficient length to address environmental matters on a broad scope;

(2) Have independent utility or significance, i.e., be usable and be a reasonable expenditure even if no additional transportation improvements in the area are made; and

(3) Not restrict consideration of alternatives for other reasonably foreseeable transportation improvements.

Horizon year is a year for which the transportation plan describes the envisioned transportation system according to § 93.106.

Hot-spot analysis is an estimation of likely future localized CO and PM10 pollutant concentrations and a comparison of those concentrations to the national ambient air quality standards. Hot-spot analysis assesses impacts on a scale smaller than the entire nonattainment or maintenance area, including, for example, congested roadway intersections and highways or transit terminals, and uses an air quality dispersion model to determine the effects of emissions on air quality.

Increase the frequency or severity means to cause a location or region to exceed a standard more often or to cause a violation at a greater concentration than previously existed and/or would otherwise exist during the future period in question, if the project were not implemented.

Lapse means that the conformity determination for a transportation plan or TIP has expired, and thus there is no currently conforming transportation plan and TIP.

Maintenance area means any geographic region of the United States previously designated nonattainment pursuant to the CAA Amendments of 1990 and subsequently redesignated to attainment subject to the requirement to develop a maintenance plan under section 175A of the CAA, as amended.

Maintenance plan means an implementation plan under section 175A of the CAA, as amended.

Metropolitan planning organization (MPO) is that organization designated as being responsible, together with the State, for conducting the continuing, cooperative, and comprehensive planning process under 23 U.S.C. 134 and 49 U.S.C. 5303. It is the forum for cooperative transportation decision-making.

Milestone has the meaning given in sections 182(g)(1) and 189(c) of the CAA. A milestone consists of an emissions level and the date on which it is required to be achieved.

Motor vehicle emissions budget is that portion of the total allowable emissions defined in the submitted or approved control strategy implementation plan revision or maintenance plan for a certain date for the purpose of meeting reasonable further progress milestones or demonstrating attainment or maintenance of the NAAQS, for any criteria pollutant or its precursors, allocated to highway and transit vehicle use and emissions.

National ambient air quality standards (NAAQS) are those standards established pursuant to section 109 of the CAA.

NEPA means the National Environmental Policy Act of 1969, as amended (42 U.S.C. 4321 et seq.).

NEPA process completion, for the purposes of this subpart, with respect to FHWA or FTA, means the point at which there is a specific action to make a determination that a project is categorically excluded, to make a Finding of No Significant Impact, or to issue a record of decision on a Final Environmental Impact Statement under NEPA.

Nonattainment area means any geographic region of the United States which has been designated as nonattainment under section 107 of the CAA for any pollutant for which a national ambient air quality standard exists.

Project means a highway project or transit project.

Protective finding means a determination by EPA that a submitted control strategy implementation plan revision contains adopted control measures or written commitments to adopt enforceable control measures that fully satisfy the emissions reductions requirements relevant to the statutory provision for which the implementation plan revision was submitted, such as reasonable further progress or attainment.

Recipient of funds designated under title 23 U.S.C. or the Federal Transit Laws means any agency at any level of State, county, city, or regional government that routinely receives title 23 U.S.C. or Federal Transit Laws funds to construct FHWA/FTA projects, operate FHWA/FTA projects or equipment, purchase equipment, or undertake other services or operations via contracts or agreements. This definition does not include private landowners or developers, or contractors or entities that are only paid for services or products created by their own employees.

Regionally significant project means a transportation project (other than an exempt project) that is on a facility which serves regional transportation needs (such as access to and from the area outside of the region, major activity centers in the region, major planned developments such as new retail malls, sports complexes, etc., or transportation terminals as well as most terminals themselves) and would normally be included in the modeling of a metropolitan area's transportation network, including at a minimum all principal arterial highways and all fixed guideway transit facilities that offer an alternative to regional highway travel.

Safety margin means the amount by which the total projected emissions from all sources of a given pollutant are less than the total emissions that would satisfy the applicable requirement for reasonable further progress, attainment, or maintenance.

Standard means a national ambient air quality standard.

Transit is mass transportation by bus, rail, or other conveyance which provides general or special service to the public on a regular and continuing basis. It does not include school buses or charter or sightseeing services.

Transit project is an undertaking to implement or modify a transit facility or transit-related program; purchase transit vehicles or equipment; or provide financial assistance for transit operations. It does not include actions that are solely within the jurisdiction of local transit agencies, such as changes in routes, schedules, or fares. It may consist of several phases. For analytical purposes, it must be defined inclusively enough to:

(1) Connect logical termini and be of sufficient length to address environmental matters on a broad scope;

(2) Have independent utility or independent significance, i.e., be a reasonable expenditure even if no additional transportation improvements in the area are made; and

(3) Not restrict consideration of alternatives for other reasonably foreseeable transportation improvements.

Transportation control measure (TCM) is any measure that is specifically identified and committed to in the applicable implementation plan that is either one of the types listed in section 108 of the CAA, or any other measure for the purpose of reducing emissions or concentrations of air pollutants from transportation sources by reducing vehicle use or changing traffic flow or congestion conditions. Notwithstanding the first sentence of this definition, vehicle technology-based, fuel-based, and maintenance-based measures which control the emissions from vehicles under fixed traffic conditions are not TCMs for the purposes of this subpart.

Transportation improvement program (TIP) means a staged, multiyear, intermodal program of transportation projects covering a metropolitan planning area which is consistent with the metropolitan transportation plan, and developed pursuant to 23 CFR part 450.

Transportation plan means the official intermodal metropolitan transportation plan that is developed through the metropolitan planning process for the metropolitan planning area, developed pursuant to 23 CFR part 450.

Transportation project is a highway project or a transit project.

Written commitment for the purposes of this subpart means a written commitment that includes a description of the action to be taken; a schedule for the completion of the action; a demonstration that funding necessary to implement the action has been authorized by the appropriating or authorizing body; and an acknowledgment that the commitment is an enforceable obligation under the applicable implementation plan.

[58 FR 62234, Nov. 24, 1993; 60 FR 57179, Nov. 14, 1995; 62 FR 43780, August 15, 1997]

40 CFR § 93.102 Applicability.

(a) Action applicability.

(1) Except as provided for in paragraph (c) of this section or § 93.126, conformity determinations are required for:

(i) The adoption, acceptance, approval or support of transportation plans and transportation plan amendments developed pursuant to 23 CFR part 450 or 49 CFR part 613 by an MPO or DOT;

(ii) The adoption, acceptance, approval or support of TIPs and TIP amendments developed pursuant to 23 CFR part 450 or 49 CFR part 613 by an MPO or DOT; and

(iii) The approval, funding, or implementation of FHWA/FTA projects.

(2) Conformity determinations are not required under this subpart for individual projects which are not FHWA/FTA projects. However, § 93.121 applies to such projects if they are regionally significant.

(b) Geographic applicability. The provisions of this subpart shall apply in all nonattainment and maintenance areas for transportation-related criteria pollutants for which the area is designated nonattainment or has a maintenance plan.

(1) The provisions of this subpart apply with respect to emissions of the following criteria pollutants: ozone, carbon monoxide (CO), nitrogen dioxide (NO2), and particles with an aerodynamic diameter less than or equal to a nominal 10 micrometers (PM10).

(2) The provisions of this subpart apply with respect to emissions of the following precursor pollutants:

(i) Volatile organic compounds (VOC) and nitrogen oxides (NOx) in ozone areas;

(ii) NOx in NO2 areas; and

(iii) VOC, NOx, and PM10 in PM10 areas if the EPA Regional Administrator or the director of the State air agency has made a finding that transportation-related precursor emissions within the nonattainment area are a significant contributor to the PM10 nonattainment problem and has so notified the MPO and DOT, or if the applicable implementation plan (or implementation plan submission) establishes a budget for such emissions as part of the reasonable further progress, attainment or maintenance strategy.

(3) The provisions of this subpart apply to maintenance areas for 20 years from the date EPA approves the area's request under section 107(d) of the CAA for redesignation to attainment, unless the applicable implementation plan specifies that the provisions of this subpart shall apply for more than 20 years.

(c) Limitations.

(1) Projects subject to this subpart for which the NEPA process and a conformity determination have been completed by DOT may proceed toward implementation without further conformity determinations unless more than three years have elapsed since the most recent major step (NEPA process completion; start of final design; acquisition of a significant portion of the right-of-way; or approval of the plans, specifications and estimates) occurred. All phases of such projects which were considered in the conformity determination are also included, if those phases were for the purpose of funding final design, right-of-way acquisition, construction, or any combination of these phases.

(2) A new conformity determination for the project will be required if there is a significant change in project design concept and scope, if a supplemental environmental document for air quality purposes is initiated, or if three years have elapsed since the most recent major step to advance the project occurred.

(d) Grace period for new nonattainment areas. For areas or portions of areas which have been continuously designated attainment or not designated for any standard for ozone, CO, PM10 or NO2 since 1990 and are subsequently redesignated to nonattainment or designated nonattainment for any standard for any of these pollutants, the provisions of this subpart shall not apply with respect to that standard for 12 months following the effective date of final designation to nonattainment for each standard for such pollutant.

[58 FR 62234, Nov. 24, 1993; 60 FR 44762, Aug. 29, 1995; 60 FR 57179, Nov. 14, 1995; 62 FR 43780, August 15, 1997; 65 FR 18911, Apr. 10, 2000; 67 FR 50808, Aug. 6, 2002]

40 CFR § 93.103 Priority.

When assisting or approving any action with air quality-related consequences, FHWA and FTA shall give priority to the implementation of those transportation portions of an applicable implementation plan prepared to attain and maintain the NAAQS. This priority shall be consistent with statutory requirements for allocation of funds among States or other jurisdictions.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.104 Frequency Of Conformity Determinations.

(a) Conformity determinations and conformity redeterminations for transportation plans, TIPs, and FHWA/FTA projects must be made according to the requirements of this section and the applicable implementation plan.

(b) Frequency of conformity determinations for transportation plans.

(1) Each new transportation plan must be demonstrated to conform before the transportation plan is approved by the MPO or accepted by DOT.

(2) All transportation plan revisions must be found to conform before the transportation plan revisions are approved by the MPO or accepted by DOT, unless the revision merely adds or deletes exempt projects listed in § 93.126 or § 93.127. The conformity determination must be based on the transportation plan and the revision taken as a whole.

(3) The MPO and DOT must determine the conformity of the transportation plan no less frequently than every three years. If more than three years elapse after DOT's conformity determination without the MPO and DOT determining conformity of the transportation plan, the existing conformity determination will lapse.

(c) Frequency of conformity determinations for transportation improvement programs.

(1) A new TIP must be demonstrated to conform before the TIP is approved by the MPO or accepted by DOT.

(2) A TIP amendment requires a new conformity determination for the entire TIP before the amendment is approved by the MPO or accepted by DOT, unless the amendment merely adds or deletes exempt projects listed in § 93.126 or § 93.127.

(3) The MPO and DOT must determine the conformity of the TIP no less frequently than every three years. If more than three years elapse after DOT's conformity determination without the MPO and DOT determining conformity of the TIP, the existing conformity determination will lapse.

(4) After an MPO adopts a new or revised transportation plan, conformity of the TIP must be redetermined by the MPO and DOT within six months from the date of DOT's conformity determination for the transportation plan, unless the new or revised plan merely adds or deletes exempt projects listed in § § 93.126 and 93.127. Otherwise, the existing conformity determination for the TIP will lapse.

(d) Projects. FHWA/FTA projects must be found to conform before they are adopted, accepted, approved, or funded. Conformity must be redetermined for any FHWA/FTA project if three years have elapsed since the most recent major step to advance the project (NEPA process completion; start of final design; acquisition of a significant portion of the right-of-way; or approval of the plans, specifications and estimates) occurred.

(e) Triggers for transportation plan and TIP conformity determinations. Conformity of existing transportation plans and TIPs must be redetermined within 18 months of the following, or the existing conformity determination will lapse, and no new project-level conformity determinations may be made until conformity of the transportation plan and TIP has been determined by the MPO and DOT:

(1) November 24, 1993;

(2) The effective date of EPA's finding that motor vehicle emissions budgets from an initially submitted control strategy implementation plan or maintenance plan are adequate pursuant to § 93.118(e) and can be used for transportation conformity purposes;

(3) EPA approval of a control strategy implementation plan revision or maintenance plan which establishes or revises a motor vehicle emissions budget;

(4) EPA approval of an implementation plan revision that adds, deletes, or changes TCMs; and

(5) EPA promulgation of an implementation plan which establishes or revises a motor vehicle emissions budget or adds, deletes, or changes TCMs.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, Aug. 15, 1997; 67 FR 50808, Aug. 6, 2002]

40 CFR § 93.106 Content Of Transportation Plans.

(a) Transportation plans adopted after January 1, 1997 in serious, severe, or extreme ozone nonattainment areas and in serious CO nonattainment areas. If the metropolitan planning area contains an urbanized area population greater than 200,000, the transportation plan must specifically describe the transportation system envisioned for certain future years which shall be called horizon years.

(1) The agency or organization developing the transportation plan may choose any years to be horizon years, subject to the following restrictions:

(i) Horizon years may be no more than 10 years apart;

(ii) The first horizon year may be no more than 10 years from the base year used to validate the transportation demand planning model;

(iii) If the attainment year is in the time span of the transportation plan, the attainment year must be a horizon year; and

(iv) The last horizon year must be the last year of the transportation plan's forecast period.

(2) For these horizon years:

(i) The transportation plan shall quantify and document the demographic and employment factors influencing expected transportation demand, including land use forecasts, in accordance with implementation plan provisions and the consultation requirements specified by § 93.105;

(ii) The highway and transit system shall be described in terms of the regionally significant additions or modifications to the existing transportation network which the transportation plan envisions to be operational in the horizon years. Additions and modifications to the highway network shall be sufficiently identified to indicate intersections with existing regionally significant facilities, and to determine their effect on route options between transportation analysis zones. Each added or modified highway segment shall also be sufficiently identified in terms of its design concept and design scope to allow modeling of travel times under various traffic volumes, consistent with the modeling methods for area-wide transportation analysis in use by the MPO. Transit facilities, equipment, and services envisioned for the future shall be identified in terms of design concept, design scope, and operating policies that are sufficient for modeling of their transit ridership. Additions and modifications to the transportation network shall be described sufficiently to show that there is a reasonable relationship between expected land use and the envisioned transportation system; and

(iii) Other future transportation policies, requirements, services, and activities, including intermodal activities, shall be described.

(b) Moderate areas reclassified to serious. Ozone or CO nonattainment areas which are reclassified from moderate to serious and have an urbanized population greater than 200,000 must meet the requirements of paragraph (a) of this section within two years from the date of reclassification.

(c) Transportation plans for other areas. Transportation plans for other areas must meet the requirements of paragraph (a) of this section at least to the extent it has been the previous practice of the MPO to prepare plans which meet those requirements. Otherwise, the transportation system envisioned for the future must be sufficiently described within the transportation plans so that a conformity determination can be made according to the criteria and procedures of § § 93.109 through 93.119.

(d) Savings. The requirements of this section supplement other requirements of applicable law or regulation governing the format or content of transportation plans.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.109 Criteria And Procedures For Determining Conformity Of Transportation Plans, Programs, And Projects: General.

(a) In order for each transportation plan, program, and FHWA/FTA project to be found to conform, the MPO and DOT must demonstrate that the applicable criteria and procedures in this subpart are satisfied, and the MPO and DOT must comply with all applicable conformity requirements of implementation plans and of court orders for the area which pertain specifically to conformity. The criteria for making conformity determinations differ based on the action under review (transportation plans, TIPs, and FHWA/FTA projects), the relevant pollutant(s), and the status of the implementation plan.

(b) Table 1 in this paragraph indicates the criteria and procedures in § § 93.110 through 93.119 which apply for transportation plans, TIPs, and FHWA/ FTA projects. Paragraphs (c) through (f) of this section explain when the budget, emission reduction, and hot spot tests are required for each pollutant. Paragraph (g) of this section addresses isolated rural nonattainment and maintenance areas. Table 1 follows:

TABLE 1 - CONFORMITY CRITERIA

All Actions at all times:	
Sec. 93.110	Latest planning assumptions
Sec. 93.111	Latest emissions model
Sec. 93.112	Consultation
Transportation Plan:	
Sec. 93.113(b)	TCMs
Sec. 93.118 or Sec. 93.119	Emissions budget or Emission reduction
TIP:	
Sec. 93.113(c)	TCMs
Sec. 93.118 or Sec. 93.119	Emissions budget or Emission reduction
Project (From a Conforming Plan and TIP):	
Sec. 93.114	Currently conforming plan and TIP
Sec. 93.115	Project from a conforming plan and TIP
Sec. 93.116	CO and PM_{10} hot spots
Sec. 93.117	PM_{10} control measures
Project (Not From a Conforming Plan and TIP):	
Sec. 93.113(d)	TCMs
Sec. 93.114	Currently conforming plan and TIP
Sec. 93.116	CO and PM_{10} hot spots
Sec. 93.117	PM_{10} control measures
Sec. 93.118 or Sec. 93.119	Emissions budget or Emission reduction

(c) Ozone nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in paragraph (b) of this section that are required to be satisfied at all times, in ozone nonattainment and maintenance areas conformity determinations must include a demonstration that the budget and/or emission reduction tests are satisfied as described in the following:

(1) In ozone nonattainment and maintenance areas the budget test must be satisfied as required by § 93.118 for conformity determinations made:

(i) 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or

(ii) After EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.

(2) In ozone nonattainment areas that are required to submit a control strategy implementation plan revision (usually moderate and above areas), the emission reduction tests must be satisfied as required by § 93.119 for conformity determinations made:

(i) During the first 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes; or

(ii) If EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan.

(3) An ozone nonattainment area must satisfy the emission reduction test for NOX, as required by § 93.119, if the implementation plan or plan submission that is applicable for the purposes of conformity determinations is a 15% plan or Phase I attainment demonstration that does not include a motor vehicle emissions budget for NOX. The implementation plan will be considered to establish a motor vehicle emissions budget for NOX if the implementation plan or plan submission contains an explicit NOX motor vehicle emissions budget that is intended to act as a ceiling on future NOX emissions, and the NOX motor vehicle emissions budget is a net reduction from NOX emissions levels in 1990.

(4) Ozone nonattainment areas that have not submitted a maintenance plan and that are not required to submit a control strategy implementation plan revision (usually marginal and below areas) must satisfy one of the following requirements:

(i) The emission reduction tests required by § 93.119; or

(ii) The State shall submit to EPA an implementation plan revision that contains motor vehicle emissions budget(s) and an attainment demonstration, and the budget test required by § 93.118 must be satisfied using the submitted motor vehicle emissions budget(s) (as described in paragraph (c)(1) of this section).

(5) Notwithstanding paragraphs (c)(1) and (c)(2) of this section, moderate and above ozone nonattainment areas with three years of clean data that have not submitted a maintenance plan and that EPA has determined are not subject to the Clean Air Act reasonable further progress and attainment demonstration requirements must satisfy one of the following requirements:

(i) The emission reduction tests as required by § 93.119;

(ii) The budget test as required by § 93.118, using the motor vehicle emissions budgets in the submitted control strategy implementation plan (subject to the timing requirements of paragraph (c)(1) of this section); or

(iii) The budget test as required by § 93.118, using the motor vehicle emissions of ozone precursors in the most recent year of clean data as motor vehicle emissions budgets, if such budgets are established by the EPA rulemaking that determines that the area has clean data.

(d) CO nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in paragraph (b) of this section that are required to be satisfied at all times, in CO nonattainment and maintenance areas conformity determinations must include a demonstration that the hot spot, budget and/or emission reduction tests are satisfied as described in the following:

(1) FHWA/FTA projects in CO nonattainment or maintenance areas must satisfy the hot spot test required by § 93.116(a) at all times. Until a CO attainment demonstration or maintenance plan is approved by EPA, FHWA/FTA projects must also satisfy the hot spot test required by § 93.116(b).

(2) In CO nonattainment and maintenance areas the budget test must be satisfied as required by § 93.118 for conformity determinations made:

(i) 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or

(ii) After EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.

(3) Except as provided in paragraph (d)(4) of this section, in CO nonattainment areas the emission reduction tests must be satisfied as required by § 93.119 for conformity determinations made:

(i) During the first 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes; or

(ii) If EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan.

(4) CO nonattainment areas that have not submitted a maintenance plan and that are not required to submit an attainment demonstration (e.g., moderate CO areas with a design value of 12.7 ppm or less or not classified CO areas) must satisfy one of the following requirements:

(i) The emission reduction tests required by § 93.119; or

(ii) The State shall submit to EPA an implementation plan revision that contains motor vehicle emissions budget(s) and an attainment demonstration, and the budget test required by § 93.118 must be satisfied using the submitted motor vehicle emissions budget(s) (as described in paragraph (d)(2) of this section).

(e) PM10 nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in paragraph (b) of this section that are required to be satisfied at all times, in PM10 nonattainment and maintenance areas conformity determinations must include a demonstration that the hot spot, budget and/or emission reduction tests are satisfied as described in the following:

(1) FHWA/FTA projects in PM10 nonattainment or maintenance areas must satisfy the hot spot test required by § 93.116(a).

(2) In PM10 nonattainment and maintenance areas the budget test must be satisfied as required by § 93.118 for conformity determinations made:

(i) 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or

(ii) After EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.

(3) In PM10 nonattainment areas the emission reduction tests must be satisfied as required by § 93.119 for conformity determinations made:

(i) During the first 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes;

(ii) If EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan; or

(iii) If the submitted implementation plan revision is a demonstration of impracticability under CAA section 189(a)(1)(B)(ii) and does not demonstrate attainment.

(f) NO2 nonattainment and maintenance areas. In addition to the criteria listed in Table 1 in paragraph (b) of this section that are required to be satisfied at all times, in NO2 nonattainment and maintenance areas conformity determinations must include a demonstration that the budget and/or emission reduction tests are satisfied as described in the following:

(1) In NO2 nonattainment and maintenance areas the budget test must be satisfied as required by § 93.118 for conformity determinations made:

(i) 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared the motor vehicle emissions budget inadequate for transportation conformity purposes; or

(ii) After EPA has declared that the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan is adequate for transportation conformity purposes.

(2) In NO2 nonattainment areas the emission reduction tests must be satisfied as required by § 93.119 for conformity determinations made:

(i) During the first 45 days after a control strategy implementation plan revision or maintenance plan has been submitted to EPA, unless EPA has declared a motor vehicle emissions budget adequate for transportation conformity purposes; or

(ii) If EPA has declared the motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan inadequate for transportation conformity purposes, and there is

no previously established motor vehicle emissions budget in the approved implementation plan or a previously submitted control strategy implementation plan revision or maintenance plan.

(g) Isolated rural nonattainment and maintenance areas. This paragraph applies to any nonattainment or maintenance area (or portion thereof) which does not have a metropolitan transportation plan or TIP and whose projects are not part of the emissions analysis of any MPO's metropolitan transportation plan or TIP. This paragraph does not apply to "donut" areas which are outside the metropolitan planning boundary and inside the nonattainment/maintenance area boundary.

(1) FHWA/FTA projects in all isolated rural nonattainment and maintenance areas must satisfy the requirements of § § 93.110, 93.111, 93.112(2)(ii), 93.113(d), 93.116, and 93.117. Until EPA approves the control strategy implementation plan or maintenance plan for a rural CO nonattainment or maintenance area, FHWA/FTA projects must also satisfy the requirements of § 93.116(b) ("Localized CO and PM10 violations (hot spots)").

(2) Isolated rural nonattainment and maintenance areas are subject to the budget and/or emission reduction tests as described in paragraphs (c) through (f) of this section, with the following modifications:

(i) When the requirements of § § 93.118 and 93.119 apply to isolated rural nonattainment and maintenance areas, references to "transportation plan" or "TIP" should be taken to mean those projects in the statewide transportation plan or statewide TIP which are in the rural nonattainment or maintenance area.

(ii) In isolated rural nonattainment and maintenance areas that are subject to § 93.118, FHWA/FTA projects must be consistent with motor vehicle emissions budget(s) for the years in the timeframe of the attainment demonstration or maintenance plan. For years after the attainment year (if a maintenance plan has not been submitted) or after the last year of the maintenance plan, FHWA/FTA projects must satisfy one of the following requirements:

(A) § 93.118;

(B) § 93.119 (including regional emissions analysis for NOX in all ozone nonattainment and maintenance areas, notwithstanding § 93.119(d)(2)); or

(C) As demonstrated by the air quality dispersion model or other air quality modeling technique used in the attainment demonstration or maintenance plan, the FHWA/FTA project, in combination with all other regionally significant projects expected in the area in the timeframe of the statewide transportation plan, must not cause or contribute to any new violation of any standard in any areas; increase the frequency or severity of any existing violation of any standard in any area; or delay timely attainment of any standard or any required interim emission reductions or other milestones in any area. Control measures assumed in the analysis must be enforceable.

(iii) The choice of requirements in paragraph (g)(2)(ii) of this section and the methodology used to meet the requirements of paragraph (g)(2)(ii)(C) of this section must be determined through the interagency consultation process required in § 93.105(c)(1)(vii) through which the relevant recipients of title 23 U.S.C. or Federal Transit Laws funds, the local air quality agency, the State air quality agency, and the State department of transportation should reach consensus about the option and methodology selected. EPA and DOT must be consulted through this process as well. In the event of unresolved disputes, conflicts may be escalated to the Governor consistent with the procedure in § 93.105(d), which applies for any State air agency comments on a conformity determination.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.110 Criteria And Procedures: Latest Planning Assumptions.

(a) The conformity determination, with respect to all other applicable criteria in § § 93.111 through 93.119, must be based upon the most recent planning assumptions in force at the time of the conformity determination. The conformity determination must satisfy the requirements of paragraphs (b) through (f) of this section.

(b) Assumptions must be derived from the estimates of current and future population, employment, travel, and congestion most recently developed by the MPO or other agency authorized to make such estimates and approved by the MPO. The conformity determination must also be based on the latest assumptions about current and future background concentrations.

(c) The conformity determination for each transportation plan and TIP must discuss how transit operating policies (including fares and service levels) and assumed transit ridership have changed since the previous conformity determination.

(d) The conformity determination must include reasonable assumptions about transit service and increases in transit fares and road and bridge tolls over time.

(e) The conformity determination must use the latest existing information regarding the effectiveness of the TCMs and other implementation plan measures which have already been implemented.

(f) Key assumptions shall be specified and included in the draft documents and supporting materials used for the interagency and public consultation required by § 93.105.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.111 Criteria And Procedures: Latest Emissions Model.

(a) The conformity determination must be based on the latest emission estimation model available. This criterion is satisfied if the most current version of the motor vehicle emissions model specified by EPA for use in the preparation or revision of implementation plans in that State or area is used for the conformity analysis. Where EMFAC is the motor vehicle emissions model used in preparing or revising the applicable implementation plan, new versions must be approved by EPA before they are used in the conformity analysis.

(b) EPA will consult with DOT to establish a grace period following the specification of any new model.

(1) The grace period will be no less than three months and no more than 24 months after notice of availability is published in the Federal Register.

(2) The length of the grace period will depend on the degree of change in the model and the scope of re-planning likely to be necessary by MPOs in order to assure conformity. If the grace period will be longer than three months, EPA will announce the appropriate grace period in the Federal Register.

(c) Transportation plan and TIP conformity analyses for which the emissions analysis was begun during the grace period or before the Federal Register notice of availability of the latest emission model may continue to use the previous version of the model. Conformity determinations for projects may also be based on the previous model if the analysis was begun during the grace period or before the Federal Register notice of availability, and if the final environmental document for the project is issued no more than three years after the issuance of the draft environmental document.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.112 Criteria And Procedures: Consultation.

Conformity must be determined according to the consultation procedures in this subpart and in the applicable implementation plan, and according to the public involvement procedures established in compliance with 23 CFR part 450. Until the implementation plan revision required by § 51.390 of this chapter is fully approved by EPA, the conformity determination must be made according to § 93.105(a)(2) and (e) and the requirements of 23 CFR part 450.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.113 Criteria And Procedures: Timely Implementation Of TCMs.

(a) The transportation plan, TIP, or any FHWA/FTA project which is not from a conforming plan and TIP must provide for the timely implementation of TCMs from the applicable implementation plan.

(b) For transportation plans, this criterion is satisfied if the following two conditions are met:

(1) The transportation plan, in describing the envisioned future transportation system, provides for the timely completion or implementation of all TCMs in the applicable implementation plan which are eligible for funding under title 23 U.S.C. or the Federal Transit Laws, consistent with schedules included in the applicable implementation plan.

(2) Nothing in the transportation plan interferes with the implementation of any TCM in the applicable implementation plan.

(c) For TIPs, this criterion is satisfied if the following conditions are met:

(1) An examination of the specific steps and funding source(s) needed to fully implement each TCM indicates that TCMs which are eligible for funding under title 23 U.S.C. or the Federal Transit Laws are on or ahead of the schedule established in the applicable implementation plan, or, if such TCMs are behind the schedule established in the applicable implementation plan, the MPO and DOT have determined that past obstacles to implementation of the TCMs have been identified and have been or are being overcome, and that all State and local agencies with influence over approvals or funding for TCMs are giving maximum priority to approval or funding of TCMs over other projects within their control, including projects in locations outside the nonattainment or maintenance area.

(2) If TCMs in the applicable implementation plan have previously been programmed for Federal funding but the funds have not been obligated and the TCMs are behind the schedule in the implementation plan, then the TIP cannot be found to conform if the funds intended for those TCMs are reallocated to projects in the TIP other than TCMs, or if there are no other TCMs in the TIP, if the funds are reallocated to projects in the TIP other than projects which are eligible for Federal funding intended for air quality improvement projects, e.g., the Congestion Mitigation and Air Quality Improvement Program.

(3) Nothing in the TIP may interfere with the implementation of any TCM in the applicable implementation plan.

(d) For FHWA/FTA projects which are not from a conforming transportation plan and TIP, this criterion is satisfied if the project does not interfere with the implementation of any TCM in the applicable implementation plan.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.114 Criteria And Procedures: Currently Conforming Transportation Plan And TIP.

There must be a currently conforming transportation plan and currently conforming TIP at the time of project approval.

(a) Only one conforming transportation plan or TIP may exist in an area at any time; conformity determinations of a previous transportation plan or TIP expire once the current plan or TIP is found to conform by DOT. The conformity determination on a transportation plan or TIP will also lapse if conformity is not determined according to the frequency requirements specified in § 93.104.

(b) This criterion is not required to be satisfied at the time of project approval for a TCM specifically included in the applicable implementation plan, provided that all other relevant criteria of this subpart are satisfied.

[58 FR 62234, Nov. 24, 1993; 60 FR 57179, Nov. 14, 1995; 62 FR 43780, August 15, 1997]

40 CFR § 93.115 Criteria And Procedures: Projects From A Plan And TIP.

(a) The project must come from a conforming plan and program. If this criterion is not satisfied, the project must satisfy all criteria in Table 1 of § 93.109(b) for a project not from a conforming transportation plan and TIP. A project is considered to be from a conforming transportation plan if it meets the requirements of paragraph (b) of this section and from a conforming program if it meets the requirements of paragraph (c) of this section. Special provisions for TCMs in an applicable implementation plan are provided in paragraph (d) of this section.

(b) A project is considered to be from a conforming transportation plan if one of the following conditions applies:

(1) For projects which are required to be identified in the transportation plan in order to satisfy § 93.106 ("Content of transportation plans"), the project is specifically included in the conforming transportation plan and the project's design concept and scope have not changed significantly from those which were described in the transportation plan, or in a manner which would significantly impact use of the facility; or

(2) For projects which are not required to be specifically identified in the transportation plan, the project is identified in the conforming transportation plan, or is consistent with the policies and purpose of the transportation plan and will not interfere with other projects specifically included in the transportation plan.

(c) A project is considered to be from a conforming program if the following conditions are met:

(1) The project is included in the conforming TIP and the design concept and scope of the project were adequate at the time of the TIP conformity determination to determine its contribution to the TIP's regional emissions, and the project design concept and scope have not changed significantly from those which were described in the TIP; and

(2) If the TIP describes a project design concept and scope which includes project-level emissions mitigation or control measures, written commitments to implement such measures must be obtained from the project sponsor and/or operator as required by § 93.125(a) in order for the project to be considered from a conforming program. Any change in these mitigation or control measures that would significantly reduce their effectiveness constitutes a change in the design concept and scope of the project.

(d) TCMs. This criterion is not required to be satisfied for TCMs specifically included in an applicable implementation plan.

[58 FR 62234, Nov. 24, 1993; 60 FR 57179, Nov. 14, 1995; 62 FR 43780, August 15, 1997]

40 CFR § 93.116 Criteria And Procedures: Localized CO And PM10 Violations (Hot Spots).

(a) This paragraph applies at all times. The FHWA/FTA project must not cause or contribute to any new localized CO or PM10 violations or increase the frequency or severity of any existing CO or PM10 violations in CO and PM10 nonattainment and maintenance areas. This criterion is satisfied if it is demonstrated that no new local violations will be created and the severity or number of existing violations will not be increased as a result of the project. The demonstration must be performed according to the consultation requirements of § 93.105(c)(1)(i) and the methodology requirements of § 93.123.

(b) This paragraph applies for CO nonattainment areas as described in § 93.109(d)(1). Each FHWA/FTA project must eliminate or reduce the severity and number of localized CO violations in the area substantially affected by the project (in CO nonattainment areas). This criterion is satisfied with respect to existing localized CO violations if it is demonstrated that existing localized CO violations will be eliminated or reduced in severity and number as a result of the project. The demonstration must be performed according to the consultation requirements of § 93.105(c)(1)(i) and the methodology requirements of § 93.123.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.117 Criteria And Procedures: Compliance With PM10 Control Measures.

The FHWA/FTA project must comply with PM10 control measures in the applicable implementation plan. This criterion is satisfied if the project-level conformity determination contains a written commitment from the project sponsor to include in the final plans, specifications, and estimates for the project those control measures (for the purpose of limiting PM10 emissions from the construction activities and/or normal use and operation associated with the project) that are contained in the applicable implementation plan.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.118 Criteria And Procedures: Motor Vehicle Emissions Budget.

(a) The transportation plan, TIP, and project not from a conforming transportation plan and TIP must be consistent with the motor vehicle emissions budget(s) in the applicable implementation plan (or implementation plan submission). This criterion applies as described in § 93.109(c) through (g). This criterion is satisfied if it is demonstrated that emissions of the pollutants or pollutant precursors described in paragraph (c) of this section are less than or equal to the motor vehicle emissions budget(s) established in the applicable implementation plan or implementation plan submission.

(b) Consistency with the motor vehicle emissions budget(s) must be demonstrated for each year for which the applicable (and/or submitted) implementation plan specifically establishes motor vehicle emissions budget(s), for the last year of the transportation plan's forecast period, and for any intermediate years as necessary so that the years for which consistency is demonstrated are no more than ten years apart, as follows:

(1) Until a maintenance plan is submitted:

(i) Emissions in each year (such as milestone years and the attainment year) for which the control strategy implementation plan revision establishes motor vehicle emissions budget(s) must be less than or equal to that year's motor vehicle emissions budget(s); and

(ii) Emissions in years for which no motor vehicle emissions budget(s) are specifically established must be less than or equal to the motor vehicle emissions budget(s) established for the most recent prior year. For example, emissions in years after the attainment year for which the implementation plan does not establish a budget must be less than or equal to the motor vehicle emissions budget(s) for the attainment year.

(2) When a maintenance plan has been submitted:

(i) Emissions must be less than or equal to the motor vehicle emissions budget(s) established for the last year of the maintenance plan, and for any other years for which the maintenance plan establishes motor vehicle emissions budgets. If the maintenance plan does not establish motor vehicle emissions budgets for any years other than the last year of the maintenance plan, the demonstration of consistency with the motor vehicle emissions budget(s) must be accompanied by a qualitative finding that there are no factors which would cause or contribute to a new violation or exacerbate an existing violation in the years before the last year of the maintenance plan. The interagency consultation process required by § 93.105 shall determine what must be considered in order to make such a finding;

(ii) For years after the last year of the maintenance plan, emissions must be less than or equal to the maintenance plan's motor vehicle emissions budget(s) for the last year of the maintenance plan; and

(iii) If an approved control strategy implementation plan has established motor vehicle emissions budgets for years in the timeframe of the transportation plan, emissions in these years must be less than or equal to the control strategy implementation plan's motor vehicle emissions budget(s) for these years.

(c) Consistency with the motor vehicle emissions budget(s) must be demonstrated for each pollutant or pollutant precursor in § 93.102(b) for which the area is in nonattainment or maintenance and for which the applicable implementation plan (or implementation plan submission) establishes a motor vehicle emissions budget.

(d) Consistency with the motor vehicle emissions budget(s) must be demonstrated by including emissions from the entire transportation system, including all regionally significant projects contained in the transportation plan and all other regionally significant highway and transit projects expected in the nonattainment or maintenance area in the timeframe of the transportation plan.

(1) Consistency with the motor vehicle emissions budget(s) must be demonstrated with a regional emissions analysis that meets the requirements of § § 93.122 and 93.105(c)(1)(i).

(2) The regional emissions analysis may be performed for any years in the timeframe of the transportation plan provided they are not more than ten years apart and provided the analysis is performed for the attainment year (if it is in the timeframe of the transportation plan) and the last year of the plan's forecast period. Emissions in years for which consistency with motor vehicle emissions budgets must be demonstrated, as required in paragraph (b) of this section, may be determined by interpolating between the years for which the regional emissions analysis is performed.

(e) Motor vehicle emissions budgets in submitted control strategy implementation plan revisions and submitted maintenance plans.

(1) Consistency with the motor vehicle emissions budgets in submitted control strategy implementation plan revisions or maintenance plans must be demonstrated if EPA has declared the motor vehicle emissions budget(s) adequate for transportation conformity purposes, or beginning 45 days after the control strategy implementation plan revision or maintenance plan has been submitted (unless EPA has declared the motor vehicle emissions budget(s) inadequate for transportation conformity purposes). However, submitted implementation plans do not supersede the motor vehicle emissions budgets in approved implementation plans for the period of years addressed by the approved implementation plan.

(2) If EPA has declared an implementation plan submission's motor vehicle emissions budget(s) inadequate for transportation conformity purposes, the inadequate budget(s) shall not be used to satisfy the requirements of this section. Consistency with the previously established motor vehicle emissions budget(s) must

be demonstrated. If there are no previous approved implementation plans or implementation plan submissions with motor vehicle emissions budgets, the emission reduction tests required by § 93.119 must be satisfied.

(3) If EPA declares an implementation plan submission's motor vehicle emissions budget(s) inadequate for transportation conformity purposes more than 45 days after its submission to EPA, and conformity of a transportation plan or TIP has already been determined by DOT using the budget(s), the conformity determination will remain valid. Projects included in that transportation plan or TIP could still satisfy § § 93.114 and 93.115, which require a currently conforming transportation plan and TIP to be in place at the time of a project's conformity determination and that projects come from a conforming transportation plan and TIP.

(4) EPA will not find a motor vehicle emissions budget in a submitted control strategy implementation plan revision or maintenance plan to be adequate for transportation conformity purposes unless the following minimum criteria are satisfied:

(i) The submitted control strategy implementation plan revision or maintenance plan was endorsed by the Governor (or his or her designee) and was subject to a State public hearing;

(ii) Before the control strategy implementation plan or maintenance plan was submitted to EPA, consultation among federal, State, and local agencies occurred; full implementation plan documentation was provided to EPA; and EPA's stated concerns, if any, were addressed;

(iii) The motor vehicle emissions budget(s) is clearly identified and precisely quantified;

(iv) The motor vehicle emissions budget(s), when considered together with all other emissions sources, is consistent with applicable requirements for reasonable further progress, attainment, or maintenance (whichever is relevant to the given implementation plan submission);

(v) The motor vehicle emissions budget(s) is consistent with and clearly related to the emissions inventory and the control measures in the submitted control strategy implementation plan revision or maintenance plan; and

(vi) Revisions to previously submitted control strategy implementation plans or maintenance plans explain and document any changes to previously submitted budgets and control measures; impacts on point and area source emissions; any changes to established safety margins (see § 93.101 for definition); and reasons for the changes (including the basis for any changes related to emission factors or estimates of vehicle miles traveled).

(5) Before determining the adequacy of a submitted motor vehicle emissions budget, EPA will review the State's compilation of public comments and response to comments that are required to be submitted with any implementation plan. EPA will document its consideration of such comments and responses in a letter to the State indicating the adequacy of the submitted motor vehicle emissions budget.

(6) When the motor vehicle emissions budget(s) used to satisfy the requirements of this section are established by an implementation plan submittal that has not yet been approved or disapproved by EPA, the MPO and DOT's conformity determinations will be deemed to be a statement that the MPO and DOT are not aware of any information that would indicate that emissions consistent with the motor vehicle emissions budget will cause or contribute to any new violation of any standard; increase the frequency or severity of any existing violation of any standard; or delay timely attainment of any standard or any required interim emission reductions or other milestones.

[58 FR 62234, Nov. 24, 1993; 60 FR 57179, Nov. 14, 1995; 62 FR 43780, August 15, 1997]

40 CFR § 93.119 Criteria And Procedures: Emission Reductions In Areas Without Motor Vehicle Emissions Budgets.

(a) The transportation plan, TIP, and project not from a conforming transportation plan and TIP must contribute to emissions reductions. This criterion applies as described in § 93.109(c) through (g). It applies to the net effect of the action (transportation plan, TIP, or project not from a conforming transportation plan and TIP) on motor vehicle emissions from the entire transportation system.

(b) This criterion may be met in moderate and above ozone nonattainment areas that are subject to the reasonable further progress requirements of CAA section 182(b)(1) and in moderate with design value greater than 12.7 ppm and serious CO nonattainment areas if a regional emissions analysis that satisfies the requirements of § 93.122 and paragraphs (e) through (h) of this section demonstrates that for each analysis year and for each of the pollutants described in paragraph (d) of this section:

(1) The emissions predicted in the "Action" scenario are less than the emissions predicted in the "Baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; and

(2) The emissions predicted in the "Action" scenario are lower than 1990 emissions by any nonzero amount.

(c) This criterion may be met in PM10 and NO2 nonattainment areas; marginal and below ozone nonattainment areas and other ozone nonattainment areas that are not subject to the reasonable further progress requirements of CAA section 182(b)(1); and moderate with design value less than 12.7 ppm and below CO nonattainment areas if a regional emissions analysis that satisfies the requirements of § 93.122 and paragraphs (e) through (h) of this section demonstrates that for each analysis year and for each of the pollutants described in paragraph (d) of this section, one of the following requirements is met:

(1) The emissions predicted in the "Action" scenario are less than the emissions predicted in the "Baseline" scenario, and this can be reasonably expected to be true in the periods between the analysis years; or

(2) The emissions predicted in the "Action" scenario are not greater than baseline emissions. Baseline emissions are those estimated to have occurred during calendar year 1990, unless the conformity implementation plan revision required by § 51.390 of this chapter defines the baseline emissions for a PM10 area to be those occurring in a different calendar year for which a baseline emissions inventory was developed for the purpose of developing a control strategy implementation plan.

(d) Pollutants. The regional emissions analysis must be performed for the following pollutants:

(1) VOC in ozone areas;

(2) NOX in ozone areas, unless the EPA Administrator determines that additional reductions of NOX would not contribute to attainment;

(3) CO in CO areas;

(4) PM10 in PM10 areas;

(5) Transportation-related precursors of PM10 in PM10 nonattainment and maintenance areas if the EPA Regional Administrator or the director of the State air agency has made a finding that such precursor emissions from within the area are a significant contributor to the PM10 nonattainment problem and has so notified the MPO and DOT; and

(6) NOX in NO2 areas.

(e) Analysis years. The regional emissions analysis must be performed for analysis years that are no more than ten years apart. The first analysis year must be no more than five years beyond the year in which the conformity determination is being made. The last year of transportation plan's forecast period must also be an analysis year.

(f) "Baseline" scenario. The regional emissions analysis required by paragraphs (b) and (c) of this section must estimate the emissions that would result from the "Baseline" scenario in each analysis year. The "Baseline" scenario must be defined for each of the analysis years. The "Baseline" scenario is the future transportation system that will result from current programs, including the following (except that exempt projects listed in § 93.126 and projects exempt from regional emissions analysis as listed in § 93.127 need not be explicitly considered):

(1) All in-place regionally significant highway and transit facilities, services and activities;

(2) All ongoing travel demand management or transportation system management activities; and

(3) Completion of all regionally significant projects, regardless of funding source, which are currently under construction or are undergoing right-of-way acquisition (except for hardship acquisition and protective buying); come from the first year of the previously conforming transportation plan and/or TIP; or have completed the NEPA process.

(g) "Action" scenario. The regional emissions analysis required by paragraphs (b) and (c) of this section must estimate the emissions that would result from the "Action" scenario in each analysis year. The "Action" scenario must be defined for each of the analysis years. The "Action" scenario is the transportation system that would result from the implementation of the proposed action (transportation plan, TIP, or project not from a conforming transportation plan and TIP) and all other expected regionally significant projects in the nonattainment area. The "Action" scenario must include the following (except that exempt projects listed in § 93.126 and projects exempt from regional emissions analysis as listed in § 93.127 need not be explicitly considered):

(1) All facilities, services, and activities in the "Baseline" scenario;

(2) Completion of all TCMs and regionally significant projects (including facilities, services, and activities) specifically identified in the proposed transportation plan which will be operational or in effect in the analysis year, except that regulatory TCMs may not be assumed to begin at a future time unless the regulation is already adopted by the enforcing jurisdiction or the TCM is identified in the applicable implementation plan;

(3) All travel demand management programs and transportation system management activities known to the MPO, but not included in the applicable implementation plan or utilizing any Federal funding or approval, which have been fully adopted and/or funded by the enforcing jurisdiction or sponsoring agency since the last conformity determination;

(4) The incremental effects of any travel demand management programs and transportation system management activities known to the MPO, but not included in the applicable implementation plan or utilizing any Federal funding or approval, which were adopted and/or funded prior to the date of the last conformity determination, but which have been modified since then to be more stringent or effective;

(5) Completion of all expected regionally significant highway and transit projects which are not from a conforming transportation plan and TIP; and

(6) Completion of all expected regionally significant non-FHWA/FTA highway and transit projects that have clear funding sources and commitments leading toward their implementation and completion by the analysis year.

(h) Projects not from a conforming transportation plan and TIP. For the regional emissions analysis required by paragraphs (b) and (c) of this section, if the project which is not from a conforming transportation plan and TIP is a modification of a project currently in the plan or TIP, the `Baseline' scenario must include the project with its original design concept and scope, and the 'Action' scenario must include the project with its new design concept and scope.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.120 Consequences Of Control Strategy Implementation Plan Failures.

(a) Disapprovals.

(1) If EPA disapproves any submitted control strategy implementation plan revision (with or without a protective finding), the conformity status of the transportation plan and TIP shall lapse on the date that highway sanctions as a result of the disapproval are imposed on the nonattainment area under section 179(b)(1) of the CAA. No new transportation plan, TIP, or project may be found to conform until another control strategy implementation plan revision fulfilling the same CAA requirements is submitted and conformity to this submission is determined.

(2) If EPA disapproves a submitted control strategy implementation plan revision without making a protective finding, then beginning 120 days after such disapproval, only projects in the first three years of the currently conforming transportation plan and TIP may be found to conform. This means that beginning 120 days after disapproval without a protective finding, no transportation plan, TIP, or project not in the first three years of the currently conforming plan and TIP may be found to conform until another control strategy implementation plan revision fulfilling the same CAA requirements is submitted and conformity to this submission is determined. During the first 120 days following EPA's disapproval without a protective finding, transportation plan, TIP, and project conformity determinations shall be made using the motor vehicle emissions budget(s) in the disapproved control strategy implementation plan, unless another control strategy implementation plan revision has been submitted and its motor vehicle emissions budget(s) applies for transportation conformity purposes, pursuant to § 93.109.

(3) In disapproving a control strategy implementation plan revision, EPA would give a protective finding where a submitted plan contains adopted control measures or written commitments to adopt enforceable control measures that fully satisfy the emissions reductions requirements relevant to the statutory provision for which the implementation plan revision was submitted, such as reasonable further progress or attainment.

(b) Failure to submit and incompleteness. In areas where EPA notifies the State, MPO, and DOT of the State's failure to submit a control strategy implementation plan or submission of an incomplete control strategy implementation plan revision (either of which initiates the sanction process under CAA sections 179 or 110(m)), the conformity status of the transportation plan and TIP shall lapse on the date that highway sanctions are imposed on the nonattainment area for such failure under section 179(b)(1) of the CAA, unless the failure has been remedied and acknowledged by a letter from the EPA Regional Administrator.

(c) Federal implementation plans. If EPA promulgates a Federal implementation plan that contains motor vehicle emissions budget(s) as a result of a State failure, the conformity lapse imposed by this section because of that State failure is removed.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.121 Requirements For Adoption Or Approval Of Projects By Other Recipients Of Funds Designated Under Title 23 U.S.C. Or The Federal Transit Laws.

(a) Except as provided in paragraph (b) of this section, no recipient of Federal funds designated under title 23 U.S.C. or the Federal Transit Laws shall adopt or approve a regionally significant highway or transit project, regardless of funding source, unless the recipient finds that the requirements of one of the following are met:

(1) The project was included in the first three years of the most recently conforming transportation plan and TIP (or the conformity determination's regional emissions analyses), even if conformity status is currently lapsed; and the project's design concept and scope has not changed significantly from those analyses; or

(2) There is a currently conforming transportation plan and TIP, and a new regional emissions analysis including the project and the currently conforming transportation plan and TIP demonstrates that the transportation plan and TIP would still conform if the project were implemented (consistent with the requirements of § § 93.118 and/or 93.119 for a project not from a conforming transportation plan and TIP).

(b) In isolated rural nonattainment and maintenance areas subject to § 93.109(g), no recipient of Federal funds designated under title 23 U.S.C. or the Federal Transit Laws shall adopt or approve a regionally significant highway or transit project, regardless of funding source, unless the recipient finds that the requirements of one of the following are met:

(1) The project was included in the regional emissions analysis supporting the most recent conformity determination for the portion of the statewide transportation plan and TIP which are in the nonattainment or maintenance area, and the project's design concept and scope has not changed significantly; or

(2) A new regional emissions analysis including the project and all other regionally significant projects expected in the nonattainment or maintenance area demonstrates that those projects in the statewide transportation plan and statewide TIP which are in the nonattainment or maintenance area would still conform if the project were implemented (consistent with the requirements of § § 93.118 and/or 93.119 for projects not from a conforming transportation plan and TIP).

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.126 Exempt Projects.

Notwithstanding the other requirements of this subpart, highway and transit projects of the types listed in Table 2 of this section are exempt from the requirement to determine conformity. Such projects may proceed toward implementation even in the absence of a conforming transportation plan and TIP. A particular action of the type listed in Table 2 of this section is not exempt if the MPO in consultation with other agencies (see § 93.105(c)(1)(iii)), the EPA, and the FHWA (in the case of a highway project) or the FTA (in the case of a transit project) concur that it has potentially adverse emissions impacts for any reason. States and MPOs must ensure that exempt projects do not interfere with TCM implementation. Table 2 follows:

TABLE 2 - EXEMPT PROJECTS

Safety

Railroad/highway crossing.
Hazard elimination program.
Safer non-Federal-aid system roads.
Shoulder improvements.
Increasing sight distance.
Safety improvement program.
Traffic control devices and operating assistance other than signalization projects.
Railroad/highway crossing warning devices.

Guardrails, median barriers, crash cushions.
Pavement resurfacing and/or rehabilitation.
Pavement marking demonstration.
Emergency relief (23 U.S.C. 125).
Fencing.
Skid treatments.
Safety roadside rest areas.
Adding medians.
Truck climbing lanes outside the urbanized area.
Lighting improvements.
Widening narrow pavements or reconstructing bridges (no additional travel lanes).
Emergency truck pullovers.

Mass Transit

Operating assistance to transit agencies.
Purchase of support vehicles.
Rehabilitation of transit vehicles \1\.
Purchase of office, shop, and operating equipment for existing facilities.
Purchase of operating equipment for vehicles (e.g., radios, fareboxes, lifts, etc.).
Construction or renovation of power, signal, and communications systems.
Construction of small passenger shelters and information kiosks.
Reconstruction or renovation of transit buildings and structures (e.g., rail or bus buildings, storage and maintenance facilities, stations, terminals, and ancillary structures).
Rehabilitation or reconstruction of track structures, track, and trackbed in existing rights-of-way.
Purchase of new buses and rail cars to replace existing vehicles or for minor expansions of the fleet \1\.
Construction of new bus or rail storage/maintenance facilities categorically excluded in 23 CFR part 771.

Air Quality

Continuation of ride-sharing and van-pooling promotion activities at current levels.
Bicycle and pedestrian facilities.

Other

Specific activities which do not involve or lead directly to construction, such as:
- Planning and technical studies.
- Grants for training and research programs.
- Planning activities conducted pursuant to titles 23 and 49 U.S.C.
- Federal-aid systems revisions.

Engineering to assess social, economic, and environmental effects of the proposed action or alternatives to that action.
Noise attenuation.
Emergency or hardship advance land acquisitions (23 CFR 712.204(d)).
Acquisition of scenic easements.
Plantings, landscaping, etc.
Sign removal.
Directional and informational signs.
Transportation enhancement activities (except rehabilitation and operation of historic transportation buildings, structures, or facilities).
Repair of damage caused by natural disasters, civil unrest, or terrorist acts, except projects involving substantial functional, locational or capacity changes.

Note: \1\ In PM_{10} nonattainment or maintenance areas, such projects are exempt only if they are in compliance with control measures in the applicable implementation plan.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

40 CFR § 93.127 Projects Exempt From Regional Emissions Analyses.

Notwithstanding the other requirements of this subpart, highway and transit projects of the types listed in Table 3 of this section are exempt from regional emissions analysis requirements. The local effects of these projects with respect to CO or PM10 concentrations must be considered to determine if a hot-spot analysis is required prior to making a project-level conformity determination. These projects may then proceed to the project development process even in the absence of a conforming transportation plan and TIP. A particular action of the type listed in Table 3 of this section is not exempt from regional emissions analysis if the MPO in consultation with other agencies (see § 93.105(c)(1)(iii)), the EPA, and the FHWA (in the case of a highway project) or the FTA (in the case of a transit project) concur that it has potential regional impacts for any reason. Table 3 follows:

TABLE 3 - PROJECTS EXEMPT FROM REGIONAL EMISSIONS ANALYSES

Intersection channelization projects.
Intersection signalization projects at individual intersections.
Interchange reconfiguration projects.
Changes in vertical and horizontal alignment.
Truck size and weight inspection stations.
Bus terminals and transfer points.

[58 FR 62234, Nov. 24, 1993; 62 FR 43780, August 15, 1997]

Copies of the signed Memorandum of Agreement may be obtained by contacting Dennis Camit at the South Carolina Department of Health and Environmental Control, Division of Air Planning, Development, and Outreach, 2600 Bull Street, Columbia, SC 29201, or by calling (803) 898-4284.

DEPARTMENT OF LABOR, LICENSING AND REGULATION
BUILDING CODES COUNCIL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 6-9-60(C) of the 1976 Code of Laws of South Carolina, as amended, the South Carolina Building Codes Council intends to review and adopt the following building codes for use within the state:

Mandatory codes will include:
International Building Code, 2003 Edition;
International Residential Code, 2003 Edition;
International Fire Code, 2003 Edition;
International Plumbing Code, 2003 Edition;
International Mechanical Code, 2003 Edition;
International Fuel Gas Code, 2003 Edition;
International Energy Conservation Code, 2003 Edition.

Permissive codes will include:
International Property Maintenance Code, 2003 Edition;
International Existing Building Code, 2003 Edition.

The Council specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to Gary Wiggins, Board Administrator, at 110 Centerview Drive, 2nd Floor, Columbia, South Carolina, 29211-1329, (803) 896-4620.

DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 70, National Electrical Code, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Regulation 71-8300.10

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

If no comments are received within sixty (60) days of publication of this notice, the Office of State Fire Marshal will promulgate this latest edition without amendment.

DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 72, National Fire Alarm Code, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Regulation 71-8300.11(A)(1) and (A)(2)
   South Carolina Regulation 71-8308.4(A)
   South Carolina Regulation 71-8309.4(A)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

If no comments are received within sixty (60) days of publication of this notice, the Office of State Fire Marshal will promulgate this latest edition without amendment.

DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 99, Standard for Health Care Facilities, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Regulation 71-8300.11(C)(4)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 102, Standard for Grandstands, Folding and Telescopic Seating, Tents, and Membrane Structures, 1995 Edition

2. The original promulgating authority for this code is:

National Fire Protection Association
1 Batterymarch Park
Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Regulation 71-8306.1(A)
South Carolina Regulation 71-8306.2(A)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2001 Edition

2. The original promulgating authority for this code is:
National Fire Protection Association
1 Batterymarch Park
Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Regulation 71-8307.3 (A)(9)(h)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 2001, Standard on Clean Agent Fire Extinguishing Systems, 2003 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Regulation 71-8307.3(A)(9)(i)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 17, Standard for Dry Chemical Extinguishing Systems, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Regulation 71-8307.3(A)(9)(f)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

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1. National Fire Protection Association 17A, Standard for Wet Chemical Extinguishing Systems, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Regulation 71-8307.3(A)(9)(g)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 11, Standard for Low-, Medium-, and High-Expansion Systems, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. The code is referenced by:
South Carolina Regulation Section 71-8307.3(A)(9)(a)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
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Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 11A, Standard for Medium- and High-Expansion Foam Systems, 1999 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Regulation, Section 71-8307.3(A)(9)(b)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 12, Standard on Carbon Dioxide Extinguishing Systems, 2000 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:

South Carolina Regulation, Section 71-8307.3(A)(9)(c)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 12A, Standard on Halon 1301 Extinguishing Systems, 2003 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Regulation, Section 71-8307.3(A)(9)(d)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF LABOR, LICENSING AND REGULATION
OFFICE OF STATE FIRE MARSHAL

NOTICE OF GENERAL PUBLIC INTEREST

Notice is hereby given that, in accordance with Section 1-34-30 of the 1976 Code of Laws of South Carolina, as amended, the Department of Labor, Licensing and Regulation, Office of State Fire Marshal intends to adopt the latest edition of the following nationally recognized code.

1. National Fire Protection Association 13, Standard for the Installation of Sprinkler Systems, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:

South Carolina Code of Law, Section 23-45-140

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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1. National Fire Protection Association 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Law, Section 23-45-140

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1. National Fire Protection Association 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up to and Including Four Stories in Height, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park

Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Law, Section 23-45-140

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1. National Fire Protection Association 14, Standard for the Installation of Standpipe, Private Hydrants, and Hose Systems, 2003 Edition

2. The original promulgating authority for this code is:
National Fire Protection Association
1 Batterymarch Park
Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Law, Section 23-45-140

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1. National Fire Protection Association 20, Standard for the Installation of Stationary Pumps for Fire Protection, 2003 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Laws Section 23-45-140

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1. National Fire Protection Association 22, Standard for Water Tanks for Private Fire Protection, 2003 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Code of Laws Section 23-45-140

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1. National Fire Protection Association 24, Standard for the Installation of Private Fire Service Mains and Their Appurtenances, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Laws Section 23-45-140

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1. National Fire Protection Association 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Laws Section 23-45-140

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1. National Fire Protection Association 54, National Fuel Gas Code, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Laws Section 40-82-70(A)(3)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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1. National Fire Protection Association 59, Utility LP Gas Plant Code, 2001 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Laws Section 40-82-70(A)(3)

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1. National Fire Protection Association 409, Standard on Aircraft Hangars, 2001 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Laws, Section 23-45-140

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1. National Fire Protection Association 1126, Standard for the Use of Pyrotechnics before a Proximate Audience, 2001 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
South Carolina Code of Laws, Section 23-35-45

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1. National Fire Protection Association 10, Standard for Portable Fire Extinguishers, 2002 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Code of Laws Section 23-45-140
   South Carolina Regulation 71-8307.3(A)(3)

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1. National Fire Protection Association 30, Flammable and Combustible Liquids Code, 2003 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Code of Laws Section 39-41-260(A)
   South Carolina Regulation 71-8300.11 (C)(5)
   South Carolina Regulation 71-8301.6
   South Carolina Regulation 71-8303.1

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1. National Fire Protection Association 30A, Code for Motor Fuel Dispensing Facilities and Repair Garages, 2003 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Code of Laws Section 39-41-260(A)
   South Carolina Regulation 71-8303.1

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1. National Fire Protection Association 58, Liquefied Petroleum Gas Code, 2001 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. This code is referenced by:
   South Carolina Code of Laws Section 40-82-70(A)(3)
   South Carolina Regulation 71-8304.1

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1. National Fire Protection Association 101, Life Safety Code, 2003 Edition

2. The original promulgating authority for this code is:
   National Fire Protection Association
   1 Batterymarch Park
   Quincy, Massachusetts 02269

3. The code is referenced by:
   South Carolina Code of Laws, Section 23-45-140
   South Carolina Regulation 71-8300.11(D)(2)(d)
   South Carolina Regulation 71-8300.11(E)(6)(b)(l)
   South Carolina Regulation 71-8300.11(E)(7)(b)(l)
   South Carolina Regulation 71-8300.11(F)(1)(c)
   South Carolina Regulation 71-8300.12(B)

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1. International Building Code, 2003 Edition. The International Building Code, 2000 Edition, is the current successor code to the 1997 edition of the Standard Building Code.

2. The original promulgating authority for this code is:
International Code Council
900 Montclair Road
Birmingham, Alabama 35213-1206

3. This code is referenced by:
South Carolina Regulation 71-8300.9(A).

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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1. International Fire Code, 2003 Edition. The International Fire Code, 2000 Edition, is the current successor code to the 1997 edition of the Standard Fire Prevention Code.

2. The original promulgating authority for this code is:
International Code Council
900 Montclair Road
Birmingham, Alabama 35213-1206

3. This code is referenced by:
   South Carolina Regulation 71-8301.3(A)

The Office of State Fire Marshal specifically requests comments concerning sections of these editions which may be unsuitable for enforcement in South Carolina. Written comments may be submitted to William Galloway at 141 Monticello Trail, Columbia, SC 29203, by fax at 803-896-9806, or by e-mail to gallowayb@llr.sc.gov.

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DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

CHAPTER 61

Statutory Authority: 1976 Code Section 44-56-30

R. 61-79 HAZARDOUS WASTE MANAGEMENT REGULATIONS

Notice of Drafting:

The Department of Health and Environmental Control proposes to amend R.61-79, Hazardous Waste Management Regulations, to adopt federal amendments through June 30, 2003. Interested persons are invited to present their views in writing to John Litton, Director of the Division of Waste Management, Bureau of Land and Waste Management, Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201. To be considered, comments must be received by 5:00 p.m. on November 28, 2003.

Synopsis:

The United States Environmental Protection Agency (USEPA) promulgates amendments to 40 CFR 124, 260 through 266, 268, 270, and 273 throughout each calendar year. Recent amendments affect: zinc fertilizer made from recycled hazardous secondary materials, treatment standards for some hazardous and radioactive batteries, and technical corrections to Combustor standards. These rules have been published in the Federal Register between July 1, 2002, and June 30, 2003.

In addition, the Department will make minor clarifications and corrections to R.61-79 to more closely reflect the federal regulations.

The Department intends to amend R.61-79 to maintain conformity with federal requirements and ensure compliance with federal standards. No preliminary assessment report, fiscal impact statement, nor legislative review of this amendment will be required.

COMMISSION ON HIGHER EDUCATION

CHAPTER 77

Statutory Authority: 1976 Code Section 2-77-20, et seq.

Notice of Drafting:

The South Carolina Commission on Higher Education proposes to draft a new regulation that addresses the "Higher Education Excellence Enhancement Program" act. Interested persons may submit comments to Mr. Charles FitzSimons, Director, Division of Finance, Facilities & Statistical Services, South Carolina Commission on Higher Education, 1333 Main Street (Suite 200), Columbia, SC 29201. To be considered, comments must be received no later than 5PM November 24, 2003, the close of the drafting period.

Synopsis:

The General Assembly passed the "Higher Education Excellence Enhancement Program" Act that establishes the South Carolina Commission on Higher Education as the administrative state agency that enhances the educational opportunities for the students attending historically black colleges. The act is to be funded by appropriations from the Education Lottery Account. The Act requires the South Carolina Commission on Higher Education to allocate 50% of the appropriations equally among the eligible institutions. The South Carolina Commission on Higher Education must promulgate regulations to allocate the remaining appropriated funds to eligible institutions based upon merit, through criteria developed by the South Carolina Commission on Higher Education.

The proposed regulations will address the remaining appropriated funds to eligible institutions based upon merit. The criteria for the eligible institutions will be to submit proposals using the guidelines from "Section 2-77-30 of the 1976 Code".

DEPARTMENT OF TRANSPORTATION

CHAPTER 63

Statutory Authority: 1976 Code Section 57-25-170

Specific Information Service Signing

Notice of Drafting:

The South Carolina Department of Transportation proposes to draft new regulations that address the logo program. Interested persons may submit comments to Ms. Deborah Brooks Durden, SCDOT, PO Box 191, Columbia, SC 29202-0191. To be considered, comments must be received no later than 5 p.m. on November 12, 2003, the close of the drafting comment period.

Synopsis:

SCDOT administers the specific information service signing program on controlled access highways within South Carolina to inform motorists of gas, food, lodging, camping facilities and attractions.

The proposed regulation will provide for the following changes:

1. Provide for a bid solicitation and selection process at intersections where the number of qualifying businesses exceeds the available spaces on the service panel to allow qualified businesses the opportunity to bid on available positions on the specific service panels.

2. Delete language concerning a potential increase in the number of business signs displayed on a single panel to conform with federal requirements.

3. Amend a reference to the South Carolina Manual on Uniform Traffic Control Devices for Streets and Highways because that publication has become obsolete.

4. Delete the requirement that an attraction must have public telephones to qualify for participation on an Attraction service panel to make the regulations conform with the federal requirements.

Legislative review of this proposal will be required.

Document No. 2867
STATE BOARD OF EDUCATION
CHAPTER 43
Statutory Authority: S.C. Code Ann. Section(s) 59-5-60(1990), 59-1-445(1990), 59-18-310 (Supp. 2002), 59-18-320(Supp. 2002), 59-18-330(Supp. 2002), 59-18-340(Supp. 2002), 59-20-60(4)(c)(Supp. 2002), 59-30-10(Supp. 2002), and No Child Left Behind Act of 2001, 20 U.S.C. *et seq*. (2001)

R 43-262 Assessment Program

Preamble:

The proposed amendments to R 43-262 are intended to update the regulation to make it consistent with the requirements of current state and federal legislation. Section A defines the statewide assessment program to make it consistent with the provisions of the Education Accountability Act of 1998 (EAA) and the No Child Left Behind Act of 2001, 20 U.S.C. § 6301 *et seq*. (2001) (NCLB) and defines the responsibilities of the State Department of Education and local school boards in implementing the program. Section B updates the requirements relative to the high school assessment program. Section C addresses first-and second-grade readiness tests and ensures that provisions are consistent with the EAA. Section D addresses the norm-referenced testing program. In particular, amendments are proposed for Section B to address the change from the Basic Skills Assessment Program (BSAP) to the High School Assessment Program (HSAP).

Section-by-Section Discussion

General: "boards" changed to "districts"; "State Board of Education" changed to "State Department of Education"

Section A: Although there are a few other edits in Section A, the primary changes were made to reflect NCLB.

Section B: Although there are a few other edits in Section B, the primary changes reflect the inclusion of the High School Assessment Program (HSAP) and the phase out of the Basic Skills Assessment Program (BSAP) exit examination. HSAP is designed to meet state and local requirements.

Section C: Minor edits for clarification.

Section D: Unchanged.

Section E: State assessment as part of the National Assessment of Educational Progress (NAEP) is required by NCLB; therefore, a section has been added.

Notice of Public Hearing and Opportunity for Public Comment:

Interested members of the public and regulated community are invited to make oral or written comments on the proposed regulation at a public hearing to be conducted by the State Board of Education at its meeting on December 9, 2003, at 10:00 A.M. at the Rutledge Building, State Department of Education, Columbia, South Carolina. Persons desiring to make oral comments at the hearing are asked to limit their statements to five minutes or less, and as a courtesy are asked to provide written copies of their presentation for the record.

Interested persons are also provided an opportunity to submit written comments on the proposed amendments by writing to Dr. Teri Siskind, Office of Assessment, Division of Curriculum Services and Assessment, 1429 Senate Street, Rm. 607E, Rutledge Building, Columbia, South Carolina 29201 or e-mail tsiskind@sde.state.sc.us. Comments must be received no later than 5:00 P.M. on November 24, 2003. Comments received by the deadline shall be submitted to the Board in a summary of public comments and department responses for consideration at the public hearing.

Preliminary Fiscal Impact Statement: Non-compliance with NCLB would result in a loss of federal funds for the state. The Assessment Program has been amended to include the High School Assessment Program as included in the State Consolidated Plan submitted by the state to the United States Department of Education. A section has been added to include the National Assessment of Educational Progress (NAEP) as required by NCLB.

Statement of Need and Reasonableness: This item proposes amendments to 24 S.C. Code Ann. Reg. 43-262 (Supp. 2002), Assessment Program, in part, to comply with the NCLB.

The proposed amendments to R 43-262 are intended to update the regulation to make it consistent with the requirements of current state and federal legislation. Section A defines the statewide assessment program to make it consistent with the provisions of the EAA and the NCLB and defines the responsibilities of the State Department of Education and local school boards in implementing the program. Section B updates the requirements relative to the high school assessment program. Section C addresses first-and second-grade readiness tests and ensures that provisions are consistent with the EAA. Section D addresses the National Assessment of Educational Progress to be compliant with NCLB. In particular, amendments are proposed for Section B to address the change from the Basic Skills Assessment Program (BSAP) to the High School Assessment Program (HSAP).

DESCRIPTION OF REGULATION: R 43-262, Assessment Program

Purpose: Regulation 43-262, Assessment Program, is being amended. The proposed amendments to R 43-262 are intended to update the regulation to make it consistent with the requirements of current state and federal legislation.

Legal Authority: S.C. Code Ann. §§ 59-5-60 (1990), 59-1-445 (1990), 59-18-310 (Supp. 2002), 59-18-320 (Supp. 2002), 59-18-330 (Supp. 2002), 59-18-340(Supp. 2002), 59-20-60(4)(c) (Supp. 2002), 59-30-10 (Supp. 2002), and No Child Left Behind Act of 2001, 20 U.S.C. § 6301 *et seq*. (2001).

Plan for Implementation: The proposed amendments will be posted on the State Department of Education's Web site for review and comment. The amendments will take effect upon approval by the General Assembly and publication in the *State Register*.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS: The State Consolidated Plan submitted by the U.S. Department of Education pursuant to provisions of NCLB required the state to operationalize a high school assessment on an expedited schedule. These amendments reflect those changes as well as the inclusion of NAEP, as required by NCLB.

DETERMINATION OF COSTS AND BENEFITS: It is difficult to determine the costs of the federal requirements over the state requirements.

UNCERTAINTIES OF ESTIMATES: Non-compliance with NCLB would result in a loss of funding to the state.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH: This regulation does not have any effect on the environment or public health.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED: There will be no detrimental effect on the environment or public health if this regulation is not implemented.

Statement of Rationale:

A copy of the detailed statement of rationale may be obtained by contacting Dr. Teri Siskind, Director, Office of Assessment, 1429 Senate Street, Rm. 607E, Rutledge Building, Columbia, South Carolina 29201.

Text:

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

Document No. 2868
STATE BOARD OF EDUCATION
CHAPTER 43
Statutory Authority: S. C. Code Ann. Sections 59-5-60 (1990), 59-18-110 (Supp. 2002), 59-29-10, *et seq*. (1990 and Supp. 2002), 59-29-200 (1990), 59-33-30 (1990), 59-53-1810 (1990), 20 U.S.C. Section 1232(g), and 20 U.S.C. Section 6301 *et seq.* (2001)

43-234. Defined Program, Grades 9–12

Preamble:

The State Board of Education proposes amending Regulation 43-234, Defined Program, Grades 9–12. This regulation requires all public high schools to provide a rigorous, relevant curriculum to help students meet the requirements for the state high school diploma. This regulation also provides for the administration and operation of high school programs.

The Notice of Drafting was published in the *State Register* on June 27, 2003.

Section-by-Section Discussion

Section I(A)	Deletes pre-algebra completing the phase out of general curriculum courses. Mathematics for the technologies 3 is added as a course required to be offered. AP calculus is added as an alternative offering to calculus, a course required to be offered. Changes discrete mathematics and integrated science to courses recommended to be offered. A requirement that each student must take physical science prior to taking the exit examination at the end of the tenth grade is added. Text related to the STAR diploma is deleted. Maintains the requirement that environmental studies must be offered and deletes the requirement that the subject must be offered as a separate one semester elective course.
Section I(E)	New language is inserted requiring core unit alternative courses to be aligned with curriculum standards and requires schools to reapply for approval when substantial changes are made to course content.
Section I(F)(4)	Adds provisions for granting high school credit earned in adult education aligning with R 43-259, Graduation Requirements.
Section I(F)(5)	Moves the provision for accepting credits from schools accredited by regional accrediting associations from Section I(G)(4) to this section.
Section I(G)(4)	Adds an additional provision for the issuance of dual credit aligning with R 43-259, Graduation Requirements.

Section I(I)(5)	New language is inserted regarding a modified school day under certain conditions for pupils with disabilities.
Section III(A)	Deletes the twenty-unit high school diploma requirements.
Section III(A)(2)	Former Footnote 1. Adds language regarding prerequisites for business and marketing computer courses aligning with R 43-259, Graduation Requirements.
Section III(A)(3)	Former Footnote 2.
Section III(A)(4)	Former Section C.
Section III(A)(5)	Former Section D.
Section III(A)(6)	Former Section E. Inserts text referencing the inclusion of Appendix B, Exit Examination, in R 43-262, Assessment Program.
Section III(B)(1)	New text addressing the phase-out of out-of-field teaching permits in special education under the federal No Child Left Behind Act, 20 U.S.C. Section 6301 *et seq.* (2001) has been inserted. Inserts a relocated footnote concerning the certification status of a teacher of students with disabilities. Inserts language for clarification of special needs student placement in alignment with text from R 43-259, Graduation Requirements.
Section V	Deletes out-dated language defining a student identified as a Tech Prep completer.
Section VI	The listing of other State Board of Education regulation titles related to this regulation is updated.
Section VII(3)	New language adds a reference to the Family Education Rights and Privacy Act (20 U.S.C. § 1232(g)) regarding student records.
Section VIII	Language is updated to reflect procedure changes.
Appendix A	The List of Courses and Activity Codes are removed, since the listing will be available on the Department of Education Web site.
Appendix B	Deletes the exit exam regulations since Appendix B is included in Regulation 43-262, Assessment Program.

Notice of Public Hearing and Opportunity for Public Comment:

Interested members of the public and regulated community are invited to make oral or written comments on the proposed regulation at a public hearing to be conducted by the State Board of Education at its meeting on December 9, 2003, at 10:00 A.M. at the Rutledge Building, State Department of Education, Columbia, South Carolina. The notice for public hearings will be noted in the Board's agenda to be published by the Department two days in advance of the meeting. Persons desiring to make oral comments at the hearing are asked to limit their statements to five minutes or less, and as a courtesy are asked to provide written copies of their presentation for the record.

Interested persons are also provided an opportunity to submit written comments on the proposed amendments by writing to Dr. Leonard McIntyre, Deputy Superintendent, Division of Professional Development and School Quality, 1429 Senate Street, Room 1102, Rutledge Building, Columbia, South Carolina 29201 or e-mail lmcintyr@sde.state.sc.us. Comments must be received no later than 5:00 P.M. on November 24, 2003, as noticed above. Comments received by the deadline shall be submitted to the Board in a summary of public comments and department responses for consideration at the public hearing.

Preliminary Fiscal Impact Statement: The Department of Education anticipates there will be additional costs to the State or its political subdivisions.

Statement of Need and Reasonableness:

This statement of need and reasonableness was determined by staff analysis pursuant to S.C. Code Ann. Section 1-23-115 (Supp. 2002).

DESCRIPTION OF REGULATION: 43-234, Defined Program, Grades 9–12

Purpose: Regulation 43-234, Defined Program, Grades 9–12, is being amended. The proposed amendments delete references to the STAR Diploma; delete the twenty-unit diploma requirements; delete Appendix A, List of Courses and Instructional Activity Codes; delete Appendix B, Exit Examination; insert amendments addressing the phase-out of out-of-field teaching permits in special education under No Child Left Behind; delete pre-algebra as a core unit mathematics course; add mathematics for the technologies 3 as a course required to be offered; and add AP calculus as an alternative offering to calculus, a course required to be offered. Additionally, the proposed amendments change discrete mathematics and integrated science to courses recommended to be offered, add the requirement that a student must take physical science prior to taking the exit examination at the end of the tenth grade, clarify the innovative approach approval procedures, add a provision for awarding dual credit, and include text advocating compliance with the Family Educational Rights and Privacy Act (FERPA) regarding student records.

Legal Authority: S.C. Code Ann. Sections 59-5-60 (1990), 59-18-110 (Supp. 2002), 59-29-10, *et seq*. (1990 and Supp. 2002), 59-29-200 (1990), 59-33-30 (1990), 59-53-1810 (1990), 20 U.S.C. Section 1232(g), and 20 U.S.C. Section 6301 *et seq*. (2001)

Plan for Implementation: The proposed amendments will be placed on the State Department of Education Web site for review and comment. The proposed amendments will take effect upon approval by the General Assembly and publication in the *State Register.*

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS: The proposed amendments reflect program changes and recommendations from school and district administrators and collaborative efforts of numerous State Department of Education divisions. The proposed amendments provide alignment with additional State Board regulations.

DETERMINATION OF COSTS AND BENEFITS: Implementation of the requirement that every student must take physical science by the end of the tenth grade prior to taking the exit examination will require the purchase of additional textbooks. Estimating a fiscal impact required the use of 2002–03 SASI course enrollment data and use of Appendix B, Acceptable Areas of Certification for teacher certification and staffing considerations. In 2002–03, over 70 percent of the freshman class enrolled in physical science.

Currently, the Physical Science textbook adoption bid is scheduled to be opened in December 2005, with new books in the classroom in August 2007. This would mean that if most ninth graders enroll in physical science in the 2005–06 and 2006–07 years, there will be an additional cost to purchase more current textbooks. If all ninth graders took the course in one year, 20,602 additional books would be needed for a cost of $1,111,889.90 at $53.97 per book. There should be no additional cost for facilities.

To teach physical science, a teacher must hold certification in one of these four areas: Science, General Science, Chemistry, or Physics. Since a majority of high school science teachers would hold one of these areas of certification, the current pool of teachers should be sufficient to cover student enrollment.

Implementation of the physical science course requirement prior to taking the new High School Assessment Program Science examination will provide students the opportunity to be prepared to take the exam.

UNCERTAINTIES OF ESTIMATES: Estimating the timing of student enrollment in physical science is strictly anticipatory. All ninth-grade students will probably not enroll in physical science at once. However, the enrollment percentage of students could eventually approach 85 to 90 percent of the class.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH: The proposed amendments to the Defined Program, Grades 9–12 regulation, if implemented, will have no effect on the environment or public health.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED: There will be no detrimental effect on the environment and public health if these amendments are not implemented.

Statement of Rationale: The proposed amendments reflect program changes and recommendations from school and district administrators and collaborative efforts of numerous Department of Education divisions. The proposed amendments provide alignment with other State Board regulations and the No Child Left Behind Act of 2001 (20 U.S.C. Section 6301 *et seq*. (2001)).

Text:

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

Document No. 2869
STATE BOARD OF EDUCATION
CHAPTER 43
Statutory Authority: S. C. Code Ann. Section 59-65-90 (1990) and 20 U.S.C. 7165 (2001)

43-273. Transfers and Withdrawals

Preamble:

In accordance with federal legislation, the No Child Left Behind Act (NCLB), 20 U.S.C. 7165 (2001), South Carolina must provide an assurance that a procedure is in place to facilitate the transfer of disciplinary records, with respect to a suspension or expulsion, by local school districts to public or private schools upon enrollment of a student.

The Notice of Drafting was published in the *State Register* on September 26, 2003.

Section-by-Section Discussion

The following sentence will be added to two sections of the regulation “Schools must transfer student disciplinary records of suspensions and expulsions to the public or private school to which the student is transferring.”

Notice of Public Hearing and Opportunity for Public Comment:

Interested members of the public and regulated community are invited to make oral or written comments on the proposed regulation at a public hearing to be conducted by the State Board of Education at its meeting on December 9, 2003, at 10:00 A.M. at the Rutledge Building, State Department of Education, Columbia, South Carolina. The notice for public hearings will be noted in the Board's agenda to be published by the Department two days in advance of the meeting. Persons desiring to make oral comments at the hearing are asked to limit their statements to five minutes or less, and as a courtesy are asked to provide written copies of their presentation for the record.

Interested persons are also provided an opportunity to submit written comments on the proposed amendments by writing to Mrs. Carolyn Donges, Interim Director, Division of District and Community Services, Office of Safe Schools and Youth Services, 1429 Senate Street, Room 606, Rutledge Building, Columbia, South Carolina 29201 or e-mail cdonges@sde.state.sc.us. Comments must be received no later than 5:00 P.M. on November 24, 2003, as noticed above. Comments received by the deadline shall be submitted to the Board in a summary of public comments and department responses for consideration at the public hearing.

Preliminary Fiscal Impact Statement: The Department of Education anticipates there will be no additional cost to the State or its political subdivisions.

Statement of Need and Reasonableness:

This statement of need and reasonableness was determined by staff analysis pursuant to S.C. Code Ann. Section 1-23-115 (Supp. 2002).

DESCRIPTION OF REGULATION: 43-273. Transfers and Withdrawals

Purpose: Regulation 43-273, Transfers and Withdrawals, is being amended to comply with federal law, 20 U.S.C. Section 7165 (2001).

Legal Authority: The legal authority for the regulations are S.C. Code Ann. Section 59-65-90 (1990) and 20 U.S.C. Section 7165 (2001)

Plan for Implementation: The proposed amendments will be placed on the State Department of Education Web site for review and comment. The proposed amendments will take effect upon publication in the *State Register.*

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

This proposed amendment is needed to ensure that the South Carolina Department of Education is in compliance with the No Child Left Behind Act of 2001 regarding the transfer of disciplinary records to a public or private school.

DETERMINATION OF COSTS AND BENEFITS: None

UNCERTAINTIES OF ESTIMATES: None

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH: The proposed amendments will have no effect on the environment or public health.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED: There will be no detrimental effect on the environment and public health if these amendments are not implemented.

Statement of Rationale:

In accordance with federal legislation the No Child Left Behind Act (NCLB), 20 U.S.C. Section 7165 (2001), South Carolina must provide an assurance that a procedure is in place to facilitate the transfer of disciplinary records, with respect to a suspension or expulsion, by local school districts to public or private schools upon enrollment of a student.

Text:

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

Document No. 2873
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61
Statutory Authority: S.C. Code Section 48-1-10 et seq.

R.61-62.1, *Definitions And General Requirements*

Preamble:

The United States Environmental Protection Agency (EPA) promulgated a final rule referred to as the Consolidated Emissions Reporting Rule (CERR) in the *Federal Register* on June 10, 2002 [67 FR 39602]. Pursuant to its authority under section 110 of Title I of the Clean Air Act (CAA), EPA has long required State Implementation Plans (SIPs) to provide for the submission by states to EPA of emission inventories containing information regarding the emissions of criteria pollutants and their precursors.

The purpose of the CERR is to simplify emissions reporting, establish new reporting requirements for $PM_{2.5}$ (fine particulate matter) and NH_3 (ammonia), and establish new requirements for the statewide reporting of area source and mobile source emissions.

R.61-62.1, *Definitions And General Requirements,* currently requires all facilities that are required to obtain a Title V permit from the Department to submit an emissions inventory every two years. The Department is revising these requirements in an effort to streamline the emissions inventory reporting process and to be consistent with the CERR. Accordingly, approximately 50 of the 335 current Title V sources (referred to as Type A sources) will be required to increase their emissions inventory reporting to an annual basis. However, the vast majority of new and existing Title V sources will realize a decrease in their reporting burden. The CERR requires approximately 80 of the 335 current Title V sources with fewer emissions (referred to as Type B sources) to report their emissions inventory every three years. This will reduce the reporting burden for these sources from every other year to every third year. For the remaining Title V sources, except those that emit significant hazardous air pollutants (HAPs), there will be an even greater decrease in the reporting burden. If these sources have submitted an initial inventory, no further reporting will be required. Those sources that emit significant HAPs will also realize a decrease in their reporting burden. Instead of submitting inventories every other year, they will be required to submit a summary of their HAP emissions every three years.

A Notice of drafting was published in the *State Register* on November 22, 2002. A second notice to extend the drafting period was published in the *State Register* on August 22, 2003.

Discussion of Proposed Revisions:

SECTION CITATION:	EXPLANATION OF CHANGE
Section III	The entire section has been revised to incorporate the requirements of the CERR and to streamline the existing regulation.

Notice of Staff Informational Forum:

Staff of the Department of Health and Environmental Control invite interested persons of the public to attend a staff-conducted informational forum to be held on November 25, 2003, at 10:00 a.m. on the second floor of the Aycock Building in room 2280 at the Department of Health and Environmental Control at 2600 Bull Street, Columbia, S.C. 29201.

Interested persons are also provided an opportunity to submit written comments to Frank Cramer, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201. To be considered, written comments must be received no later than 5:00 pm on November 25, 2003. Comments received by the deadline will be submitted to the Board in a Summary of Public Comments and Department Responses.

Copies of the proposed regulation for public notice and comment may be obtained by contacting Frank Cramer, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201.

Notice of Board Public Hearing and Opportunity for Public Comment Pursuant to S.C. Code Sections 1-23-111:

Interested members of the public and regulated community are invited to make oral or written comments on the proposed regulation at a public hearing to be conducted by the Board of Health and Environmental Control at its regularly-scheduled meeting on December 11, 2003, to be held in Room 3420 (Board Room) of the Commissioner's Suite, third floor, Aycock Building of the Department of Health and Environmental Control, 2600 Bull Street, Columbia, S.C. The Board meeting commences at 10:00 a.m. at which time the Board will consider items on its agenda in the order presented. The order of presentation for public hearings will be noted in the Board's agenda to be published by the Department 24 hours in advance of the meeting. Persons desiring to make oral comments at the hearing are asked to limit their statements to five minutes or less, and as a courtesy are asked to provide written copies of their presentation for the record.

Interested persons are also provided an opportunity to submit written comments on the proposed amendments by writing to Frank Cramer, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201. To be considered, written comments must be received no later than 5:00 pm on November 25, 2003. Comments received shall be submitted to the Board in a Summary of Public Comments and Department Responses for consideration at the public hearing.

Copies of the proposed regulation for public notice and comment may be obtained by contacting Frank Cramer, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201.

Preliminary Fiscal Impact Statement:

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

Statement of Need and Reasonableness:

This statement of need and reasonableness was determined by staff analysis pursuant to S.C. Code Section 1-23-115(C)(1)-(3) and (9)-(11).

DESCRIPTION OF REGULATION:

Purpose: The proposed amendment will amend R.61-62.1, *Definitions and General Requirements,* to make the necessary revisions to be consistent with the new Federal emissions reporting requirements. In addition, the Department is proposing to revise existing State specific requirements to streamline the reporting process.

Legal Authority: The legal authority for R.61-62 is Sections 48-1-10 et seq., S.C. Code of Laws.

Plan for Implementation: The proposed amendments will take effect upon approval by the Board of Health and Environmental Control, General Assembly and publication in the *State Register*. The proposed amendments will be implemented by providing the regulated community with copies of the regulation.

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

The United States Environmental Protection Agency (EPA) promulgated a final rule referred to as the Consolidated Emissions Reporting Rule (CERR) in the *Federal Register* on June 10, 2002 [67 FR 39602]. Pursuant to its authority under section 110 of Title I of the Clean Air Act (CAA), EPA has long required State Implementation Plans (SIPs) to provide for the submission by states to EPA of emission inventories containing information regarding the emissions of criteria pollutants and their precursors.

The purpose of the CERR is to simplify emissions reporting, establish new reporting requirements for $PM_{2.5}$ (fine particulate matter) and NH_3 (ammonia), and establish new requirements for the statewide reporting of area source and mobile source emissions.

R.61-62.1, *Definitions And General Requirements,* currently requires all facilities that are required to obtain a Title V permit from the Department to submit an emissions inventory every two years. The Department is revising these requirements in an effort to streamline the emissions inventory reporting process and to be consistent with the CERR. Accordingly, approximately 50 of the 354 current Title V sources (referred to as Type A sources) will be required to increase their emissions inventory reporting to an annual basis. However, the vast majority of new and existing Title V sources will realize a decrease in their reporting burden. The CERR requires approximately 80 of the 354 current Title V sources with fewer emissions (referred to as Type B sources) to report their emissions inventory every three years. This will reduce the reporting burden for these sources from every other year to every third year. For the remaining Title V sources, except those that emit significant hazardous air pollutants (HAPs), there will be an even greater decrease in the reporting burden. If these sources have submitted an initial inventory, no further reporting will be required. Those sources that emit significant HAPs will also realize a decrease in their reporting burden. Instead of submitting inventories every other year, they will be required to submit a summary of their HAP emissions every three years.

The Department believes that this approach is necessary and reasonable because staff currently spends a great deal of time processing emissions inventories from smaller sources that have fewer pollutants. This streamlined approach will allow staff to focus their efforts on the larger facilities which emit the greatest amount of criteria pollutants and their precursors.

DETERMINATION OF COSTS AND BENEFITS:

There will be no increased cost to the State or its political subdivisions resulting from this proposed revision. The revision will allow the Department to streamline the emissions reporting process by focusing its efforts on large

facilities that have the greatest impact on the inventory. This will result in a more efficient use of staff time and will allow staff more time to work on other emissions inventories like mobile sources. In addition, most of the regulated community will realize a decrease in their reporting burden.

Currently, the Department collects emissions inventories every other year from about 354 sources. The CERR will require sources with the greatest emissions to increase the frequency of their reporting from every other year to annually. However, the majority of sources will realize a decrease in their reporting burden. The EPA has provided the estimated costs and benefits in the *Federal Register* notices that are cited in this regulation.

UNCERTAINTIES OF ESTIMATES:

There are no uncertainties of estimates relative to the costs to the State or its political subdivisions. Refer to the above paragraph for cost estimates for the regulated community.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

By implementing this rule, the Department will be able to more efficiently and effectively track emissions of criteria air pollutants and their precursors from large facilities in South Carolina and, thereby, more effectively protect public health.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATIONS ARE NOT IMPLEMENTED: none.

STATEMENT OF RATIONALE:

These revisions will streamline the emissions reporting process by enabling Department staff to make better use of their time. No new scientific studies or information precipitated the development of the proposed revisions. The bulk of these revisions are being made to comply with the Federal mandate. These revisions will change the reporting requirements for all facilities that are required to obtain a Title V permit issued by the Department. The Title V sources with the greatest emissions will realize an increase in their reporting burden from every other year to reporting on an annual basis. Also, they will be required to report additional pollutants. However, the majority of Title V sources will realize a decrease in their reporting burden. Some will only be required to report their emissions inventories every three years and still others will only be required to report an initial emissions inventory.

Text:

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

Document No. 2872
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61
Statutory Authority: S.C. Code Section 48-1-10 et seq.

R.61-62, *Air Pollution Control Regulations and Standards*

Preamble:

On July 18, 1997, the United States Environmental Protection Agency (EPA) revised the National Ambient Air Quality Standard for ground-level ozone from 0.12 parts per million (ppm) 1-hour "peak" standard to 0.08 ppm 8-hour "average" standard. The National Ambient Air Quality Standards are health -based standards established at levels intended to protect public health. This "new" ozone standard is commonly referred to as the 8-hour ozone standard. Currently, all areas of South Carolina meet or "attain" all national ambient air quality standards, including the 1-hour ozone standard. However, when implemented, the 8-hour ozone standard could result in numerous areas of the state being determined not to meet the 8-hour standard and being designated as "non-attainment" for ground-level ozone. In South Carolina, 18 of 23 ozone monitors, particularly those in the more populated urban areas, regularly exceed the 8-hour standard. When air quality standards are revised, the state must recommend to EPA the boundaries of the areas that are not in compliance with the standard and must submit a plan to EPA that demonstrates how the state will bring those areas designated as non-attainment for the standard back into attainment. EPA will make the 8-hour ozone non-attainment designations by April 15, 2004, with input from the Department.

When EPA designates areas as non-attainment, these areas automatically become subject to additional permitting requirements referred to as non-attainment new source review and complex transportation planning requirements referred to as transportation conformity. In an effort to be proactive and bring cleaner air sooner to the citizens of South Carolina, the Department, with EPA support, has begun the process with state and local governments, industry, environmental groups, and other interested parties to consider possible ozone reduction strategies. The Department has been working with these stakeholder groups over the last year to develop strategies sooner than would be required by the current federal timeframes to reduce the pollution that creates ground-level ozone.

This strategy of bringing cleaner air to the state sooner than would be required under the current federal timeframes is referred to as the Early Action Compact or EAC. In accordance with the EAC, EPA has laid out specific milestones that the state must meet to reduce ozone precursors so that our ozone monitors will be attaining the 8-hour standard by 2007 and beyond. Aside from the public health benefits realized by meeting the new standard sooner than required, another reason for embarking on this approach is that if we are successful, EPA will defer the effective date of the non-attainment designations.

The purpose of the proposed regulations is to reduce or regulate the growth of ozone precursors so that the ozone monitors in the state are attaining the ozone standard in 2007 and to ensure that the Department is meeting the milestones specified by EPA for the EAC process. As part of the EAC process, the Department is proposing to promulgate a new regulation, R.61-62.5, Standard 5.2, *Control of Oxides of Nitrogen (NO_x)*. In addition, the Department proposes to revise R.61-62.5, Standard 5.1, *Lowest Achievable Emission Rate (LAER) Applicable to Volatile Organic Compounds,* and R.61-62.2, *Prohibition of Open Burning.* Finally, the South Carolina State Implementation Plan (SIP) will be amended.

A Notice of Drafting was published in the *State Register* on August 23, 2002. A second notice extending the drafting comment period was published on April 25, 2003.

Discussion of Proposed Revisions:

SECTION CITATION: EXPLANATION OF CHANGE

R.61-62.5, STANDARD 5.2, CONTROL OF OXIDES OF NITROGEN (NOX)

A new regulation has been added.

R.61-62.5, STANDARD 5.1, LOWEST ACHIEVABLE EMISSION RATE (LAER) APPLICABLE TO VOLATILE ORGANIC COMPOUNDS

Regulation title The title of the regulation has been changed to *Best Available Control Technology (BACT)/Lowest Achievable Emission Rate (LAER) Applicable to Volatile Organic Compounds*.

Section I (A)(3) The definition of "actual emissions" has been revised.

Section I (C) A new definition has been added for "Best Available Control Technology (BACT)."

Section II (A) The paragraph has been revised to indicate that new construction permits issued after the effective date of this regulation shall apply BACT.

Section II (B) A new paragraph has been added to specify that, if the Department determines that the application of BACT/LAER controls would result in the emission of pollutants which might cause or significantly contribute to an exceedance of an ambient air quality standard, a lesser degree of control may be allowed.

R.61-62.2, PROHIBITION OF OPEN BURNING

Section I (C) The paragraph has been revised to clarify that only clean wood products shall be used for fires set for human warmth.

Section I (D) The paragraph has been revised for clarity.

Section I (E) The paragraph has been renumbered and revised to stipulate that material to be burned must be generated onsite.

Section I (H) The paragraph has been renumbered and revised to specify that only permanent fire-fighter training facilities are exempt and that non-permanent locations must receive Department approval prior to any burning activity.

Section I (I) The paragraph allowing the burning of household trash on the premises of and originating from private residences has been deleted.

Section I (J) The paragraph allowing for burning of construction waste from building and construction operations has been deleted.

Section I (K) The paragraph has been revised for clarity.

Notice of Staff Informational Forum:

Staff of the Department of Health and Environmental Control invite interested persons of the public to attend a staff-conducted informational forum to be held on November 24, 2003, at 10:00 am in Room 2380 at the Department of Health and Environmental Control at 2600 Bull Street, Columbia, S.C. 29201.

Interested persons are also provided an opportunity to submit written comments to Heather Preston, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201. To be considered, written comments must be received no later than 5:00 pm on November 24, 2003. Comments

received by the deadline will be submitted to the Board in a Summary of Public Comments and Department Responses.

Copies of the proposed regulation for public notice and comment may be obtained by contacting Heather Preston, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201.

Notice of Board Public Hearing and Opportunity for Public Comment Pursuant to S.C. Code Sections 1-23-111:

Interested members of the public and regulated community are invited to make oral or written comments on the proposed regulation at a public hearing to be conducted by the Board of Health and Environmental Control at its regularly-scheduled meeting on January 8, 2004, to be held in Room 3420 (Board Room) of the Commissioner's Suite, third floor, Aycock Building of the Department of Health and Environmental Control, 2600 Bull Street, Columbia, S.C. The Board meeting commences at 10:00 a.m. at which time the Board will consider items on its agenda in the order presented. The order of presentation for public hearings will be noted in the Board's agenda to be published by the Department 24 hours in advance of the meeting. Persons desiring to make oral comments at the hearing are asked to limit their statements to five minutes or less, and as a courtesy are asked to provide written copies of their presentation for the record.

Interested persons are also provided an opportunity to submit written comments on the proposed amendments by writing to Heather Preston, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201. To be considered, written comments must be received no later than 5:00 pm on November 24, 2003. Comments received shall be submitted to the Board in a Summary of Public Comments and Department Responses for consideration at the public hearing.

Copies of the proposed regulation for public notice and comment may be obtained by contacting Heather Preston, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201.

Preliminary Fiscal Impact Statement:

The proposed regulations will not result in any increased costs to the State or its political subdivisions. Existing staff and resources will be utilized to implement these amendments.

Statement of Need and Reasonableness:

This statement of need and reasonableness was determined by staff analysis pursuant to S.C. Code Section 1-23-115(C)(1)-(3) and (9)-(11).

DESCRIPTION OF REGULATION:

Purpose: On July 18, 1997, the United States Environmental Protection Agency (EPA) revised the National Ambient Air Quality Standard for ground-level ozone from 0.12 parts per million (ppm) 1-hour "peak" standard to 0.08 ppm 8-hour "average" standard. The National Ambient Air Quality Standards are health-based standards established at levels intended to protect public health. This "new" ozone standard is commonly referred to as the 8-hour ozone standard. Currently, all areas of South Carolina meet or "attain" all national ambient air quality standards, including the 1-hour ozone standard. However, when implemented, the 8-hour ozone standard could result in numerous areas of the state being determined not to meet the 8-hour standard and being designated as "non-attainment" for ground-level ozone. In South Carolina, 18 of 23 ozone monitors, particularly those in the more populated urban areas, regularly exceed the 8-hour standard. When air quality standards are revised, the state must recommend to EPA the boundaries of the areas that are not in compliance with the standard and must submit a plan to EPA that demonstrates how the state will bring those areas designated as non-attainment for the

standard back into attainment. EPA will make the 8-hour ozone non-attainment designations by April 15, 2004, with input from the Department.

When EPA designates areas as non-attainment, these areas automatically become subject to additional permitting requirements referred to as non-attainment new source review and complex transportation planning requirements referred to as transportation conformity. In an effort to be proactive and bring cleaner air sooner to the citizens of South Carolina, the Department, with EPA support, has begun the process with state and local governments, industry, environmental groups, and other interested parties to consider possible ozone reduction strategies. The Department has been working with these stakeholder groups over the last year to develop strategies sooner than would be required by the current federal timeframes to reduce the pollution that creates ground-level ozone.

This strategy of bringing cleaner air to the state sooner than would be required under the current federal timeframes is referred to as the Early Action Compact or EAC. In accordance with the EAC, EPA has laid out specific milestones that the state must meet to reduce ozone precursors so that our ozone monitors will be attaining the 8-hour standard by 2007 and beyond. Aside from the public health benefits realized by meeting the new standard sooner than required, another reason for embarking on this approach is that if we are successful, EPA will defer the effective date of the non-attainment designations.

The purpose of the proposed regulations is to reduce or regulate the growth of ozone precursors so that the ozone monitors in the state are attaining the ozone standard in 2007 and to ensure that the Department is meeting the milestones specified by EPA for the EAC process. As part of the EAC process, the Department is proposing to promulgate a new regulation, R.61-62.5, Standard 5.2, *Control of Oxides of Nitrogen (NO_x)*. In addition, the Department proposes to revise regulation 61-62.5, Standard 5.1, *Lowest Achievable Emission Rate (LAER) Applicable to Volatile Organic Compounds,* and regulation 61-62.2, *Prohibition of Open Burning.* Finally, the South Carolina State Implementation Plan (SIP) will be amended.

Legal Authority: The legal authority for regulation 61-62 is Sections 48-1-10 et seq., S.C. Code of Laws.

Plan for Implementation: The proposed amendments will take effect upon approval by the General Assembly and publication in the *State Register*. The proposed amendments will be implemented by providing the regulated community with copies of the regulation.

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

As the national air quality standards are health-based standards, it is important that efforts are made to improve air quality to meet these standards as soon as possible. Further, when non-attainment designations occur, areas automatically become subject to new additional permitting requirements and complex transportation planning requirements. These prescriptive federal requirements represent a one-size-fits-all approach to reducing ozone pollution. They are an economic burden for areas with a non-attainment designation and may not be the best strategy for reducing ozone pollution in South Carolina. Furthermore, this approach encourages sprawl by penalizing sources that locate in non-attainment areas. The EAC approach ensures that we bring cleaner air sooner to the state by meeting the new ozone standard sooner than required under the current federal timeframes. In addition to the public health benefits, under the EAC process, EPA will defer of the effective date of the non-attainment designations and thereby allow us the opportunity to develop strategies better suited to South Carolina's needs.

DETERMINATION OF COSTS AND BENEFITS:

The economic impacts associated with non-attainment are significant. When an area is designated as non-attainment, new sources, or existing facilities in need of major modifications, must install the Lowest Achievable Emission Rate (LAER) technology. LAER does not allow economic costs to be considered when determining what pollution controls are to be installed. Thus, if the controls are technically feasible, they must be installed regardless of the costs. Furthermore, pollution offsets are required in non-attainment areas and this is an additional cost to be considered.

As a result of the expenses involved, new facilities will choose not to locate in non-attainment areas and will choose instead to locate outside the non-attainment boundary. This approach encourages sprawl by providing incentives for sources to locate outside of non-attainment areas. It also puts certain areas of the state at a significant economic disadvantage. This inequity is further compounded by the fact that air pollution knows no boundaries and thus, facilities can locate outside of the non-attainment area and still have emissions that negatively impact the non-attainment area's air quality.

The EAC approach requires that our monitors attain the 8-hour standard sooner than the current federal timeframes. This translates into cleaner air sooner for our citizens. There are obvious public health benefits to be derived from this approach that are hard to quantify. In addition, the EAC approach allows us to design our own strategy for attaining the 8-hour standard. The primary focus of the regulations the Department is proposing is to control the growth of emission of oxides of nitrogen (NOx). Proposed Regulation 61-62.5, Standard 5.2, *Control of Oxides of Nitrogen (NOx)*, requires reasonable NOx controls on fuel combustion sources. This regulation will ensure uniform controls across the state rather than the current federal system that requires stringent controls in select areas. Thus, in terms of a cost/benefit analysis for this regulation, we need to compare the stringent LAER and offsets that would occur in select areas of the state under a non-attainment designation with the more reasonable controls that would apply statewide as a result of these regulations. As an example of the cost differential, a new 125mmBTU/hr boiler under this regulation would be required to install low NOx burners capable of achieving 30 ppmv corrected to 3% O_2. According to vendor information and other sources, this technology would cost about $700 per ton of NOx reduced. If this same unit were installed in a non-attainment area, LAER for this unit would most likely be Selective Catalytic Reduction (SCR). A recent NESCAUM (The Northeast States for Coordinated Air Use Management) report estimates that the SCR on gas fired boilers is estimated to provide reductions for $2,000/ton for boilers of about 350mmBTU/hr that operate at high capacity factors. This number jumps to around $3,500/ton of NOx reduced for smaller, gas-fired boilers of a 100mmBTU/hr and this does not include the cost of offsets. Thus, it is evident that for non-attainment areas, the cost of controls under this regulation is significantly less than the costs would be if the area had a non-attainment designation.

Another regulation that the Department is revising in an effort to reduce NOx emissions statewide as part of the EAC process is Regulation 61-62.2, *Prohibition of Open Burning*. The most significant revisions to this regulation are as follows: deleting the exception for the burning of household trash, deleting the exception for the burning of construction waste, and revising the exception for fires set for the purpose of firefighter training. The burning of household trash and construction waste presents health and environmental concerns for many communities. The smoke generated from these activities is a nuisance to some and a health threat to others with asthma or other respiratory problems. Furthermore, the Department spends a lot of staff time and resources responding to complaints relating to these activities. The Department believes that deleting these exceptions from the regulation will not result in any significant cost or hardship because other disposal options for household trash and construction waste are readily available. Furthermore, most construction sites currently use other means of disposing of construction waste. The Department is also proposing to revise the exceptions for the purposes of firefighter training to ensure consistency and to ensure that minimum health, environmental and safety concerns are addressed. The Department will do a review of permanent firefighter training facilities and will evaluate non-permanent sites and require Department approval prior to a burn. The Department does not anticipate that this will result in any significant costs because existing firefighter training facilities will not be adversely impacted and

non-permanent sites will still be allowed, but held to consistent standards. This revision allows the Department to collect information and to grant prior approval for firefighter training sites.

Finally, the Department is proposing to revise Regulation 61-62.5, Standard 5.1, *Lowest Achievable Emission Rate (LAER) Applicable to Volatile Organic Compounds*. This regulation is being revised to require Best Available Control Technology (BACT) to be applied to any new construction permit issued after effective date of this revision when the net VOC emissions increase exceeds 100 tons per year. As stated above, LAER requires very stringent pollution controls regardless of costs. This revision will require BACT controls on new construction that results in a net VOC emissions increase of greater than 100 tons per year. This is consistent with the Department's proposed regulation for controlling NOx emissions which requires reasonable NOx controls on fuel combustion sources. The Department believes that less costly VOC controls that will result from this revision will further offset the costs to the regulated community of the NOx controls that the Department is proposing with Regulation 61-62.5, Standard 5.2, while still being protective of the environment and public health.

UNCERTAINTIES OF ESTIMATES:

Proposed Regulation 61-62.5, Standard 5.2, *Control of Oxides of Nitrogen (NOx)*, requires reasonable NOx controls on new, as well as some existing, fuel combustion sources. The cost of NOx controls will vary from source to source depending on size, fuel, and other factors. While the cost of this regulation will depend on the source in question, what is certain is that for sources locating in non-attainment areas, the costs will be far greater than the cost of the controls required by this regulation.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

The combination of these three regulations will have a positive impact on the environment and public health by reducing ozone pollution sooner than would be required under the federal timelines.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATIONS ARE NOT IMPLEMENTED:
Ozone can irritate lung airways and cause inflammation much like a sunburn. Other symptoms include wheezing, coughing, pain when taking a deep breath, and breathing difficulties during exercise or outdoor activities. People with respiratory problems are most vulnerable, but even healthy people that are active outdoors can be affected when ozone levels are elevated. Repeated exposure to ozone pollution for several months may cause permanent lung damage. These regulations are designed to reduce ozone pollution sooner than would be required under the federal timelines. If these regulations are not implemented, the public health benefits will not be realized. Furthermore, if these regulations are not implemented, the state will fail to meet the EAC milestone and EPA will not defer the effective date of the non-attainment designations. This will encourage sprawl by providing incentives for sources to locate outside of non-attainment areas.

STATEMENT OF RATIONALE:

In accordance with S.C. Code Section 1-23-110(A)(3)(h), copies of a detailed statement of rationale may be obtained by contacting Heather Preston, Division of Air Planning, Development and Outreach, Bureau of Air Quality, 2600 Bull Street, Columbia, SC 29201.

Text:

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

Document No. 2871
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61
Statutory Authority: S.C. Code Ann. Section 48-1-10, *et seq*. (1976 as amended)

R.61-101, *Water Quality Certification*

Preamble:

DHEC has historically reviewed U.S. Army Corps of Engineer permits for activities that altered wetlands in South Carolina. Through the Bureau of Water's Section 401 water quality certification and the Office of Ocean and Coastal Resource Management's coastal zone consistency certification, DHEC was able to regulate activities, most notably placement of fill material, in wetlands. As a result of the U.S. Supreme Court decision, *Solid Waste Agency of Northern Cook County (SWANCC) v. United States Army Corps of Engineers,* that held that the Corps does not have jurisdiction over isolated waters, DHEC's opportunity to review these impacts and issue appropriate certifications has been removed.

Since wetlands are waters of the state as defined in the SC Pollution Control Act, DHEC has the legal authority to regulate activities directly in wetlands. However, since there is currently no permitting program in place specifically for wetlands, DHEC has attempted to use existing permitting programs to review impacts to wetlands. This approach still leaves thousands of acres of isolated wetlands in South Carolina unprotected. In October 2002, several environmental groups, including the Southern Environmental Law Center, petitioned DHEC to begin rulemaking to protect South Carolina's wetlands.

Amendment to this regulation would provide a permitting program for DHEC to issue a State permit, modeled after the 401 water quality certification, for fill in waters, including wetlands, no longer subject to jurisdiction and therefore permitting by the Corps. This approach would simply restore DHEC's ability to regulate those waters previously regulated by DHEC through the prerequisites to the Corps permit. There is no intention to expand the authority of DHEC.

R. 61-101 will be replaced in its entirety because of recodification and stylistic changes made throughout the existing regulation. The proposed amendment will be submitted to the General Assembly for review.

Discussion of Revisions:

All revisions listed below will reinstate the Department's ability to review and regulate the placement of dredged or fill material into isolated waters by establishing a permit program modeled after the water quality certification program. This includes application procedures, review criteria, determination of nonfederal waters including wetlands, requirements for compensatory mitigation, and compliance and enforcement authority. There is also a new severability section. Sections I.4. and I.10 also include modifications for clarification to the present water quality certification program.

SECTION	REVISION
R. 61-101	Added language to include State permits.
R. 61-101. A.1.	Added language to establish water quality permits pursuant to State Pollution Control Act.
R. 61-101. A.2.	Added language that either a State water quality permit or Federal permit is required prior to discharge of dredged or fill material into waters of the State.

R. 61-101.A.3.	Added language that no permit or certification will be issued unless activity complies with certain regulations and plans.
R. 61-101.A.4.	Added language to include State permits.
R. 61-101.A.5.	Added language to include State permits.
R. 61-101.A.6.	Added language to include State permits.
R. 61-101.A.7.	Added language to include State permits.
R. 61-101.B.1.	Added numbering for codification.
R. 61-101.B.4.	Added definition for coastal zone consistency certification.
R. 61-101.B.7.	Added a definition for mitigation consistent with Federal National Environmental Policy Act.
R. 61-101.B.8	Added a definition for nonfederal waters removed from the jurisdiction of the US Army Corps of Engineers.
R. 61-101.B.9.	Added a definition for water quality permit.
R. 61-101.B.10.	Added a definition for water quality standards.
R. 61-101.B.11.	Added a definition for wetlands consistent with the Federal definition.
R. 61-101.B.12.	Added definition for wetlands master planning.
R. 61-101.C.1.–2.	New section which includes information currently in the regulation regarding applicability of water quality certifications and new information regarding applicability of water quality permits.
R. 61-101.D.1.	Added language to include State permits.
R. 61-101.D.1.(a)	Added language to require agent's phone number.
R. 61-101.D.3.	Grammatical correction and change to reflect renumbering.
R. 61-101.D.4.	Added language to include State permits.
R. 61-101.E.1.	Added language to include State permits.
R. 61-101.E.2.	Added language to include State permits.
R. 61-101E.4.	Renumbered for codification.
R. 61-101.E.4.(c)	Added provision for public notice on internet.
R. 61-101.F.1.	Changes to reflect renumbering.
R. 61-101.G.1.–2.	New section regarding determination of wetlands consistent with Federal procedures and determination of nonfederal wetlands.

R. 61-101.H.1.–2.	New section describing exempt activities consistent with Federal exemptions.
R. 61-101.I.1.	Added language to include State permits.
R. 61-101.I.3.(c)	Renumbered for codification.
R. 61-101.I.2.	Added language to include State permits.
R. 61-101.I.4.	Added language to include State permits and clarification of current practices.
R. 61-101.I.5.	Added provision for use of mitigation.
R. 61-101.I.6.	Added provision for wetlands master planning.
R. 61-101.I.7.	Added factors the Department will use in evaluating wetlands to be impacted and references table in the Appendix for computing required compensatory mitigation.
R. 61-101.I.8.	Added provision that projects with wetlands master planning may be eligible for expedited review.
R. 61-101.I.9.	Added language to include State permits.
R. 61-101.I.10.	Added language to include State permits and clarification of current practices.
R. 61-101.I.11.	Added language to include State permits.
R. 61-101.J.	Deleted language that specifies applicability to water quality certifications only.
R. 61-101J.1.	Added language to include State permits.
R. 61-101.J.2.	Added language to include State permits.
R. 61-101.J.3.	Added language to include State permits.
R. 61-101.J.5.	Added language to include State permits.
R. 61-101.K.	Added language to include State permits.
R. 61-101.K.3.	Added language to include State permits.
R. 61-101.K.4.	Added clarification that conditions of permits and certifications may not be violated.
R. 61-101.K.5.	Added statement that Department may enforce compliance and may assess penalties for violations of permits and conditions.
R. 61-101.L.	Added severability section.
Appendix A	Added tables and instructions for evaluating wetlands impacts and computing required compensatory mitigation.

Stylistic changes, including corrections for clarity and readability, grammar, punctuation, typography, codification, references, language style and overall improvement of the text of the regulation were also made.

The entire regulation includes revisions due to recodification of additional or deleted language from the proposed text changes so that every section, subsection, subitem and item could be cited correctly.

Notice of Staff Informational Forum:

Staff of the Department of Health and Environmental Control invite members of the public and regulated community to attend a staff-conducted informational forum to be held on November 18, 2003, at 2:00 pm in Peeples Auditorium, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina. The purpose of the forum is to answer questions, clarify the issues, and receive comments from interested parties on the proposed amendment to the regulation. Due to admittance procedures at the DHEC Building, all visitors must enter through the Bull Street entrance and register at the front desk. Comments received shall be considered by staff in formulating the final draft proposal for submission to the Board of Health and Environmental Control for the Board public hearing scheduled for December 11, 2003, as noticed below.

Interested parties are also provided an opportunity to submit written comments to the staff forum by writing to M. Rheta Geddings at Bureau of Water, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina, 29201, fax number (803) 898- 4140. To be considered, written comments submitted must be received no later than 5:00 p.m. on November 24, 2003. Comments received shall be submitted in a Summary of Public Comments and Department Responses for the Board's consideration at the public hearing as noticed below.

Copies of the text of the proposed amendment to the regulation for public notice and comment may be obtained by contacting M. Rheta Geddings at Bureau of Water, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina, 29201, telephone number (803) 898-4229, email address geddinmr@dhec.sc.gov, fax number (803) 898-4140, or from the Department’s website at http://www.scdhec.net/water/.

Notice of Public Hearing and Opportunity for Public Comment Pursuant to S.C. Code Sections 1-23-110 and 1-23-111:

Interested members of the public and regulated community are invited to make oral and written comments on the proposed amendment to the regulation at a public hearing to be conducted by the Board of Health and Environmental Control at its regularly-scheduled meeting on December 11, 2003. The public hearing will be held in the Board Room of the Commissioner's Suite, Third Floor, Aycock Building of the Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina. The Board meeting commences at 10:00 a.m. at which time the Board will consider items on its agenda in order presented. The order of presentation for public hearings will be noticed in the Board's agenda to be published by the Department 24 hours in advance of the meeting. Persons desiring to make oral comments at the hearing are asked to limit their statements to five minutes and, as a courtesy, are asked to provide written copies of their presentation for the record. Due to admittance procedures at the DHEC Building, all visitors must enter through the Bull Street entrance and register at the front desk.

Interested parties are also provided an opportunity to submit written comments on the proposed amendment to the regulation by writing to M. Rheta Geddings at Bureau of Water, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina, 29201. To be considered, written comments submitted must be received no later than 5:00 pm on November 24, 2003. Comments received shall be submitted in a Summary of Public Comments and Department Responses for the Board's consideration at the public hearing as noticed above.

Copies of the final proposed regulation for public hearing may be obtained by contacting M. Rheta Geddings at Bureau of Water, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, South Carolina, 29201, telephone number (803) 898-4229, email address geddinmr@dhec.sc.gov, fax number (803) 898-4140, or from the Department's website at http://www.scdhec.net/water/.

Preliminary Fiscal Impact Statement:

No costs to the State or significant cost to its political subdivisions as a whole should be incurred by these amendment. See Statement of Need and Reasonableness below.

Statement of Need and Reasonableness:

The statement of need and reasonableness was determined by staff analysis pursuant to S.C. Code Ann. Section 1-23-115(C)(1)-(3) and (9)-(11) (1976, as amended):

DESCRIPTION OF REGULATION: Amendment of Regulation 61-101, Water Quality Certification.

Purpose: Proposed amendment of R.61-101 will strengthen the existing regulation by creating a water quality permitting process for impacts to nonfederal waters.

Legal Authority: S.C. Code Ann. Sections 48-1-30 and 48-1-50 (1976, as amended), implementing the S.C. Pollution Control Act and the Federal Clean Water Act.

Plan for Implementation: The proposed amendment would be incorporated within R.61-101 upon approval of the General Assembly and publication in the *State Register*. The proposed amendment will be implemented in the same manner in which the present regulation is implemented.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFIT: This amendment is necessary to protect waters of the State that are not under federal jurisdiction.

DHEC has historically reviewed U.S. Army Corps of Engineer permits for activities that altered wetlands in South Carolina. Through the Bureau of Water's Section 401 water quality certification and the Office of Ocean and Coastal Resource Management's coastal zone consistency certification, DHEC was able to regulate activities, most notably placement of fill material, in wetlands. As a result of the U.S. Supreme Court decision, *Solid Waste Agency of Northern Cook County (SWANCC) v. United States Army Corps of Engineers*,that held that the Corps does not have jurisdiction over isolated waters, DHEC's opportunity to review these impacts and issue appropriate certifications has been removed.

Since wetlands are waters of the state as defined in the SC Pollution Control Act, DHEC has the legal authority to regulate activities directly in wetlands. However, since there is currently no permitting program in place specifically for wetlands, DHEC has attempted to use existing permitting programs to review impacts to wetlands. This approach still leaves thousands of acres of isolated wetlands in South Carolina unprotected. In October 2002, several environmental groups, including the Southern Environmental Law Center, petitioned DHEC to begin rulemaking to protect South Carolina's wetlands.

Amendment to this regulation will provide a permitting program for DHEC to issue a State permit, modeled after the 401 water quality certification, for fill in waters, including wetlands, no longer subject to jurisdiction and therefore permitting by the Corps. This approach would simply restore DHEC's ability to regulate those waters previously regulated by DHEC through the prerequisites to the Corps permit. There is no intention to expand the authority of DHEC.

Stylistic and grammatical changes are necessary for readability, punctuation, typography, codification, references, and language style.

DETERMINATION OF COSTS AND BENEFITS: Existing staff and resources will be utilized to implement this amendment to the regulation. No additional cost will be incurred by the State if the revisions are implemented and therefore, no additional State funding is being requested.

In reviewing the potential for significant economic impact of the proposed amendment, the Department evaluated situations in which costs would most likely be incurred by the regulated community. The Department found that the overall impact to the State's political subdivisions or the regulated community as a whole was not likely to be significant in that prior to the SWANCC decision similar costs would have been incurred.

UNCERTAINTIES OF ESTIMATES: Minimal to moderate.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH: Implementation of this amendment will improve the protection of the environment. The amendment will promote and protect water quality and aquatic life of waters of the State.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED: Failure by the Department to incorporate protection of nonfederal waters into the regulation will lead to contamination of and loss of waters of the State with detrimental effects on the health of flora and fauna in the State as well as the citizens of South Carolina.

Statement of Rationale:

The statement of rationale was determined by staff analysis pursuant to S.C. Code Ann. Section 1-23-110(A)(3)(h) (1976, as amended).

The U.S. Supreme Court decision, *Solid Waste Agency of Northern Cook County (SWANCC) v. United States Army Corps of Engineers,* issued January 9, 2001, in effect removed isolated waters from the permitting jurisdiction of the Corps of Engineers. Since the Corps of Engineers no longer issues permits for the discharge of fill material into isolated wetlands, there is no requirement nor is there any mechanisism for the Department to issue water quality certification and coastal zone consistency certification. Presently, there is State review for fill into isolated wetlands only if another State permit is required. The proposed amendment will provide a permitting program to reinstate the Department's previous authority to regulate all discharges into isolated waters. It will also streamline the process for obtaining a permit for discharges into isolated waters including wetlands.

Text:

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

Document No. 2870
DEPARTMENT OF LABOR, LICENSING AND REGULATION
DIVISION OF LABOR
CHAPTER 71
Statutory Authority: 1976 Code Section 41-15-210

Preamble:

The purpose of the amendment is to revise the regulation to delete the two provisions concerning musculoskeletal disorders (MSDs). This amendment is required by the United States Department of Labor 29 CFR 1904.37 "State Recordkeeping Regulations."

Section-by-Section Discussion:

Revise Regulation 71, Article I, Subarticle 3 - Recording and Reporting Occupational Injuries and Illnesses, as follows:
SCRR 71-300 to 311 remains the same
SCRR 71-312 Delete
SCRR 71-313 to 328 remains the same
SCRR 71-329 (a) and (b)(1) through (7)(v) remain the same.
SCRR 71-329 paragraph (b)(7)(vi) replace in its entirety; revised to delete the delayed effective date.
SCRR 71-329 paragraph (b)(8) through (10) remain the same.
SCRR 71-330 to 346 remains the same

Notice of Public Hearing and Opportunity for Public Comment:

Should a hearing be requested pursuant to Section 1-23-110(b) of the 1976 Code, as amended, such a hearing will be conducted at the Administrative Law Judge Division at 9:00 a.m. Tuesday, December 9, 2003. Written comments may be directed to Karl Maddox, OSHA Standards Officer, Division of Labor, Department of Labor, Licensing, and Regulation, Post Office Box 11329, Columbia, South Carolina 29211-1329, no later than 5:00 p.m., Monday, November 24, 2003.

Preliminary Fiscal Impact Statement:

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

Statement of Need and Reasonableness:

This statement of need and reasonableness was developed by staff analysis pursuant to S.C. Code Section 1-23-115(C).

DESCRIPTION OF REGULATION:

Purpose: The Division of Labor is updating the recordkeeping regulations to reflect changes made in the federal recordkeeping regulations. South Carolina operates a state occupational safety and health program under the provisions of 29 U.S.C. 667. One of the provisions of this statute requires the state to maintain standardized reporting and recording of occupational injuries and illnesses and ensure uniformity in national statistical data collection. 29 U.S.C. 667(C)(7).

Legal Authority: 1976 Code, Section 41-15-210

Plan for Implementation: The revised regulations will take effect on the national level on January 1, 2004, and will become enforceable in South Carolina upon final approval by the General Assembly and upon publication in the State Register. The United States Department of Labor has published the amendments in the Federal Register and posting them on various government web sites. The Department will post the revised regulations on the agency's web site.

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

The proposed regulation will maintain a standardized format in relation to the federal regulation for recording injuries and illnesses in the workplace thus preventing confusion for employers in South Carolina and especially employers who have operations in other states and assuring that the state occupational safety and health plan maintains its federal approval status.

DETERMINATION OF COSTS AND BENEFITS:

No additional costs to protesting parties will result from these regulations.

UNCERTAINTIES OF ESTIMATES:

There are no uncertainties of estimates concerning the regulation.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

This regulation will have no effect on the environment. This regulation contributes to the Division's function of protecting employee safety and health in the state of South Carolina.

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

There will be no detrimental effect on the environment and public health of this State if this regulation is not implemented.

Statement of Rationale:

There was no scientific or technical basis relied upon in developing the regulation.

Text:

SCRR 71-312 Recording criteria for cases involving work-related musculoskeletal disorders. [Reserved]

SCRR 71-329 Forms.
(b) (7) (vi) Other illnesses, if the employee voluntarily requests that his or her name not be entered on the log.

Document No. 2874
COMMISSION FOR MINORITY AFFAIRS
CHAPTER 139
Statutory Authority: S.C. Code Section 1-31-40 (A)(10)

Article I

139-100 Purpose
139-101 Scope
139-102 Definitions
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139-106 Purpose of Native American Indian Advisory Committee
139-107 Membership Requirements for the Native American Advisory Committee
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139-109 Duties of State Recognition Committee
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Preamble:

The South Carolina Commission for Minority Affairs submits the following new regulation to govern the process for State Recognition of Native American Indian entities in the State of South Carolina. A Notice of Drafting of proposed regulations was published in the State Register commencing July 25, 2003. Additionally, meetings were held with tribal leaders and citizens over a one year period to solicit input for the drafting of these regulations.

Section-by-Section Discussion

139-100 Purpose
Text defines purpose of proposed regulations as stated in the enabling legislation.

139-101 Scope
Text identifies categories under which Native American entities may seek State Recognition.

139-102 Definitions
Text defines terms used throughout proposed regulations.

139-103 Notification of Recognition Status
Text defines what body will recognize and how recognition will be acknowledged.

139-104 Limitations
Text identifies matters exempt from and not covered by the proposed regulations. The text spells out the limitations of the proposed regulations.

139-105 Criteria for State Recognition
Text identifies the requirements that must be met to obtain one of three possible recognition levels.

139-106 Purpose of the Native American Advisory Committee
Text defines the purpose of the committee and identifies the nature of its work.

139-107 Membership Requirements for the Native American Advisory Committee
Text identifies membership, term of service, schedule of meetings, and other matters related to the operation of the committee.

139-108 Membership, Terms, and Voting Power of the State Recognition Committee
Text defines who will sit to review all information regarding State Recognition, when, the length of service, number of votes needed to obtain favorable recommendation, and how replacement of members will be made.

139-109 Duties of the State Recognition Committee
Text spells out the provisions used to determine State Recognition, when applications are due, length of deliberations, notification of action to CMA Board and how often entities may apply for State Recognition.

139-110 Verification of Authenticity of Documents
Text identifies the nature of the documents to be considered by the State Recognition Committee, how such documents will be determined to be authentic and valid for consideration, and the extent to which Committee members can go to verify authenticity of documents.

139-111 Confidentiality
Text defines what documents, deliberations, and matters are exempt for the State Freedom of Information Act and any penalties for violating the privacy rights of entities and persons affected by these regulations.

Notice of Public Hearing and Opportunity for Public Comment:

Interested members of the public are invited to make oral and written comments on the proposed regulation at a public hearing to be conducted by the Board of the Commission for Minority Affairs on December 12, 2003 at 10:00 a.m. The hearing will be held in the Board Room at the South Carolina Commission for Minority Affairs, 6904 North Main Street, Suite 107, Columbia, South Carolina 29203 located at US21 at Interstate 20, Exit 71. Persons desiring to make oral comments at the hearing are asked to limit their statements to five minutes or less, and as a courtesy are asked to provide written copies of their presentations for the record.

Additionally, interested persons are also provided an opportunity to submit written comments on the proposed regulations by writing to Janie A. Davis at the South Carolina Commission for Minority Affairs, 6904 North Main Street, Suite 107, Columbia, South Carolina 29203, or by calling (803) 333-9621, Extension 11. Comments must be received no later than 5:00 p.m. on November 14, 2003. Comments received shall be considered by the staff in formulating the final proposed regulations for public hearing on December 12, 2003, as noted above. Comments received by the deadline shall be submitted to the Board in a summary of public comments and agency responses for consideration at the public hearing.

Preliminary Fiscal Impact Statement:

The South Carolina Commission for Minority Affairs estimates that costs incurred by the State in complying with the proposed regulation will be approximately $60,000.00. These new funds would be used to hire a Program Coordinator for Native American Indian Affairs and cover administrative costs. See FY 2004-2005 Budget Request.

Statement of Need and Reasonableness:

This statement of need and reasonableness was determined by the agency based upon an analysis enumerated in Section 23-115(c) (1) through (3) and (9) through (11).

DESCRIPTION OF REGULATION: State Recognition of Native American Indian Entities

Purpose: New regulation to guide process for determining State Recognition of Native American Indian entities in South Carolina.

Legal Authority: The legal authority is found in Section 1-31-40(A)(10), South Carolina Code of Laws.

Plan for Implementation: The proposed regulation will take effect upon approval by the General Assembly and in keeping with all provisions of the Commission's enabling legislation. The proposed regulation will be published in the State Register and will be implemented by providing the Native American Indian community with copies of the regulation.

DETERMINATION OF NEED AND REASONABLENESS OF THE REGULATION AND THE EXPECTED BENEFIT OF THE REGULATION:

The proposed regulation reflects the desire of the Native American Indian community to formally establish a process for recognizing the true aboriginal people of the State of South Carolina. This regulation is needed to provide a formal mechanism through which to acknowledge genuine descendents of Indian genealogy. The proposed regulation is needed to preserve the true aboriginal culture of the Americas in the State of South Carolina so that future generations may learn of and respect the contributions of the Native American Indian people.

DETERMINATION OF THE COSTS AND BENEFITS:

The proposed regulation is expected to cost approximately $60,000.00 per fiscal year in personnel and administrative costs. It will cost the State of South Carolina much less to place this responsibility under the Commission than to establish another freestanding agency to oversee Native American Indian Affairs in the State.

UNCERTAINTIES OF ESTIMATES:

None.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

None.

DETRIMENTAL EFFECTS ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATIONS ARE NOT IMPLEMENTED:

None.

TEXT

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

Document No. 2847
CLEMSON UNIVERSITY
STATE LIVESTOCK-POULTRY HEALTH COMMISSION
CHAPTER 27
Statutory authority: 1976 Code Section 47-4-30 and 47-17-130

R.27-1023 State Meat Inspection Regulation

Synopsis:

These regulations are being promulgated to modernize, clarify and update existing regulations which govern, to the extent authorized by S. C. Code, Title 47, Chapter 4, the inspection of meat and meat food products produced for intrastate commerce. These updated regulations are necessary to comply with the Federal Meat Inspection Act (21USCA 661, Section 301) which established Federal-State Cooperative Meat Inspection Programs. This is a grant program with equal federal-state funding. A cooperating state is required to adopt regulations "at least equal to" those adopted by the federal government. This regulation will, in effect, adopt the current Federal Meat Inspection Regulations with some minor exceptions for some state specific requirements. The Notice of Drafting was published in the State Register on June 27, 2003

Instructions:

Replace R27-1023 with the following amendment.

Text:

R.27-1023 State Meat Inspection Regulation

A. Definitions.

1. *Commission* means the State Livestock-Poultry Health Commission, Clemson University.
2. *Director* means the Director, Livestock-Poultry Health Programs, Clemson University.
3. *Custom Processor* means the custom preparation by any person of carcasses, parts thereof, meat or meat food products derived from the slaughter by any individual of cattle, sheep, swine or goats of his own raising or from game animals, delivered by the owner thereof for such custom preparation and transportation in commerce of such custom prepared article, exclusively for the use in the household by the owner and members of the owners household and the owners non-paying guests and employees in an establishment permitted by the State Meat Inspection Department for that purpose.

B. Permit required; fee; application; refusal, revocation or suspension.

1. Custom processors shall secure a permit from the Commission.
2. The permit fee is twenty-five dollars ($25.00) annually or for part of a year. The permit year is July 1 to June 30. The fee must be retained by the Commission. The Commission by regulation may increase the fee to not more than fifty dollars ($50.00).
3. The Commission, for cause, may refuse to grant a permit, may revoke or modify a permit, or assess a civil penalty in accordance with Section 47-4-130, South Carolina Code of Laws (1976) as amended.

C. Adoption of Federal Meat Inspection Regulations.

The United States Department of Agriculture, Food Safety and Inspection Service, Meat Inspection Regulations, 9 CFR, Chapter III, Subchapter A, Parts 300-320, 325, 329, 335,352 and 354, and Subchapter E, Parts 416-417, 424, 430, 441 and 500 and all changes thereto in effect as of July 1, 2003 are hereby adopted as the State Meat Inspection Regulations, with exceptions as noted below.

D. Exceptions to the Federal Meat Inspection Regulations.

1. Subchapter A, Part 303 – Exemptions, Section 303.1(a)(2). The provisions of this section related to custom slaughter of livestock do not apply. Custom slaughtering is not a specified exemption in the State Meat and Meat Foods Regulations and Inspection Law of 1967.
2. Subchapter A, Part 307, Section 307.5(a) – Overtime Inspection Service. Fees and charges for overtime inspection service will be established, as required, by the Commission.
3. Subchapter A, Part 307, Section 307.5(b) – Holiday Inspection Service. State holidays as designated by the State Budget and Control Board will be utilized by the state inspection program.
4. Subchapter A, Part 312 – Official Marks, Devices and Certificates. Official state marks, devices and certificates of inspection will be utilized by the state inspection program.
5. Subchapter A, Part 352, Section 352.5 – Holiday and Overtime Inspection Services. Fees and charges for overtime and state holiday inspection services will be established, as required by the Commission.
6. Subchapter A, Part 352, Section 352.7 – Marking Inspected Products. Official state marks, devices and certificates of inspection will be utilized by the state inspection program.

E. In addition to temporary suspension in whole or in part of inspection services, as provided for in this regulation, the Director may, when he determines that the operator of any official establishment or any subsidiary therein, acting within the scope of his office, employment or agency, has threatened to forcible assault or has forcibly assaulted, intimidated, harassed or interfered with any program employees in or on account of his official duties under the law, assess a civil penalty in accordance with Section 47-4-130(b), S.C. Code of Laws, (1976) as amended.

F. The complete text of these regulations is available for review at the Meat-Poultry Inspection Department, Livestock-Poultry Health Programs, Clemson University.

Document No. 2849
CLEMSON UNIVERSITY
STATE LIVESTOCK-POULTRY HEALTH COMMISSION
CHAPTER 27
Statutory Authority: 1976 Code Section 47-4-30, 47-19-30, and 47-19-170

R 27-1022 State Poultry Regulations

Synopsis:

These regulations are being promulgated to modernize, clarify and update existing regulations which govern, to the extent authorized by S.C. Code, Title 47, Chapter 4, the inspection of poultry products produced for intrastate commerce. These updated regulations are necessary to comply with the federal Poultry Products Inspection Act (21USCA 454, Section 5) which establishes Federal-State Cooperative Poultry Inspection Programs. This is a grant program with equal federal-state funding. A cooperating state is required to adopt regulations "at least equal to" those adopted by the federal government. This regulation will, in effect, adopt the current Federal Poultry Products Inspection Regulations with some minor exceptions for some state specific requirements. The Notice of Drafting was published in the State Register on June 27, 2003.

Instructions:

Replace R27-1022 to the regulations

Text:

R.27-1022 – State Poultry Inspection Regulation

A. Definitions.

1. *Commission* means the State Livestock-Poultry Health Commission, Clemson University.
2. *Director* means the Director, Livestock-Poultry Health Programs, Clemson University.

B. Adoption of Federal Poultry Products Regulations.

The United States Department of Agriculture, Food Safety and Inspection Service, Poultry Products Inspection Regulations, 9 CFR, Chapter III, Subchapter A, Parts 362 and 381 and Subchapter E. Parts 416-417, 424, 430, 441 and 500 and all changes thereto in effect as of July 1, 2003 are hereby adopted as the State Poultry Inspection Regulations, with exception as noted below.

C. Exceptions to the Federal Poultry Products Inspection Regulations.

(1) Subchapter A, Part 362, Voluntary Poultry Inspection Regulations, Section 362.5. Fees and charges for voluntary inspection services will be established, as required, by the Commission.

(2) Subchapter A, Part 381, Subpart G, Facilities for Inspection, Section 381.38. State holidays as designated by the State Budget and Control Board will be utilized by the state inspection program.

(3) Subchapter A, Part 381, Subpart G, Facilities for Inspection, Section 381.39. Fees and charges for overtime and holiday inspection services will be established, as required, by the Commission.

(4) Subchapter A, Part 381, Subpart M, Official Marks, Devices and Certificates. Official state marks, devices and certificates of inspection will be utilized by the state inspection program.

D. The complete text of these regulations is available for review at the Meat-Poultry Inspection Department, Livestock-Poultry Health Programs, Clemson University.

Document No. 2848
DEPARTMENT OF INSURANCE
CHAPTER 69
Statutory Authority: S. C. Code Sections 38-3-110(2), 38-71-530(b), 1-23-10 et seq. (1976), as amended.

69-46. Medicare Supplement Insurance

Synopsis:

The Department has amended Regulation 69-46 in order to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and health insurance coverages to persons eligible for Medicare. The Department amends Regulation 69-46 in order to comply with State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA). BIPA essentially replaces provisions that determine the period during which a Medicare beneficiary with guarantee issue rights may apply for a Medigap policy. To the extent that BIPA defines these time periods differently than they were defined in the Balanced Budget Act of 1997 and the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, State regulatory programs must comply with BIPA. The provisions of BIPA became effective upon enactment, and issuers of Medicare supplement insurance are now required to comply with these provisions.

Instructions:

Strike existing Regulation 69-46 in its entirety and replace with the language provided.

Text:

R. 69-46. Medicare Supplement Insurance.

Section I. Purpose
The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and health insurance coverages to persons eligible for Medicare.

Section II. Authority
This regulation is issued pursuant to the authority vested in the Director of Insurance under S. C. Code Sections 38-3-110(2), 38-71-530(b), 1-23-10 et seq. (1976), as amended.

Section III. Applicability And Scope
A. Except as otherwise specifically provided in Sections VII, XIII, XIV, XVII and XXII, this regulation shall apply to:
1. All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this regulation; and
2. All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this State.
B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section IV. Definitions

For purposes of this regulation:

A. "Applicant" means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

2. In the case of a group Medicare supplement policy, the proposed certificate holder.

B. "Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

D. "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

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

a. A group health plan;

b. Health insurance coverage;

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

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

e. Chapter 55 of Title 10 United States Code (CHAMPUS);

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

g. A State health benefits risk pool;

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

i. A public health plan as defined in federal regulation; and

j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

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

a. Coverage only for accident or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; and

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

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

a. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

c. Similar supplemental coverage provided to coverage under a group health plan.

G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. "Insolvency," for purposes of this regulation, means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

I. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

J. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in [refer to definition of Medicare+Choice plan in 42 U.S.C. 1395w-28(b)(1)], and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

3. Medicare+Choice private fee-for-service plans.

L. "Medicare Supplement Policy" means a group or individual policy of accident and health insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395 Subsection (g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

M. "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

N. "Secretary" means the Secretary of the United States Department of Health and Human Services.

Section V. Policy Definitions And Terms

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

A. "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

Expenses shall not include:

1. Home office and overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; and

7. Claims processing costs.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section VI. Policy Provisions

A. Except for permitted preexisting condition clauses as described in Section VII.A.1. and Section VIII.A.1. of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare.

Section VII. Minimum Benefit Standards For Policies Or Certificates Issued For Delivery Prior To May 1, 1992

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

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

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes, subject to approval as required in Section XIV.

4. A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

a. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

b. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5. a. An issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

b. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph 5.d., the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section VII B of this regulation.

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

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

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

d. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

B. Minimum Benefit Standards.

1. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

3. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

5. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section VIII. Benefit Standards For Policies Or Certificates Issued Or Delivered On Or After May 1, 1992

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

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

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

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

deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes, subject to approval as required in Section XIV.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable

a. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

b. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section VII.A.5.e., the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder)

(i) Provides for continuation of the benefits contained in the group policy, or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

d. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificateholder the conversion opportunity described in Section VII A 5 c, or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

e. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

7. a. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

b. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

d. Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

B. Standards for Basic (Core) Benefits Common to All Benefit Plans.

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section IX. of this regulation.

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

7. Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

8. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit: Coverage for the following preventive health services:

a. An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph b. and patient education to address preventive health care measures.

b. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) Digital rectal examination;

(ii) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

(iii) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(iv) Serum cholesterol screening (every five (5) years);

(v) Thyroid function test;

(vi) Diabetes screening.

c. Tetanus and Diphtheria booster (every ten (10) years).

d. Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

10. At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

a. For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

b. Coverage Requirements and Limitations

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

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

(iii) Coverage is limited to:

(a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(b) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(c) One thousand six hundred dollars ($1,600) per calendar year;

(d) Seven (7) visits in any one week;

(e) Care furnished on a visiting basis in the insured's home;

(f) Services provided by a care provider as defined in this section;

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(h) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

c. Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

11. New or Innovative Benefits: An issuer may, with the prior approval of the Director of Insurance, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

Section IX. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Section VIII B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section VIII C (11) and in Section X of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in Section IV of this regulation. Each benefit shall be structured in accordance with the format provided in Sections VIII B and VIII C and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-up of benefit plans:

1. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic (Core) Benefits Common to All Benefit Plans, as defined in Section VIII B of this regulation.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in Section VIII B of this regulation, plus the Medicare Part A Deductible as defined in Section VIII C 1.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in Section VIII B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections VIII C 1, 2, 3, and 8 respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit (as defined in Section VIII B of this regulation), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Sections VIII C 1, 2, 8, and 10. respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in Section VIII B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Sections VIII C 1, 2, 8, and 9 respectively.

6. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in Section VIII B. of this regulation, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections VIII C 1, 2, 3, 5, and 8 respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the Core Benefit as defined in Section VII B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, the Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections VIII C 1, 2, 3, 5 and 8 respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in Section VIII B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Sections VIII C 1, 2, 4, 8, and 10 respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in Section VIII B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care,

Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Sections VIII C 1, 2, 6, and 8 respectively.

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in Section VIII B. of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Sections VIII C 1, 2, 5, 6, 8, and 10 respectively.

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in Section VIII B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Sections VIII C 1, 2, 3, 5, 7, 8, 9 and 10 respectively.

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the Core Benefit as defined in Section VII B of this regulation, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit as defined in Sections VIII C 1, 2, 3, 5, 7, 8, 9 and 10 respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

Section X. Medicare Select Policies And Certificates

A. 1. This section shall apply to Medicare Select policies and certificates, as defined in this section.

2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

1. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

2. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

3. "Medicare Select Issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

4. "Medicare Select Policy" or "Medicare Select Certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

5. "Network Provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

6. "Restricted Network Provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

7. "Service Area" means the geographic area approved by the Director of Insurance within which an issuer is authorized to offer a Medicare Select policy.

C. The Director of Insurance may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Director of Insurance finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Director of Insurance.

E. A Medicare Select issuer shall file a proposed plan of operation with the Director of Insurance in a format prescribed by the Director of Insurance. The plan of operation shall contain at least the following information:

1. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

a. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

b. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

c. There are written agreements with network providers describing specific responsibilities.

d. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2. A statement or map providing a clear description of the service area.

3. A description of the grievance procedure to be utilized.

4. A description of the quality assurance program, including:

a. The formal organizational structure;

b. The written criteria for selection, retention and removal of network providers; and

c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

5. A list and description, by specialty, of the network providers.

6. Copies of the written information proposed to be used by the issuer to comply with Subsection I.

7. Any other information requested by the Director of Insurance.

F. 1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Director of Insurance prior to implementing the changes. Changes shall be considered approved by the Director of Insurance after thirty (30) days unless specifically disapproved.

2. An updated list of network providers shall be filed with the Director of Insurance at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

2. It is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

a. Other Medicare supplement policies or certificates offered by the issuer; and

b. Other Medicare Select policies or certificates.

2. A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

5. A description of limitations on referrals to restricted network providers and to other providers.

6. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

7. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I. of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March 31st to the Director of Insurance regarding its grievance procedure. The report shall be in a format prescribed by the Director of Insurance and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M. 1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section XI. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with

the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. 1. If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

Section XII. Guaranteed Issue For Eligible Persons

A. Guaranteed Issue

1. Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons

An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare+Choice plan:

(a) The certification of the organization or plan has been terminated; or

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide;

3.a. The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

b. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section XII B 2;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

a. (i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

b. The issuer of the policy substantially violated a material provision of the policy; or

c. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5. a. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and

b. The subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare+Choice plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

C. Guaranteed Issue Time Periods

1. In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation) and ends sixty-three (63) days after the date of the applicable notice;

2. In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

3. In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer’s bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

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

5. In the case of an individual described in Subsection B but not described in the preceding provisions of the Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

D. Extended Medigap access for interrupted trial periods

1. In the case of an individual described in Subsection B(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

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

3. For purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Person are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

1. Section 12B(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

2. Section 12B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subsection C(1).

3. Section 12B(6) shall include any Medicare supplement policy offered by any issuer.

F. Notification provisions

1. At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 12A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Section XIII. Standards For Claims Payment

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. Notifying the participating physician or supplier and the beneficiary of the payment determination;

3. Paying the participating physician or supplier directly;

4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

5. Paying user fees for claim notices that are transmitted electronically or otherwise; and

6. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

Section XIV. Loss Ratio Standards And Refund Or Credit Of Premium

A. Loss Ratio Standards.

1. a. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or

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

b. calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3. For policies issued prior to May 1 1992, expected claims in relation to premiums shall meet:

a. The originally filed anticipated loss ratio when combined with the actual experience since inception;

b. The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with April 28, 1996 to date; and

c. The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation.

1. An issuer shall collect and file with the Director of Insurance by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after April 28, 1996. The first such report shall be due by May 31, 1998.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds *a de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual Filing of Premium Rates.

An issuer of Medicare supplement policies and certificates issued before or after the effective date of May 1, 1992 in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Director of Insurance in accordance with the filing requirements and procedures prescribed by the Director of Insurance. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this State shall file with the Director of Insurance, in accordance with the applicable filing procedures of this State:

1. a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents as necessary to justify the adjustment shall accompany the filing.

b. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

c. If an issuer fails to make premium adjustments acceptable to the Director of Insurance, the Director of Insurance may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings.

The Director of Insurance may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this regulation if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the Director of Insurance.

Section XV. Filing And Approval Of Policies And Certificates And Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the Director of Insurance in accordance with filing requirements and procedures prescribed by the Director of Insurance.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Director of Insurance in accordance with the filing requirements and procedures prescribed by the Director of Insurance.

C. 1. Except as provided in Paragraph 2. of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the Director of Insurance, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

a. The inclusion of new or innovative benefits;

b. The addition of either direct response or agent marketing methods;

c. The addition of either guaranteed issue or underwritten coverage;

d. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

D. 1. Except as provided in Paragraph 1.a., an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the Director of Insurance. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Director of Insurance in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Director of Insurance, the issuer shall no longer offer for sale the policy form or certificate form in this State.

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph a. shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Director of Insurance of the discontinuance. The period of discontinuance may be reduced if the Director of Insurance determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. A change in the rating structure or methodology shall be considered a discontinuance under Paragraph 1. unless the issuer complies with the following requirements:

a. The issuer provides an actuarial memorandum, in a form and manner prescribed by the Director of Insurance, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

b. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Director of Insurance may approve a change to the differential which is in the public interest.

E. 1. Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section XIV B.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Section XVI. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity may discriminate in the commission or other compensation provided to an agent or other representative for the sale of a Medicare supplement policy or certificate on the basis of an individual exercising his open enrollment option as described in Section XI of this regulation.

D. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

E. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Section XVII. Required Disclosure Provisions

A. General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6. a. Issuers of accident and health policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than twelve (12) point type. Delivery of the *Guide* shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgement of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

b. For the purposes of this Section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Director of Insurance. The notice shall:

a. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

b. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:
"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium and renewability information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE-COVER PAGE
BENEFIT PLAN(S) _____[INSERT LETTER(S) OF PLAN(S) BEING OFFERED]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan “A%”. Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

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

*Plans F and J also have an option called a high deductible Plan F and a High deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plan F and after one has paid a calendar year [$1530] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [$1530. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plan F and J, the plan's separate foreign travel emergency deductible.

PREMIUM AND RENEWABILITY INFORMATION
(Boldtype)
[Include a statement describing the renewability provision.]
We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]
DISCLOSURES
Use this outline to compare benefits and premiums among policies.
READ YOUR POLICY VERY CAREFULLY
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.
RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.
POLICY REPLACEMENT
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.
NOTICE
This policy may not fully cover all of your medical costs.
[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[insert company's name] is not connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section VIII.D. of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director of Insurance]

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$0	$[840](Part A deductible)
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility			
Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[101.50] a day	$0	Up to $[101.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN A

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

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

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

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840](Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	$0	Up to $[105] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN B

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

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

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

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840](Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN C

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

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

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

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day $0	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN D

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

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

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

(continued)

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

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

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

PARTS A & B

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

(continued)

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1620] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $[420] a day	$[420] a day	$0
Once lifetime reserve days Are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

(continued)

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

****This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [$1620] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
First $100 of Medicare Approved amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $100 of Medicare Approved amounts*	$0	$100 (Part B deductible	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $100 of Medicare approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN G

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

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

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

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN H

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

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

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

PARTS A & B

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

(continued)

PLAN H

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs

BLOOD First 3 pints Additional amounts	 $0 100%	 All costs $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

PLAN I

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

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

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

(continued)

PLAN I

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual charges to $40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All costs

PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

**** This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1620] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[840]	$[840] (Part A deductible)	$0
61st thru 90th day	All but $[210] a day	$[210] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[420] a day	$[420] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[105] a day	Up to $[105] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

(continued)

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

PLAN J or HIGH DEDUCTIBLE PLAN J

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

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

****This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1620] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are [$1620]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $100 (Part B deductible) 20%	 $0 $0 $0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	 $0 $0 $0	 Actual charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	 Balance

(continued)

PLAN J or HIGH DEDUCTIBLE PLAN J
PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[1620] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[1620] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar Year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar Year	$0	$0	All costs
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and health insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Section III.B. of this regulation, issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statements shall be provided as a part of, or together with, the application for the policy or certificate.

Section XVIII. Requirements For Application Forms And Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and health policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force?
   a. If so, with which company?
   b. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?
2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?
   a. If so, with which company?
   b. What kind of policy?
3. Are you covered for medical assistance through the Medicaid program:
   a. As a Specified Low-Income Medicare Beneficiary,(SLMB)?
   b. As a Qualified Medicare Beneficiary (QMB)?
   c. For other Medicaid medical benefits?

B. Agents shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.
2. List policies sold in the past five (5) years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D. above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and health coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other. (please specify)

_____
_____
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative) *

_____
(Typed Name and Address of Issuer, Agent or Broker)

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

F. Paragraphs 1. and 2. of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Section XIX. Filing Requirements For Advertising

An issuer shall provide a copy of any Medicare supplement advertisement prior to its use in this State whether through written, radio or television medium to the Director of Insurance of this State.

Section XX. Standards For Marketing

A. An issuer, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

2. Establish marketing procedures to assure excessive insurance is not sold or issued.

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses." [Boldface Type]

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and health insurance and the types and amounts of any such insurance.

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

B. In addition to the practices prohibited in the Unfair Trade Practices Act, Chapter 57 of Title 38, the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Section XXI. Appropriateness Of Recommended Purchase And Excessive Insurance

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

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

Section XXII. Reporting Of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this State for which the issuer has in force more than one Medicare supplement policy or certificate:

1. Policy and certificate number, and

2. Date of issuance.

B. The items set forth above must be grouped by individual Policyholder.

Editor's Note: Appendix B contains a reporting form for compliance with this section.

Section XXIII. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods And Probationary Periods In Replacement Policies Or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive, at no additional charge, any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

Section XXIV. Separability

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

Section XXV. Effective Date

This Regulation shall be effective upon publication of the final regulation in the State Register.

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a–1b		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		

4.	Refunds Last Year (Excluding Interest)	
5.	Previous Since Inception (Excluding Interest)	
6.	Refunds Since Inception (Excluding Interest)	
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)	
8.	Experienced Ratio Since Inception (*Ratio 2*) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a)–Refunds Since Inception (line 6)	
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.	
10.	Tolerance Permitted (obtained from credibility table)	

Medicare Supplement Credibility Table

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

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

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2]_____
For the State of _____ Company Name_____
NAIC Group Code _____ NAIC Company Code_____
Address _____ Person Completing Exhibit _____
Title_____ Telephone Number _____

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

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

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

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

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

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

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

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number _____

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

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

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

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

TYPE[1] _____ SMSBP[2]_____
For the State of _____ Company Name_____
NAIC Group Code _____ NAIC Company Code_____
Address _____ Person Completing Exhibit _____
Title_____ Telephone Number _____

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

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

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans
3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

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

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C

DISCLOSURE STATEMENTS

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS
This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
This insurance duplicates Medicare benefits when it pays:
• hospital or medical expenses up to the maximum stated in the policy
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
• hospitalization
• physician services
• other approved items and services

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.
This insurance duplicates Medicare benefits when:
• any of the services covered by the policy are also covered by Medicare
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
• hospitalization
• physician services
• other approved items and services

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnosis named in the policy.

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.
This insurance duplicates Medicare benefits when:
• any of the services covered by the policy are also covered by Medicare
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
• hospitalization
• physician services
• hospice
• other approved items and services

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy. This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy. This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.

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

- hospitalization
- physician services
- other approved items and services

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits from the policy. Medicare generally pays for most or all of these expenses.
This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice
- other approved items and services

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

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.

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

- hospitalization
- physician services
- hospice
- other approved items and services

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice
- other approved items and services

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

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits from the policy. This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice care
- other approved items and services

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

Before You Buy This Insurance

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATE SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
- hospitalization
- physician services
- hospice
- other approved items and services

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

Before You Buy This Insurance

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

Fiscal Impact Statement:

No additional state funding is requested.

Statement of Rationale:

The following sources were relied upon in the drafting of this regulation: the National Association of Insurance Commissioners Model Regulation related to Medicare Supplement Insurance; the Balanced Budget Refinement Act and the Benefits and Improvement Protection Act.