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Submissions for Review

Within 10 calendar days after adoption by an agency of a proposed PERMANENT rulemaking action, the agency must submit the proposed rules to the Governor and the Legislature for review. In addition, the agency must publish in the *Register* a "statement" that the rules have been submitted for gubernatorial/legislative review.

For additional information on submissions for gubernatorial/legislative review, see 75 O.S., Section 303.1, 303.2, and 308.

TITLE 535. OKLAHOMA STATE BOARD OF PHARMACY CHAPTER 15. PHARMACIES

[OAR Docket #09-793]

RULEMAKING ACTION:

Submission for gubernatorial and legislative review

PROPOSED RULES:

Subchapter 10. Good Compounding Practices

Part 1. Good Compounding Practices for Non-sterile Products [NEW]

535:15-10-1. Purpose [AMENDED]

535:15-10-2. Definitions [AMENDED]

535:15-10-3. Pharmacist responsibilities [AMENDED]

535:15-10-4. Drug compounding facilities [AMENDED]

535:15-10-5. Compounding equipment [AMENDED]

535:15-10-6. Component selection requirements [AMENDED]

535:15-10-7. Control of drug product containers [AMENDED]

535:15-10-8. Drug compounding controls [AMENDED]

535:15-10-8.1. Transfer of compounded prescription [NEW]

535:15-10-8.2. Beyond use dating [NEW]

535:15-10-9. Labeling [AMENDED]

535:15-10-10. Records and reports [AMENDED]

535:15-10-11. Pharmacy generated product requirements [AMENDED]

535:15-10-12. Compounding for a prescriber's office use [AMENDED]

535:15-10-13. Compounding veterinarian products [AMENDED]

535:15-10-14. Compounding of non-sterile hazardous drugs [NEW]

535:15-10-15. Compounding of non-sterile radiopharmaceuticals [NEW]

Part 3. Good Compounding Practices for Sterile Products [NEW]

535:15-10-50. Purpose [NEW]

535:15-10-51. Definitions [NEW]

535:15-10-52. Pharmacist responsibilities [NEW]

535:15-10-53. General requirements [NEW]

535:15-10-54. CSP microbial risk levels [NEW]

535:15-10-55. Drug compounding facilities [NEW]

535:15-10-56. Compounding equipment [NEW]

535:15-10-57. Component selection requirements [NEW]

535:15-10-58. Control of drug product containers [NEW]

535:15-10-59. Drug compounding controls [NEW]

535:15-10-60. Transfer of compounded prescription [NEW]

535:15-10-61. Beyond-use dating [NEW]

535:15-10-62. Labeling [NEW]

535:15-10-63. Records and reports [NEW]

535:15-10-64. Compounding for institution and/or practitioner administration [NEW]

535:15-10-65. Compounding of sterile hazardous drugs [NEW]

535:15-10-66. Compounding of sterile radiopharmaceuticals [NEW]

535:15-10-67. Compounding of sterile allergen extracts [NEW]

SUBMITTED TO GOVERNOR:

March 30, 2009

SUBMITTED TO HOUSE:

March 30, 2009

SUBMITTED TO SENATE:

March 30, 2009

[OAR Docket #09-793; filed 4-28-09]

Gubernatorial Approvals

Upon notification of approval by the Governor of an agency's proposed PERMANENT rulemaking action, the agency must submit a notice of such gubernatorial approval for publication in the *Register*.

For additional information on gubernatorial approvals, see 75 O.S., Section 303.2.

TITLE 5. OKLAHOMA ABSTRACTORS BOARD **CHAPTER 2. ADMINISTRATIVE OPERATIONS**

[OAR Docket #09-809]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 2. General Provisions [NEW]
5:2-1-1 through 5:2-1-4 [NEW]
Subchapter 3. Administrative Operations [NEW]
5:2-3-1 through 5:2-3-7 [NEW]

GUBERNATORIAL APPROVAL:

April 24, 2009

[OAR Docket #09-809; filed 5-1-09]

TITLE 5. OKLAHOMA ABSTRACTORS BOARD **CHAPTER 11. ADMINISTRATION OF ABSTRACTORS ACT**

[OAR Docket #09-811]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions [NEW]
5:11-1-1 [NEW]
Subchapter 3. Abstract Licenses, Certificates of Authority, and Permits [NEW]
5:11-3-1 through 5:11-3-9 [NEW]
Subchapter 5. Regulation of Licensees, Certificate Holders and Permit Holders [NEW]
5:11-5-1 through 5:11-5-4 [NEW]
Subchapter 7. Application for Permit to Develop Abstract Plant [NEW]
5:11-7-1 [NEW]
Subchapter 9. Application for Certificate of Authority [NEW]
5:11-9-1 [NEW]
Subchapter 11. Temporary Certificate of Authority [NEW]
5:11-11-1 [NEW]

GUBERNATORIAL APPROVAL:

April 24, 2009

[OAR Docket #09-811; filed 5-1-09]

TITLE 5. OKLAHOMA ABSTRACTORS BOARD **CHAPTER 21. COMPLAINTS AND ENFORCEMENT**

[OAR Docket #09-810]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions [NEW]
5:21-1-1 through 5:21-1-5 [NEW]
Subchapter 3. Complaint Investigation Procedures [NEW]
5:21-3-1 through 5:21-3-2 [NEW]
Subchapter 5. Formal Complaint Procedures [NEW]
5:21-5-1 through 5:21-5-9 [NEW]

GUBERNATORIAL APPROVAL:

April 24, 2009

[OAR Docket #09-810; filed 5-1-09]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY **CHAPTER 2. FEES**

[OAR Docket #09-827]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Fee Schedules
35:2-3-2.2 [AMENDED]
35:2-3-2.3 [AMENDED]
35:2-3-2.4 [AMENDED]
35:2-3-2.6 [AMENDED]

GUBERNATORIAL APPROVAL:

April 27, 2009

[OAR Docket #09-827; filed 5-4-09]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY **CHAPTER 3. FINE MATRICES [REVOKED]**

[OAR Docket #09-828]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Fine Schedules [REVOKED]

Gubernatorial Approvals

Part 15. Consumer Protection Services Violations
[REVOKED]

35:3-1-16 [REVOKED]

GUBERNATORIAL APPROVAL:

April 27, 2009

[OAR Docket #09-828; filed 5-4-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF
AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 15. ANIMAL INDUSTRY**

[OAR Docket #09-794]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions [AMENDED]

35:15-1-2 [AMENDED]

GUBERNATORIAL APPROVAL:

April 21, 2009

[OAR Docket #09-794; filed 4-29-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF
AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. CONSUMER PROTECTION**

[OAR Docket #09-795]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 13. Imported Fire Ant Quarantine

35:30-13-3 [AMENDED]

GUBERNATORIAL APPROVAL:

April 21, 2009

[OAR Docket #09-795; filed 4-29-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF
AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. CONSUMER PROTECTION**

[OAR Docket #09-829]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 17. Combined Pesticide

Part 5. Prerequisites for Licensing

35:30-17-10 [AMENDED]

GUBERNATORIAL APPROVAL:

April 27, 2009

[OAR Docket #09-829; filed 5-4-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF
AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 40. MARKET DEVELOPMENT**

[OAR Docket #09-796]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Agriculture Enhancement and
Diversification Program

Part 1. Definitions

35:40-5-1 [AMENDED]

Part 3. Applicant Eligibility

35:40-5-31 [AMENDED]

Part 5. Evaluation and Funding Criteria

35:40-5-51 [AMENDED]

Part 7. Procedure for Loan or Grant Requests

35:40-5-71 [AMENDED]

Part 9. Supplemental Program Information

35:40-5-91 [AMENDED]

Part 11. Terms of Loans or Grants

35:40-5-111 [AMENDED]

Part 13. Marketing and Utilization Loans

35:40-5-131 [AMENDED]

Part 15. Cooperative Marketing Loans

35:40-5-151 [AMENDED]

Part 17. Farm Diversification Grants

35:40-5-171 [AMENDED]

Part 18. Basic and Applied Research Loans or Grants

35:40-5-181 [AMENDED]

Part 19. Disbursements

35:40-5-191 [AMENDED]

GUBERNATORIAL APPROVAL:

April 21, 2009

[OAR Docket #09-796; filed 4-29-09]

**TITLE 165. CORPORATION COMMISSION
CHAPTER 10. OIL AND GAS
CONSERVATION RULES**

[OAR Docket #09-803]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Administration

Part 1. General Provisions

165:10-1-6. Duties and authority of the Conservation Division [AMENDED]
165:10-1-7. Prescribed forms [AMENDED]
165:10-1-49. Filing of nominations [AMENDED]
Subchapter 3. Drilling, Developing, and Producing
Part 1. Drilling
165:10-3-2. Notification of spudding of a new well [AMENDED]
165:10-3-4. Casing, cementing, wellhead equipment, and cementing reports [AMENDED]
Part 3. Completions
165:10-3-17. Well site and surface facilities [AMENDED]
Part 5. Operations
165:10-3-29. Oil storage [AMENDED]
Subchapter 5. Underground Injection Control
165:10-5-2. Approval of enhanced recovery injection wells or disposal wells [AMENDED]
165-10-5-5. Application for approval of enhanced recovery injection and disposal operations [AMENDED]
165:10-5-7. Monitoring and reporting requirements for wells covered by 165:10-5-1 [AMENDED]
165:10-5-9. Duration of underground injection well orders or permits [AMENDED]
Subchapter 7. Pollution Abatement
Part 1. General Provisions
165:10-7-2. Administration and enforcement of rules [AMENDED]
165:10-7-4. Water quality standards [AMENDED]
Part 3. Storage and Disposal of Fluids
165:10-7-26. One-time land application of contaminated soils and petroleum hydrocarbon based drill cuttings [AMENDED]
Subchapter 11. Plugging and Abandonment
165:10-11-9. Temporary exemption from plugging requirements [AMENDED]
Subchapter 13. Determination of Allowables - Oil and Gas Wells
165:10-13-3. Production tests on new, re-entered, and recompleted wells [AMENDED]
Subchapter 15. Oil Well Production and Allowables
165:10-15-3. Effect of percentage penalty on oil wells [AMENDED]
165:10-15-5. Discovery oil allowables [AMENDED]
165:10-15-6. Production tests and reports for discovery oil pools [AMENDED]
165:10-15-13. Production tests and reports for unallocated oil wells [AMENDED]
Subchapter 17. Gas Well Operations and Permitted Production
165:10-17-9. Special allocated gas pools [AMENDED]
Subchapter 21. Application for Tax Exemptions
Part 8. Deep Wells
165:10-21-45. General [AMENDED]

GUBERNATORIAL APPROVAL:

April 23, 2009

[OAR Docket #09-803; filed 4-30-09]

**TITLE 165. CORPORATION COMMISSION
CHAPTER 45. GAS SERVICE UTILITIES**

[OAR Docket #09-804]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions [AMENDED]

165:45-1-2. Definitions [AMENDED]

Subchapter 23. Demand Programs [NEW]

165:45-23-1. Purpose [NEW]

165:45-23-2. Goals [NEW]

165:45-23-3. Definitions [NEW]

165:45-23-4. Demand portfolio submission and implementation [NEW]

165:45-23-5. Commission consideration [NEW]

165:45-23-6. Evaluation, measurement, and verification [NEW]

165:45-23-7. Reporting [NEW]

GUBERNATORIAL APPROVAL:

April 23, 2009

[OAR Docket #09-804; filed 4-30-09]

**TITLE 235. OKLAHOMA FUNERAL BOARD
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #09-837]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

235:1-1-2 [AMENDED]

GUBERNATORIAL APPROVAL:

April 21, 2009

[OAR Docket #09-837; filed 5-5-09]

**TITLE 235. OKLAHOMA FUNERAL BOARD
CHAPTER 10. FUNERAL SERVICES
LICENSING**

[OAR Docket #09-838]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

Gubernatorial Approvals

235:10-1-2 [AMENDED]
Subchapter 3. Qualification and **Requirements**
Requirements for Licensure

235:10-3-1 [AMENDED]

235:10-3-2 [AMENDED]

235:10-3-5 [AMENDED]

Subchapter 5. Licensing fees

235:10-5-1 [AMENDED]

Subchapter 7. Licensure Renewal, Revocation, and
Suspension

235:10-7-2 [AMENDED]

Subchapter 11. Minimum Standards of Performance

235:10-11-1 [AMENDED]

Subchapter 13. Continuing Education

235:10-13-10 [AMENDED]

Subchapter 14. Crematories [NEW]

235:10-14-1 [NEW]

GUVERNATORIAL APPROVAL:

April 21, 2009

[OAR Docket #09-838; filed 5-5-09]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 4. RULES OF PRACTICE AND PROCEDURE

[OAR Docket #09-782]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 9. Administrative Proceedings

Part 3. Individual Proceedings

252:4-9-32. Individual proceedings filed by others
[AMENDED]

GUVERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-782; filed 4-28-09]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 100. AIR POLLUTION CONTROL

[OAR Docket #09-783]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 9. Excess Emission Reporting Requirements

252:100-9-1. Purpose [AMENDED]

252:100-9-1.1. Applicability [AMENDED]

252:100-9-2. Definitions [AMENDED]

252:100-9-3.1. Excess emission reporting requirements
[AMENDED AND RENUMBERED TO 252:100-9-7]

252:100-9-3.3. Demonstration of cause [AMENDED AND
RENUMBERED TO 252:100-9-8]

252:100-9-8. Affirmative defenses [NEW]

GUVERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-783; filed 4-28-09]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 100. AIR POLLUTION CONTROL

[OAR Docket #09-784]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 33. Control of Emission of Nitrogen Oxides

252:100-33-1.1. Definitions [AMENDED]

252:100-33-1.2. Applicability [AMENDED]

252:100-33-2. Emission limits [AMENDED]

GUVERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-784; filed 4-28-09]

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 606. OKLAHOMA POLLUTANT DISCHARGE ELIMINATION SYSTEM (OPDES) STANDARDS

[OAR Docket #09-785]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Introduction

252:606-1-2. Definitions [AMENDED]

252:606-1-4. Date of federal regulations incorporated
[AMENDED]

Subchapter 7. Biosolids Permit Requirements
[REVOKED]

252:606-7-1. Permit required [REVOKED]

252:606-7-2. Permit applications [REVOKED]

252:606-7-3. Certification required [REVOKED]

252:606-7-4. Sludge (biosolids) management plan
[REVOKED]

252:606-7-5. Permit modifications [REVOKED]

252:606-7-6. Restrictions applicable to all land application
[REVOKED]

252:606-7-7. Laboratory analyses [REVOKED]

252:606-7-8. Compliance required [REVOKED]

- 252:606-7-9. Monitoring wells [REVOKED]
- Subchapter 8. Biosolids Requirements [NEW]
- 252:606-8-1. Permits and prohibitions [NEW]
- 252:606-8-2. Permit applications [NEW]
- 252:606-8-3. Sludge (biosolids) management plan [NEW]
- 252:606-8-4. Class A biosolid production [NEW]
- 252:606-8-5. Class B biosolid production [NEW]
- 252:606-8-6. Land application of biosolids [NEW]
- Subchapter 9. Land Application of Biosolids [REVOKED]
- 252:606-9-1. Prohibitions [REVOKED]
- 252:606-9-2. Land application exceptions and alternatives [REVOKED]
- 252:606-9-3. Site use for land application [REVOKED]
- 252:606-9-4. pH and nutrient limits [REVOKED]
- 252:606-9-5. Soil sampling [REVOKED]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-785; filed 4-28-09]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 616. INDUSTRIAL WASTEWATER SYSTEMS**

[OAR Docket #09-786]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. Introduction
- 252:616-1-2. Definitions [AMENDED]
- Subchapter 3. Permit Procedures
- 252:616-3-4. Applications [AMENDED]
- Subchapter 13. Closure Standards
- 252:616-13-1. Termination of activities [AMENDED]
- Appendix A. Application for Permit to Discharge and/or Treat Industrial Wastewater of Sludge General Information [REVOKED]
- Appendix B. Application for Permit to Discharge and/or Treat Industrial Wastewater or Sludge Surface Impoundments and Septic Tanks [REVOKED]
- Appendix C. Application for Permit to Land Apply Industrial Wastewater and/or Sludge [REVOKED]
- Appendix C. Table of Rainfall and Evaporation Data [NEW]
- Appendix D. Class III Surface Impoundment Design [REVOKED]
- Appendix D. Class III Surface Impoundment Design [NEW]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-786; filed 4-28-09]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 623. PRETREATMENT FOR CENTRAL TREATMENT TRUSTS**

[OAR Docket #09-787]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. General Provisions
- 252:623-1-7. Incorporation by reference [AMENDED]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-787; filed 4-28-09]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 631. PUBLIC WATER SUPPLY OPERATION**

[OAR Docket #09-788]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Subchapter 1. Introduction
- 252:631-1-3. Adoption of U.S. EPA regulations by reference [AMENDED]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-788; filed 4-28-09]

**TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY
CHAPTER 641. INDIVIDUAL AND SMALL PUBLIC ON-SITE SEWAGE TREATMENT SYSTEMS**

[OAR Docket #09-789]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

- Appendix H. Size Charts for On-Site Sewage Treatment Systems [REVOKED]
- Appendix H. Size Charts for On-Site Sewage Treatment Systems [NEW]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-789; filed 4-28-09]

Gubernatorial Approvals

TITLE 252. DEPARTMENT OF ENVIRONMENTAL QUALITY CHAPTER 690. WATER QUALITY STANDARDS IMPLEMENTATION

[OAR Docket #09-790]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Introduction

252:690-1-1. Purpose and applicability [AMENDED]

252:690-1-2. Definitions [AMENDED]

252:690-1-4. Incorporation of USEPA regulations by reference [AMENDED]

Subchapter 3. Point Source Discharges

252:690-3-19. TRES, TIEs and WET limits [AMENDED]

252:690-3-27. Intermittent lethality ~~or persistent sublethality~~ [AMENDED]

252:690-3-31. WET test requirements [AMENDED]

252:690-3-34. Test duration for WET tests [AMENDED]

252:690-3-37. ~~Dilution~~ WET test ~~dilution~~ water for discharges to perennial streams and lakes [AMENDED]

252:690-3-39. Endpoint and test failure criteria for acute tests [AMENDED]

252:690-3-40. Endpoint and test failure criteria for chronic tests [AMENDED]

252:690-3-42. WET testing frequency reductions after WET testing trial period [AMENDED]

252:690-3-75. Wasteload allocations for implementation of human health and raw water criteria for toxic substances to protect the Public and Private Water Supply beneficial use [AMENDED]

252:690-3-93. Monitoring for a nutrient limited watershed [NEW]

Appendix A. Water Quality Standards Implementation Plan Department of Environmental Quality [REVOKED]

Appendix A. Water Quality Standards Implementation Plan Department of Environmental Quality [NEW]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-790; filed 4-28-09]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 2. ADMINISTRATIVE COMPONENTS

[OAR Docket #09-839]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. Human Resources Management Division (HRMD)

Part 7. Recruitment, Selection, and Placement

340:2-1-83 [AMENDED]

(Reference APA WF 09-05)

GUBERNATORIAL APPROVAL:

April 27, 2009

[OAR Docket #09-839; filed 5-6-09]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 2. ADMINISTRATIVE COMPONENTS

[OAR Docket #09-840]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Office of Client Advocacy

Part 1. Administration

340:2-3-1 through 340:2-3-2 [AMENDED]

Part 5. Grievances

340:2-3-45 through 340:2-3-48 [AMENDED]

340:2-3-50 through 340:2-3-51 [AMENDED]

340:2-3-54 [AMENDED]

Part 7. Grievance and Abuse Review Committee

340:2-3-64 [AMENDED]

Part 9. ~~Ombudsman~~ Advocacy Programs

340:2-3-71 through 340:2-3-75 [AMENDED]

(Reference APA WF 09-03)

GUBERNATORIAL APPROVAL:

April 27, 2009

[OAR Docket #09-840; filed 5-6-09]

TITLE 340. DEPARTMENT OF HUMAN SERVICES CHAPTER 10. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

[OAR Docket #09-841]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 2. Temporary Assistance For Needy Families (TANF) Work Program

340:10-2-8 [AMENDED]

(Reference APA WF 09-01)

GUBERNATORIAL APPROVAL:

April 27, 2009

[OAR Docket #09-841; filed 5-6-09]

**TITLE 360. OKLAHOMA STATE AND
EDUCATION EMPLOYEES GROUP
INSURANCE BOARD
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #09-844]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 5. Hearing Procedures

360:1-5-1 [AMENDED]

360:1-5-2 [AMENDED]

360:1-5-3 [AMENDED]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-844; filed 5-6-09]

**TITLE 360. OKLAHOMA STATE AND
EDUCATION EMPLOYEES GROUP
INSURANCE BOARD
CHAPTER 10. STATE AND EDUCATION
EMPLOYEES HEALTH, DENTAL, VISION
AND LIFE PLANS**

[OAR Docket #09-846]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

360:10-1-2. [AMENDED]

Subchapter 3. Administration of Plans

360:10-3-3.5. [AMENDED]

360:10-3-24.1. [NEW]

360:10-3-25. [AMENDED]

Subchapter 5. Coverage and Limitations

Part 3. The Plans

360:10-5-16. [AMENDED]

360:10-5-20. [AMENDED]

Part 5. Life Benefits

360:10-5-34. [AMENDED]

Part 15. Subrogation

360:10-5-100. [AMENDED]

Subchapter 9. COBRA Health Insurance Continuation

360:10-9-1. [AMENDED]

360:10-9-2. [AMENDED]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-846; filed 5-6-09]

**TITLE 360. OKLAHOMA STATE AND
EDUCATION EMPLOYEES GROUP
INSURANCE BOARD
CHAPTER 15. THE DISABILITY PLAN**

[OAR Docket #09-845]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

360:15-1-14.1. [AMENDED]

GUBERNATORIAL APPROVAL:

March 24, 2009

[OAR Docket #09-845; filed 5-6-09]

**TITLE 380. DEPARTMENT OF LABOR
CHAPTER 20. WELDING RULES**

[OAR Docket #09-855]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

380:20-1-3 [AMENDED]

380:20-1-14 [AMENDED]

380:20-1-15 [NEW]

GUBERNATORIAL APPROVAL:

April 24, 2009

[OAR Docket #09-855; filed 5-7-09]

**TITLE 380. DEPARTMENT OF LABOR
CHAPTER 25. BOILER AND PRESSURE
VESSEL RULES**

[OAR Docket #09-854]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 3. Administration

380:25-3-7 [AMENDED]

GUBERNATORIAL APPROVAL:

April 24, 2009

[OAR Docket #09-854; filed 5-7-09]

Gubernatorial Approvals

TITLE 380. DEPARTMENT OF LABOR CHAPTER 55. AMUSEMENT RIDE SAFETY RULES

[OAR Docket #09-856]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

380:55-1-2 [AMENDED]

Subchapter 5. Fees

380:55-5-5 [AMENDED]

Subchapter 13. Miscellaneous

380:55-13-1 [AMENDED]

380:55-13-2 [AMENDED]

GUBERNATORIAL APPROVAL:

April 13, 2009

[OAR Docket #09-856; filed 5-7-09]

TITLE 380. DEPARTMENT OF LABOR CHAPTER 70. ELEVATOR SAFETY ACT

[OAR Docket #09-864]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

380:70-1-2 [AMENDED]

Subchapter 3. Administration

380:70-3-4 [AMENDED]

Subchapter 5. Licenses

380:70-5-1 [AMENDED]

380:70-5-3 [AMENDED]

GUBERNATORIAL APPROVAL:

April 21, 2009

[OAR Docket #09-864; filed 5-8-09]

TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES CHAPTER 1. ADMINISTRATION

[OAR Docket #09-819]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 9. Certification and Designation of Facility
Services

450:1-9-1. Applicability of certification [AMENDED]

450:1-9-5. Qualifications for certifications of facilities,
programs and individuals [AMENDED]

GUBERNATORIAL APPROVAL:

April 28, 2009

[OAR Docket #09-819; filed 5-1-09]

TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES CHAPTER 15. CONSUMER RIGHTS

[OAR Docket #09-820]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provisions

450:15-1-2. Definitions [AMENDED]

Subchapter 7. Office of Consumer Advocacy

Part 2. Investigations

450:15-7-6. Reporting suspected maltreatment
[AMENDED]

450:15-7-9. Investigation procedures [AMENDED]

450:15-7-15. Investigative report and findings
[AMENDED]

GUBERNATORIAL APPROVAL:

April 28, 2009

[OAR Docket #09-820; filed 5-1-09]

TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES CHAPTER 17. STANDARDS AND CRITERIA FOR COMMUNITY MENTAL HEALTH CENTERS

[OAR Docket #09-821]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 1. General Provision

450:17-1-2. Definitions [AMENDED]

450:17-1-6. Services [AMENDED]

Subchapter 3. Required Services

Part 1. Required Services

450:17-3-2. Core community mental health services
[AMENDED]

450:17-3-3. Availability of services [AMENDED]

Part 3. Screening, Intake, Assessment and Referral

450:17-3-21. Integrated screening, intake, and assessment
services [AMENDED]

Part 5. Emergency Services

450:17-3-41. Emergency Services [AMENDED]
Part 7. Outpatient Counseling Services
450:17-3-61. Outpatient counseling services [AMENDED]
450:17-3-62. Outpatient counseling services, substance abuse, co-occurring [AMENDED]
Part 9. Medication Clinic Services
450:17-3-82. Medication clinic, medication monitoring [AMENDED]
450:17-3-84. Availability of medications in a CMHC's community living setting [AMENDED]
Part 11. Case Management
450:17-3-101. Case management services, ~~adult~~ [AMENDED]
450:17-3-101.1. Case management services, child, adolescent and family [REVOKED]
450:17-3-103. ~~Case management services for the hospitalized consumer and consumers in substance abuse treatment facilities~~ Case management services for consumers admitted to higher levels of care [AMENDED]
Part 15. Adult Recovery and Rehabilitation Programs
450:17-3-141. Psychiatric rehabilitation programs [AMENDED]
Part 21. Peer Support Services [NEW]
450:17-3-191. Peer Support Services [NEW]
450:17-3-192. Peer Recovery Support Specialists Staff Requirements [NEW]
450:17-3-193. Peer Recovery Support Services Locale and Frequency [NEW]
Part 23. Wellness Services and Related Activities [NEW]
450:17-3-201. Wellness Services and Related Activities [NEW]
Subchapter 5. Optional Services
Part 15. Inpatient Services
450:17-5-95. Inpatient services within the community mental health setting [AMENDED]
450:17-5-96. Inpatient services within the community mental health setting, service issues [REVOKED]
450:17-5-97. Inpatient services within the community mental health setting, clinical medical health issues [REVOKED]
450:17-5-98. Inpatient services within the community mental health setting, activity services [REVOKED]
450:17-5-99. Inpatient services within the community mental health setting, environment [REVOKED]
450:17-5-100. Mechanical restraints [REVOKED]
Subchapter 7. Facility Clinical Records
450:17-7-8. Integrated service plan [AMENDED]

450:17-7-9. Medication record [AMENDED]
GUBERNATORIAL APPROVAL:
April 28, 2009

[OAR Docket #09-821; filed 5-1-09]

TITLE 450. DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
CHAPTER 30. STANDARDS AND CRITERIA FOR STATE-OPERATED INPATIENT SERVICES

[OAR Docket #09-822]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

Subchapter 15. Forensic Review Board [REVOKED]
450:30-15-1. Applicability [REVOKED]
450:30-15-2. Definitions [REVOKED]
450:30-15-3. Composition, powers and duties [REVOKED]

GUBERNATORIAL APPROVAL:

April 28, 2009

[OAR Docket #09-822; filed 5-1-09]

TITLE 600. REAL ESTATE APPRAISER BOARD
CHAPTER 10. LICENSURE AND CERTIFICATION REQUIREMENTS

[OAR Docket #09-818]

RULEMAKING ACTION:

Gubernatorial approval of permanent rules

RULES:

600:10-1-4. Examination [AMENDED]
600:10-1-6. Experience prerequisite [AMENDED]
600:10-1-16. Supervision of trainee appraisers [AMENDED]

GUBERNATORIAL APPROVAL:

April 24, 2009

[OAR Docket #09-818; filed 5-1-09]

Withdrawn Rules

An agency may withdraw proposed PERMANENT rules prior to final adoption (approval by Governor/Legislature) by notifying the Governor and the Legislature and by publishing a notice in the *Register* of such a withdrawal.

An agency may withdraw proposed EMERGENCY rules prior to approval/disapproval by the Governor by notifying the Governor, the Legislature, and the Office of Administrative Rules. The withdrawal notice is not published in the *Register*, however, unless the agency published a Notice of Rulemaking Intent in the *Register* before adopting the EMERGENCY rules.

For additional information on withdrawal of proposed rules, see 75 O.S., Section 308(F) and 253(K) and OAC 655:10-7-33.

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 3. FINE MATRICES [REVOKED]

[OAR Docket #09-851]

RULEMAKING ACTION:

Withdrawal of PERMANENT rulemaking

WITHDRAWN RULES:

Chapter 3. Fine Matrices [REVOKED]
Subchapter 1. Fine Schedules [REVOKED]
Part 1. General [REVOKED]
35:3-1-1. [REVOKED]
Part 3. Animal Health and Disease Violations [REVOKED]
Part 5. Food Safety Violations [REVOKED]
Part 7. Forestry and Timber Violations [REVOKED]
Part 9. Grain Warehouse Violations [REVOKED]
35:3-1-10. [REVOKED]
Part 11. Livestock Market Violations [REVOKED]
35:3-1-11. [REVOKED]
35:3-1-12. [REVOKED]
Part 13. Market Development Violations [REVOKED]
Part 15. Consumer Protection Services Violations [REVOKED]
35:3-1-15. [REVOKED]
35:3-1-17. [REVOKED]
35:3-1-18. [REVOKED]
35:3-1-19. [REVOKED]
35:3-1-20. [REVOKED]
35:3-1-21. [REVOKED]
35:3-1-22. [REVOKED]
35:3-1-23. [REVOKED]
35:3-1-24. [REVOKED]
Part 17. Agricultural Environmental Management Violations [REVOKED]
35:3-1-30. [REVOKED]
35:3-1-31. [REVOKED]
35:3-1-32. [REVOKED]

DATES:

Adoption:

March 18, 2009

Submitted to Governor:

March 25, 2009

Submitted to House:

March 25, 2009

Submitted to Senate:

March 25, 2009

Gubernatorial approval:

April 29, 2009

Withdrawn:

May 6, 2009

[OAR Docket #09-851; filed 5-6-09]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 3. FINE MATRICES [REVOKED]

[OAR Docket #09-852]

RULEMAKING ACTION:

Withdrawal of PERMANENT rulemaking

WITHDRAWN RULES:

Subchapter 1. Fine Schedules [REVOKED]
Part 15. Consumer Protection Services Violations [REVOKED]
35:3-1-16 [REVOKED]

DATES:

Adoption:

March 18, 2009

Submitted to Governor:

March 24, 2009

Submitted to House:

March 24, 2009

Submitted to Senate:

March 24, 2009

Gubernatorial approval:

April 27, 2009

Withdrawn:

May 6, 2009

[OAR Docket #09-852; filed 5-6-09]

Errors in Published Documents

If an agency discovers an error in a document after its publication in the *Register*, the agency may publish in the *Register* a notice of such error, but only if the error meets criteria set forth in OAC 655:10-7-35.

TITLE 304. STATE USE COMMITTEE CHAPTER 10. GENERAL PROVISIONS

[OAR Docket #09-879]

ACTION:

Notice of error in published document

DOCUMENT CORRECTED:

Document type:

Submission for gubernatorial and legislative review

Register publication:

26 Ok Reg 969

Docket number:

09-585

RULES:

304:10-1-3. [AMENDED]

304:10-1-4. [AMENDED]

304:10-1-5. [AMENDED]

304:10-1-9. [AMENDED]

304:10-1-10. [AMENDED]

304:10-1-12. [AMENDED]

CORRECTIONS:

Date listed for submission to Governor, Senate and House was incorrect. It should read as follows:

February 17, 2009

[OAR Docket #09-879; filed 5-8-09]

Emergency Adoptions

An agency may adopt new rules, or amendments to or revocations of existing rules, on an emergency basis if the agency determines that "an imminent peril exists to the preservation of the public health, safety, or welfare, or that a compelling public interest requires an emergency rule[s] [A]n agency may promulgate, at any time, any such [emergency] rule[s], provided the Governor first approves such rule[s]" [75 O.S., Section 253(A)].

An emergency action is effective immediately upon approval by the Governor or on a later date specified by the agency in the preamble of the emergency rule document. An emergency rule expires on July 15 after the next regular legislative session following promulgation, or on an earlier date specified by the agency, if not already superseded by a permanent rule or terminated through legislative action as described in 75 O.S., Section 253(H)(2).

Emergency rules are not published in the *Oklahoma Administrative Code*; however, a source note entry, which references the *Register* publication of the emergency action, is added to the *Code* upon promulgation of a superseding permanent rule or expiration/termination of the emergency action.

For additional information on the emergency rulemaking process, see 75 O.S., Section 253.

TITLE 330. OKLAHOMA HOUSING FINANCE AGENCY CHAPTER 36. AFFORDABLE HOUSING TAX CREDIT PROGRAM

[OAR Docket #09-824]

RULEMAKING ACTION:

Emergency adoption

RULES:

Subchapter 10. Credit Assistance/Stimulus Legislation [NEW]

330:36-10-1. [NEW]

330:36-10-2. [RESERVED]

330:36-10-3. [NEW]

330:36-10-4. [RESERVED]

330:36-10-5. [NEW]

330:36-10-6. [RESERVED]

330:36-10-7. [NEW]

330:36-10-8. [RESERVED]

330:36-10-9. [NEW]

330:36-10-10. [RESERVED]

330:36-10-11. [NEW]

330:36-10-12. [RESERVED]

330:36-10-13. [NEW]

330:36-10-14. [RESERVED]

330:36-10-15. [NEW]

AUTHORITY:

These Chapter 36 rules are authorized by the Board of Trustees of the Oklahoma Housing Finance Agency ("OHFA"), the amended trust indenture of OHFA, and the Bylaws of OHFA as established by the OHFA Board of Trustees.

DATES:

Adoption:

March 12, 2009

Effective:

Immediately upon Governor's approval

Approved by Governor:

April 24, 2009

Expiration:

Effective through July 14, 2010, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

The Trustees of OHFA have found that the following compelling extraordinary circumstances necessitate the emergency adoption of amendments to OHFA's Chapter 36. Affordable Housing Tax Credit Program Rules:

1. The promulgation of the proposed amendments was necessitated by the American Recovery and Reinvestment Act (Recovery Act) signed into law February 17, 2009 by the Honorable Barack H. Obama, President of the United States of America, contains several provisions related to Section 42 and related provisions of the Internal Revenue Code (the "Code");

2. In order to bring the QAP into conformity with the provisions relating to the Tax Credit Program, it is necessary to amend OHFA's Affordable Housing Tax Credit Rules (the "AHTC Rules");

3. Certain provisions of the Recovery Act were effective immediately;

4. It is the desire of the Board of Trustees to maximize the number of resources available to those providing affordable housing to the citizens of the State;

5. Many providers of affordable rental housing have suffered serious economic consequences as a result of the recent economic downturn such that some projects underway may not be viable if additional resources are not provided;

6. A compelling public interest exists and it is in the best interest of the citizens of the State and the mission of OHFA for this Board of Trustees to adopt and promulgate the proposed amendments utilizing the emergency rulemaking procedures of the OAPA in order to make available the resources provided by the Recovery Act as soon as possible;

The OHFA Board of Trustees find these circumstances necessitate the adoption of the proposed amendments, declaring an emergency;

ANALYSIS:

Section 42 of the Internal Revenue Code of 1986, as amended (the "Code"), provides that Affordable Housing Tax Credits (AHTCs), which are federal tax credits, may be claimed by qualified owners of residential property used to provide affordable housing for low-income persons. AHTCs, as a federal tax incentive, are governed primarily by the Code, and although the program is basically a housing program, AHTCs are administered by the United States Department of the Treasury and its Internal Revenue Service.

The Congress of the United States has created a special system for allocating the AHTC in which an agency in each state (the "State Housing Credit Agency") decides which projects receive AHTCs each year. AHTCs are limited, i.e. each State's annual "Housing Credit Ceiling" is based upon multiplying a constant established by Congress (currently \$2.20) by a state's population. See Code Section 42(h)(F)(3). Accordingly, each State Housing Credit Agency must develop a priority system to determine which projects should receive AHTC. Certain selection criteria and certain priorities established by Congress must be embodied in such "qualified allocation plan". See Code Section 42(m)(1)(A)(i).

For Oklahoma, OHFA is the State Housing Credit Agency. Thus, in order for federal tax credits to be available to developers (owners) of affordable housing located within Oklahoma, it is necessary for OHFA to develop a qualified allocation plan to carry out the intent of the Code and to develop an AHTC Program for administering the plan. The Rules embody such a qualified allocation plan, in compliance with the Code, and provide guidelines for allocating Oklahoma's state tax credit authority and administering OHFA's AHTC Program, in compliance with the Code and the Oklahoma Administrative Procedures Act (the "APA").

CONTACT PERSON:

Phillip Elzo, Agency Liaison, (405) 419-8275.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING EMERGENCY RULES ARE
CONSIDERED PROMULGATED AND EFFECTIVE
UPON APPROVAL BY THE GOVERNOR AS SET
FORTH IN 75 O.S., SECTION 253(D):**

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SUBCHAPTER 10. CREDIT ASSISTANCE/STIMULUS LEGISLATION

330:36-10-1. Purpose

The purpose of this Subchapter is to outline OHFA's procedures for implementing new funding resources specifically identified for use in connection with the OAHTC Program. The American Recovery and Reinvestment Act (ARRA), enacted on February 17, 2009 provides new federal stimulus programs for eligible Owners of Credit Developments. The purpose of this Subchapter is to outline OHFA's procedures for implementing the stimulus programs of the ARRA and future programs which may be authorized and funded federally or at the state level.

330:36-10-2. [RESERVED]

330:36-10-3. Authority

OHFA has been designated as the State's housing credit agency responsible for the Allocation of Credits made available to the State. This authority provides that OHFA shall administer any funding resources directed to the OATHC Program. Both the "Tax Credits: Grants (Exchange)" and the "Tax Credit Assistance Program (TCAP)" sections of ARRA provide that these funds shall be administered by the "State Housing Credit Agency".

330:36-10-4. [RESERVED]

330:36-10-5. Definitions

Reference is made to 330:36-1-4 and the Section 42 of the Code for any words or terms used in this Subchapter.

330:36-10-6. [RESERVED]

330:36-10-7. Tax Credits: Grants

(a) The ARRA provides that OHFA has the option of exchanging certain Credit Allocations to the State for a cash payment to OHFA. The cash payment received by OHFA may be used by OHFA to make ARRA sub-awards to selected Applicants who qualify under the QAP for a Credit Reservation and Allocation. In OHFA's sole discretion for the best use of these funds, these sub-awards may be made in the form of either a grant or a loan.

(b) OHFA shall develop an Application process for applying for ARRA funds. The Application process will be consistent with the QAP and Section 42 of the Code and any regulations provided by Treasury as to the use of the funds made available under ARRA for sub-awards.

(c) At the time of the Application for an ARRA sub-award, the Applicant must demonstrate a good faith effort to obtain investments commitments for Credits previously allocated to the Owner.

(d) The Owner of the Buildings(s) identified in the Carry-over Allocation Agreement and/or Regulatory Agreement receiving an ARRA sub-award must maintain said Building(s) as Qualified Low-Income Building(s) during the Development Compliance Period. Failure to maintain the Building(s) as Qualified Low-Income Building(s) shall result in the recapture of the ARRA sub-award.

(e) Recipients of ARRA sub-awards will be required to enter into such agreements and documentation as OHFA, in its sole discretion, deems necessary to ensure that the provisions of any requirements of the U.S. Department of the Treasury, these Chapter 36 Rules, the Code, any relevant rules, regulations, rulings or other guidance issued by the IRS and terms of the ARRA sub-award are met throughout the Development Compliance Period. Required agreements and documentation may include without limitation, loan documentation, an amended Carryover Allocation Agreement and/or Regulatory Agreement and Owner guarantees.

330:36-10-8. [RESERVED]

330:36-10-9. Tax Credit Assistance Program (TCAP)

(a) The ARRA provides funds through the HOME Investment Partnership Program (the "HOME Program") for awards to certain Owners of Credit Developments. These funds have been designated Tax Credit Assistance Program (TCAP) by HUD. In OHFA's sole discretion for the best use of these funds, these awards may be made in the form of either a grant or a loan.

(b) OHFA will develop an Application process for awarding TCAP funds to eligible Credit Development Owners. The Application process will be consistent with the QAP and Section 42 of the Code and any regulations provided by Treasury or HUD as to the use of funds made available under the ARRA for awards.

(c) The Application for the TCAP funds will include a competitive component. Evaluation Criteria will be developed, but will include, without limitation, a priority for Developments expected to be completed and Placed in Service by February 17, 2012.

(d) Any Owner failing to expend awarded TCAP funds within the time period specified in the TCAP Award Agreement between the Owner and OHFA shall return the funds to OHFA for redistribution.

(e) Recipients of ARRA TCAP funds will be required to enter into such agreements and documentation as OHFA, in its sole discretion, deems necessary to ensure that the provisions of any requirements of the U.S. Department of the Treasury, HUD, these Chapter 36 Rules, the Code, any relevant rules, regulations, rulings or other guidance issued by the IRS and terms of the ARRA TCAP are met throughout the Development Compliance Period. Required agreements and documentation may include without limitation, loan documentation, an amended Carryover Allocation Agreement and/or Regulatory Agreement and Owner guarantees.

330:36-10-10. [RESERVED]

330:36-10-11. Asset Management

(a) OHFA shall perform asset management functions to ensure compliance with section 42 of the Code and the continued long term viability of Building(s) funded by either form of assistance identified in this Subchapter. OHFA may sub-contract this function to another entity (ies).

(b) Any Building(s) receiving funds pursuant to the Grant Program of the TCAP shall be subject to all restrictions and regulations of the OAHTC Program, Section 42 of the Code and, as applicable, the HOME Program.

330:36-10-12. [RESERVED]

330:36-10-13. Fees

(a) Fees will be structured to comply with Subchapter 4, Section 4-3. Allocation or Reservation amounts will be replaced with the ARRA funding amount and so calculated. All Fees as set out in these Chapter 36 Rules will be due and payable at such times as OHFA instructs Applicants.

(b) An annual Asset Management Fee shall be due on March 17 for each year of the Development Compliance Period. The Fee shall be negotiated by all parties based upon market for such services at the time of the Award of funding from the ARRA funds. If there has been Asset Management services previously agreed upon, then they will remain in effect.

330:36-10-14. [RESERVED]

330:36-10-15. Other Enactments of Law

In the event additional federal or state assistance/stimulus programs benefiting the OAHTC Program become available to the State through OHFA, OHFA shall immediately implement such procedures as OHFA deems necessary, in its sole discretion, to access these funds for the purpose of Allocating, granting, awarding, etc. to Qualified Owners of Tax Credit Developments. The process developed for the current economic stimulus programs available and future enactments of law will be consistent with the goals of the QAP, the Chapter 36 Rules, Section 42 of the Code and any relevant rules, regulations, rulings or other guidance issued by the IRS and, as relevant the regulations of the HOME Program and guidance from HUD. The Application process and procedures developed will be reviewed annually by OHFA through normal procedures.

[OAR Docket #09-824; filed 5-4-09]

**TITLE 785. OKLAHOMA WATER RESOURCES BOARD
CHAPTER 50. FINANCIAL ASSISTANCE**

[OAR Docket #09-778]

RULEMAKING ACTION:
EMERGENCY adoption

RULES:
Subchapter 13. Oklahoma Water Conservation Grant Program [NEW]

- 785:50-13-1. Purpose [NEW]
- 785:50-13-2. Definitions [NEW]
- 785:50-13-3. Eligible Entities [NEW]
- 785:50-13-4. Pilot Project Criteria [NEW]
- 785:50-13-5. Process for consideration of proposals [NEW]
- 785:50-13-6. Requirements for operation of projects [NEW]

AUTHORITY:

Oklahoma Water Resources Board; 82 O.S. §§ 1085.2 and 1088.1.

DATES:

Adoption:

November 12, 2008

Approved by Governor:

December 8, 2008

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2009, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

A compelling public interest necessitates the promulgation of these rules on an emergency basis in order to implement the Oklahoma Water Conservation Grant Program and make appropriated funds available to eligible entities for authorized projects immediately.

ANALYSIS:

The Oklahoma Water Resources Board ("OWRB") has adopted Sections 785:50-13-1 through 785:50-13-6 as a new subchapter and sections in order to implement a new provision of law enacted by House Bill 3135 in 2008 that established the Oklahoma Water Conservation Grant Program Act to be codified in the Oklahoma Statutes as Section 1088.1 of Title 82. The intended effect of the new rules is to provide guidance and policy to implement the new law.

CONTACT PERSON:

Dean A. Couch, General Counsel, 405-530-8800.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

SUBCHAPTER 13. OKLAHOMA WATER CONSERVATION GRANT PROGRAM

785:50-13-1. Purpose

The purpose of these rules is to implement the provisions of 82 O.S. Section 1088.1, enacted as part of House Bill 3135 approved in May 2008, that creates a new financial assistance grant program specifically for water conservation.

785:50-13-2. Definitions

In addition to the definitions contained in Section 785:50-1-2 of this chapter 50, the following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Communities" means entire cities or towns, combined cities or towns, part of cities or towns, or schools, groups or entities located within a community [82:1088.1].

"Groups or entities" means non-profit corporations who hold charitable non-profit status certifications from the Internal

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Revenue Service pursuant to the Internal Revenue Code and non-profit rural water districts formed under Title 82, O.S.

"Water conservation grant" means a written contract between the Board and a recipient whereby the recipient agrees to provide described goods or services for a public purpose under terms and conditions specified in the agreement.

785:50-13-3. Eligible entities

Communities are eligible to become water conservation grant recipients.

785:50-13-4. Pilot project criteria

The Board will consider the following in determining whether to approve a water conservation grant:

- (1) The total grant requested may not exceed Seven Thousand Dollars (\$7,000);
- (2) Percentage of water efficiency improvement or water savings that may be realized by implementation of the pilot project;
- (3) Ability of the applicant community to monitor benefits of project proposed;
- (4) Amount of matching funds and/or inkind contributions to be provided;
- (5) Potential to serve as model for other communities in the state; and
- (6) Number of communities, groups or entities collaborating in the proposed project.

785:50-13-5. Process for consideration of proposals

- (a) The Board will solicit applications by placing a notice of availability of funds for the water conservation grant program on the Oklahoma Water Resources Board website. The notice will contain a cutoff date for submission of applications.
- (b) Applications for water conservation grants shall be submitted on forms provided by the Board.
- (c) Staff will prioritize applications using the following formula:
 - (1) Estimated percentage of water efficiency improvement or water savings that may be realized by the implementation of the pilot project:

(A) one to ten percent = 5 points

(B) 11 to 20 percent = 10 points

(C) 21 percent or more = 20 points

(2) Applicant will monitor actual savings/benefits resulting from the proposed project:

(A) No - 0 points

(B) Yes - 15 points

(3) Amount of matching funds and/or inkind contributions to be provided:

(A) 10 to 20% - 5 points

(B) 21 to 30% - 10 points

(C) 31 to 40% - 15 points

(D) 41% or greater - 20 points

(4) Adaptability of proposed project to other communities:

(A) No - 0 points

(B) Yes - 15 points

(5) Number of communities, groups or entities collaborating on water conservation project:

(A) two = 10 points

(B) three = 20 points

(C) four or more = 30 points

785:50-13-6. Requirements for operation of projects

- (a) In addition to other terms and conditions stated therein, the water conservation grant recipient shall monitor and evaluate actual water conservation realized from implementation of the project or provide documentation regarding the potential for improvements to water use efficiency. Such monitoring may include week-to-week or month-to-month comparisons and changes in consumption based on total meter readings from the targeted area.
- (b) Approved projects that require construction of infrastructure such as pipes and meters shall be constructed and operated in accordance with all applicable state laws and maintained in good working order by the grant recipient.

[OAR Docket #09-778; filed 4-27-09]

Permanent Final Adoptions

An agency may promulgate rules on a permanent basis upon "final adoption" of the proposed new, amended, or revoked rules. "Final adoption" occurs upon approval by the Governor and the Legislature, or upon enactment of a joint resolution of approval by the Legislature. Before proposed permanent rules can be reviewed and approved/disapproved by the Governor and the Legislature, the agency must provide the public an opportunity for input by publishing a Notice of Rulemaking Intent in the *Register*.

Permanent rules are effective ten days after publication in the *Register*, or on a later date specified by the agency in the preamble of the permanent rule document.

Permanent rules are published in the *Oklahoma Administrative Code*, along with a source note entry that references the *Register* publication of the permanent action.

For additional information on the permanent rulemaking process, see 75 O.S., Sections 303, 303.1, 303.2, 308 and 308.1.

TITLE 10. OKLAHOMA ACCOUNTANCY BOARD CHAPTER 15. LICENSURE AND REGULATION OF ACCOUNTANCY

[OAR Docket #09-853]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 18. Computer-Based Examination
10:15-18-3. [AMENDED]
10:15-18-4. [AMENDED]
10:15-18-6. [AMENDED]
10:15-18-7. [AMENDED]
Subchapter 27. Fees
10:15-27-3.1. [AMENDED]
Subchapter 30. Continuing Professional Education
10:15-30-2. [AMENDED]
10:15-30-3. [AMENDED]
10:15-30-5. [AMENDED]
Subchapter 32. Standards for Continuing Professional Education (CPE) Programs
10:15-32-2. [AMENDED]
10:15-32-5. [AMENDED]
Subchapter 33. Peer Review
10:15-33-5. [AMENDED]
10:15-33-7. [AMENDED]
Subchapter 35. Reinstatement
10:15-35-1. [AMENDED]
Subchapter 37. Enforcement Procedures
10:15-37-5. [AMENDED]
10:15-37-6. [AMENDED]
Subchapter 39. Rules of Professional Conduct
10:15-39-1. [AMENDED]
10:15-39-9. [AMENDED]
Subchapter 43. Audits Performed in Accordance with Government Auditing Standards
10:15-43-7. [NEW]
10:15-43-8. [NEW]

AUTHORITY:

Oklahoma Accountancy Board, 59 O.S. Section 15.5.B.6

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Failure of the Legislature to disapprove the rules resulted in approval on April 29, 2009

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SUPERSEDED EMERGENCY ACTIONS:

n/a

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n/a

ANALYSIS:

Sections 15.8 and 15.9 of the Oklahoma Accountancy Act (Act) set forth the requirements for the CPA/PA examination. Substantive amendments to the computer-based examination rules established to administer those requirements delete provisions regarding the paper and pencil CPA/PA examination that became obsolete with the advent of the computer-based examination. A Board policy is added which allows a letter from the registrar's office in lieu of an official transcript providing official transcripts are submitted prior to any score release. Additional amendments clarify that a qualification applicant is an individual applying to qualify to become a candidate for examination. An amendment to the fee requirements clarifies applicants as qualification applicants to be consistent with amended language in the computer-based examination rules. Section 15.35 of the Act sets forth the requirement for continuing professional education. Substantive amendments to the CPE rules established to administer those requirements clarify that if the comprehensive ethics examination course required for issuance of an initial permit or the renewal of a lapsed permit is to be counted toward the forty hours of CPE required for the permit, it must have been completed in the same period as the remaining CPE required for the permit. Amendments also clarify that the comprehensive ethics examination course must be one course recommended for at least eight hours of CPE credit and must have been passed with a score of 90% or above. Language is added to clarify that CPE reporting will take place annually by July 31 and to clarify to industry permit holders that CPE credit in the areas of taxation, accounting, or assurance must be earned each calendar year. Amendments to the standards for CPE programs require that to be considered for CPE credit, self-study courses must be offered by sponsors registered with the National Association of State Boards of Accountancy's National Registry of CPE Sponsors or be courses offered by the AICPA or other such organizations as determined by the Board. The intent is to help registrants avoid losing CPE credit from taking self-study CPE courses that do not meet the Board's CPE standards for self-study programs. These standards were developed jointly by NASBA and the AICPA. CPE sponsors who are registered with NASBA are required to demonstrate that their courses are in compliance with the CPE standards. Section 15.30 of the Act provides for a peer review requirement. Substantive amendments to the peer review rules would change the effect of consecutive deficient peer review reports from the requirement of an accelerated peer review to a pre-issuance review or team captain revisit within eighteen (18) months from the year end of the firm's last peer review. The purpose of the amendment is to educate a firm providing substandard audits and/or reviews and to provide a means for an audit or review performed by a firm that has had consecutive deficient peer review reports to be reviewed by a qualified reviewer before the audit report or review is issued. Language in the rule discussing the pre-issuance review or team captain revisit results is modified from resulting in "a modified or adverse report" to resulting in "continued oversight." Language in the rule discussing the pre-issuance review or team captain revisit results is modified from resulting in "a modified or adverse report" to resulting in "continued oversight." Additional amendments change the name of the Peer

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Review Committee to the Peer Review Oversight Committee. Section 15.24 of the Act provides for reinstatement of the CPA certificate or PA license. Amendments to the requirements for reinstatement clarify that individuals applying for reinstatement must meet the CPE requirements for returning to active status if they will be providing any services associated with accounting work and must provide evidence of successful completion of the AICPA ethics examination or its equivalent as determined by the Board. Amendments to the enforcement procedures strike language in conflict with Section 15.6A of the Oklahoma Accountancy Act regarding providing information in investigation files and hearing records to other boards of accountancy or law enforcement agencies. Amendments to the rules of professional conduct correct the name of the Public Company Accounting Oversight Board (PCAOB) and clarify that it is professional misconduct for a registrant to receive a censure, suspension, cancellation, or revocation from another state or federal regulatory agency concerning the registrant's right to practice before a state or federal agency. An amendment to audits performed in accordance with Government Auditing Standards rules is added that would disqualify a firm and remove the firm's name from the list of Registrants Performing Governmental Audits in Accordance with Government Auditing Standards if the firm's registration or permit to practice public accounting in Oklahoma is revoked, cancelled, dissolved or suspended. An additional amendment provides for reinstatement to the list.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.8(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 18. COMPUTER-BASED EXAMINATION

10:15-18-3. Retake and granting of credit requirements

(a) A grade of seventy-five (75) in each required test section shall be the minimum passing grade for purposes of granting credit.

(b) A candidate may take the required test sections individually and in any order. Credit for any test section(s) passed shall be valid for eighteen months from the date the candidate took that test section, without having to attain a minimum score on any failed test section(s) and without regard to whether the candidate has taken other test sections.

(1) A CPA candidate must pass all four test sections of the AICPA Uniform CPA Examination within a rolling eighteen-month period, which begins on the date that the first test section(s) passed is taken. In the event all four test sections of the AICPA Uniform CPA Examination are not passed within the rolling eighteen-month period, credit for any test section(s) passed outside the eighteen-month period will expire and that/those test section(s) must be retaken.

(2) A PA candidate must pass the Financial Accounting and Reporting (FAR), Auditing and Attestation (AUD), and Regulation (REG) sections of the AICPA Uniform CPA Examination within a rolling eighteen-month period, which begins on the date that the first test section(s) passed is taken. In the event all three test sections of the PA Examination are not passed within the rolling eighteen-month

period, credit for any test section(s) passed outside the eighteen-month period will expire and that/those test section(s) must be retaken.

(3) A candidate cannot retake a failed test section(s) in the same examination window. An examination window refers to a three-month period in which a candidate has an opportunity to take the CPA/PA examination (comprised of two months in which the examination is available to be taken and one month in which the examination will not be offered while routine maintenance is performed and the item bank is refreshed). Thus, a candidate will be able to test two out of the three months within an examination window.

~~(e) A candidate having earned conditional credits on the paper and pencil examination, as of the launch date of the computer based AICPA Uniform CPA Examination, will retain conditional credits for the corresponding test sections of the computer based CPA examination as follows:~~

~~(1) A candidate having earned conditional credits on the paper and pencil examination in Auditing will retain conditional credits in Auditing and Attestation (AUD) on the computer based examination.~~

~~(2) A candidate having earned conditional credits on the paper and pencil examination in Financial Accounting and Reporting (FARE) will retain conditional credits in Financial Accounting and Reporting (FAR) on the computer based examination.~~

~~(3) A candidate having earned conditional credits on the paper and pencil examination in Accounting and Reporting (ARE) will retain conditional credits in Regulation (REG) on the computer based examination.~~

~~(4) A candidate having earned conditional credits on the paper and pencil examination in Business Law and Professional Responsibilities (LPR) will retain conditional credits in Business Environment and Concepts (BEC) on the computer based examination.~~

~~(d) A candidate who has attained conditional status as of the launch date of the computer based AICPA Uniform CPA Examination will be allowed a transition period to complete any remaining test sections of the CPA/PA examination. The transition is the maximum number of opportunities that a candidate who has conditioned under the paper and pencil examination has remaining, at the launch of the computer based examination, to complete all remaining test sections or the number of remaining opportunities under the paper and pencil examination, multiplied by six months, whichever is first exhausted.~~

~~(e) If a previously conditioned candidate does not pass all remaining test sections during the transition period, conditional credits earned under the paper and pencil examination will expire and the candidate will lose credit for the test sections earned under the paper and pencil examination. However, any test section(s) passed during the transition period is subject to the conditioning credit provisions of the computer based examination as indicated in the aforementioned credit requirements, except that a previously conditioned candidate will not lose conditional credit for a test section of the computer based examination that is passed during the transition period, even though more than eighteen months may have elapsed from the~~

~~date the test section is passed, until the end of the transition period.~~

(~~fc~~) A candidate shall be deemed to have passed the CPA examination once the candidate holds at the same time valid credit for passing each of the four test sections of the examination within the rolling eighteen month period. For purposes of this section, credit for passing a test section of the computer-based examination is valid from the actual date of the testing event for that test section, regardless of the date the candidate actually receives notice of the passing grade.

(~~gd~~) A candidate shall be deemed to have passed the PA examination once the candidate holds at the same time valid credit for passing each of the three test sections of the examination within the rolling eighteen month period. For purposes of this section, credit for passing a test section of the computer-based examination is valid from the actual date of the testing event for that test section, regardless of the date the candidate actually receives notice of the passing grade.

10:15-18-4. Educational requirements

(a) ~~A~~ ~~an~~ qualification applicant shall show, to the satisfaction of the Board, that the applicant has graduated from an accredited two-year or four-year college or university.

(1) As to an applicant whose college credits are reflected in quarter hours, each quarter hour of credit shall be considered as two-thirds (2/3) of one (1) semester hour when determining semester hour credits necessary to qualify for examination or transfer of credits.

(2) When determining eligibility based on educational qualifications, the Board shall consider only educational credit reflected on official transcripts, from an accredited two-year or four-year college or university.

(3) The Board may accept as temporary consideration, an official letter signed and sealed by the registrar's office of any two-year or four-year college or university attesting to the completion of educational qualifications of any qualification applicant, provided that official transcripts be submitted to the Board prior to any score release.

(~~34~~) The specific requirement that each applicant shall have completed at least one (1) course in auditing may only be satisfied with an auditing or assurance course taken for credit from an accredited two-year or four-year college or university.

(b) When determining eligibility of ~~an~~ a qualification applicant ~~for qualification~~, the Board shall not consider any combination of education and experience.

(c) The Board will also consider ~~an~~ a qualification applicant who has graduated from a college or university located outside the United States if an educational evaluation performed by a national credential evaluation service, as approved by the Board, certifies in writing that the applicant's course of study and degree are equivalent to the requirements set forth in Section 15.8 of the Act.

(d) On and after July 1, 2003, one hundred fifty (150) semester hours or its equivalent of collegiate education is required to qualify for any examination as set forth in Section 15.8.C. of the Oklahoma Accountancy Act. Any MIS or AIS course, or derivative thereof, as defined in Code 10:15-1-2,

used by the applicant to qualify must have a substantial relationship, either direct or indirect, to the accounting profession. However, only AIS courses will qualify for the core accounting courses as required in Section 15-8.C.

(e) Any candidate who has qualified to take the examination on the basis of education prior to July 1, 2003, as provided in Section 15.8.B, is not subject to subparagraph (d) of this subsection.

10:15-18-6. Denial of application

(a) Any qualification applicant or candidate who has not met the applicable qualifications and/or whose application has been denied shall be notified in writing. The written notice shall include the reason(s) for the denial.

(b) If an application is denied, the qualification applicant or candidate may file a written request with the Board for a review of the denial. The qualification applicant or candidate shall have the burden of demonstrating to the Board that the qualifications required by the Oklahoma Accountancy Act and the rules implementing the Act have been met. Any evidence submitted by the qualification applicant or candidate shall be in documentary form.

10:15-18-7. Board review of denied applications

(a) The Board shall consider all requests for review of denied applications.

(b) The issues considered for review shall include, but not be limited to, the statutory eligibility requirements and rules upon which the denial of the application was based.

(c) The qualification applicant or candidate who has requested the review shall be notified in writing of the Board's decision. If the denial is sustained by the Board, the written notice shall include the reason(s) for sustaining the denial.

(d) If the denial of the application is sustained, and the qualification applicant or candidate is not satisfied with the decision of the Board, the qualification applicant or candidate may request in writing a public hearing before the Board. Such request shall be granted only if the qualification applicant or candidate can provide additional information to the Board which was not previously available to the Board at the time of the initial evaluation or review. Any additional evidence shall be in documentary form. If any additional evidence is to be presented by oral testimony, a written synopsis of that oral evidence shall accompany the request for a public hearing.

(e) If the Board grants a public hearing to the qualification applicant or candidate, the hearing may be held in conjunction with the next regular meeting of the Board or at a special meeting of the Board.

SUBCHAPTER 27. FEES

10:15-27-3.1. Qualification and examination fees

~~Applicants~~ Qualification applicants and candidates shall, for each application filed with the Board, pay a Fifty-Dollar (\$50.00) fee and shall be responsible for all fees charged by the American Institute of Certified Public Accountants, National

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Association of State Boards of Accountancy (NASBA), and test delivery service provider which are payable to NASBA prior to scheduling the examination.

SUBCHAPTER 30. CONTINUING PROFESSIONAL EDUCATION

10:15-30-2. Required CPE for issuance of an original permit

Certificate and license holders applying for their first permit to practice public accounting must report a minimum of forty (40) hours of CPE, earned within the previous calendar year or within 365 days immediately preceding the date of the application and shall also provide evidence of the successful completion of the AICPA Ethics Examination or its equivalent as determined by the Board ~~earned within the previous calendar year or within 365 days immediately preceding the date of the application~~ before a permit will be issued. If the ethics examination course is to be counted toward the CPE required for the permit, it must have been completed during the same period as the remaining CPE reported to obtain the permit. The passing score is determined by the Board. Any ethics course meeting the requirements for issuance of an original permit:

- (1) must be one course which has been recommended for at least eight (8) hours of CPE credit by the course provider; and
- (2) must have been passed with a score of 90% or above.

10:15-30-3. Required CPE for issuance of a lapsed permit

Certificate and license holders previously holding a permit to practice public accounting must report a minimum of forty (40) hours of CPE earned within the previous calendar year or within 365 days immediately preceding the date of the application and shall also provide evidence of the successful completion of the AICPA Ethics Examination or its equivalent as determined by the Board ~~earned within the previous calendar year or within 365 days immediately preceding the date of the application~~ before a permit will be issued. If the ethics examination course is to be counted toward the CPE required for the permit, it must have been completed during the same period as the remaining CPE reported to obtain the permit. The passing score is determined by the Board. Any ethics course meeting the requirements for the renewal of a lapsed permit:

- (1) must be one course which has been recommended for at least eight (8) hours of CPE credit by the course provider; and
- (2) must have been passed with a score of 90% or above.

10:15-30-5. Reporting and documentation by certificate and license holders

(a) Certificate and license holders not otherwise exempt must complete one hundred twenty (120) hours of qualifying CPE within a rolling three (3) calendar year period. A certificate or license holder's three (3) year period begins January 1 in the year the certificate or license holder was required to earn CPE. A minimum of twenty (20) hours of acceptable CPE, ~~including~~ shall be completed each calendar year. Effective January 1, 2009, four hours of professional ethics must be completed within each rolling three (3) calendar year period. CPE shall be reported annually by July 31 on a form prescribed by the Board.

(b) The professional ethics requirement as mandated in this section may be met by courses from other licensed professional disciplines that relate directly to the practice of public accounting, such as law or securities and may be met by courses on ethical codes in jurisdictions other than Oklahoma.

(c) Each certificate and license holder required to report CPE shall certify, in a format prescribed by the Board, information regarding the CPE hours claimed for credit for the calendar year.

(d) CPE hours claimed for credit may be claimed only for the compliance period in which the course was completed and credit granted.

(e) Each letter or certificate of completion shall include the date of completion of the seminar or course as evidenced by:

- (1) Date the in-attendance course was completed;
- (2) Date a self-study course was completed and evidenced by the date of certified mailing or date of facsimile transmission to the program sponsor;
- (3) Date an internet self-study course is transmitted to the program sponsor.

(f) At the time of completing each course, or within sixty (60) days thereafter, the certificate or license holder shall obtain a letter or certificate attesting to completion of the course from the sponsor of the course. Such letters or certificates shall be retained for a period of five (5) years after the end of the compliance period in which the program is completed and shall include the specific information set forth in the Board's CPE Standards.

(g) Participants in structured CPE programs shall also retain descriptive material for five (5) years which reflects the content of a course in the event the participant is requested by the Board to substantiate the course content.

(h) If a certificate or license holder's main area of employment is industry and the certificate or license holder holds a permit to practice, at least seventy-two (72) hours of the one hundred twenty (120) hour requirement within a three (3) year period of the qualifying CPE completed by the certificate or license holder shall be in subjects related to the practice of public accounting and shall earn a minimum of eight (8) hours in the areas of taxation, accounting or assurance per calendar year.

SUBCHAPTER 32. STANDARDS FOR CONTINUING PROFESSIONAL EDUCATION (CPE) PROGRAMS

10:15-32-2. Standards for CPE Program Sponsors

- (a) CPE program sponsors are responsible for compliance with all applicable standards and other CPE requirements.
- (b) CPE program sponsors may have to meet specific CPE requirements of state licensing bodies, other governmental entities, membership associations, and/or other professional organizations or bodies. Professional guidance for CPE program sponsors is available from the AICPA and NASBA; state-specific guidance is available from the state boards of accountancy. CPE program sponsors should contact the appropriate entity to determine requirements.
- (c) Self-study courses considered for CPE credit must be:
 - (1) offered by sponsors registered with NASBA's National Registry of CPE Sponsors; or
 - (2) courses offered by the AICPA or other such organizations as determined by the Board.

10:15-32-5. Standards for CPE program measurement

- (a) Sponsored learning activities are measured by program length, with one 50-minute period equal to one CPE credit. One-half CPE credit increments (equal to 25 minutes) are permitted after the first credit has been earned in a given learning activity.
 - (1) For learning activities in which individual segments are less than 50 minutes, the sum of the segments should be considered one total program. For example, five 30-minute presentations would equal 150 minutes and should be counted as three CPE credits. When the total minutes of a sponsored learning activity are greater than 50, but not equally divisible by 50, the CPE credits granted should be rounded down to the nearest one-half credit. Thus, learning activities with segments totaling 140 minutes should be granted two and one-half CPE credits.
 - (2) While it is the participant's responsibility to report the appropriate number of credits earned, CPE program sponsors must monitor group learning activities to assign the correct number of CPE credits.
 - (3) For university or college credit courses that meet these CPE Standards, each unit of college credit shall equal the following CPE credits:
 - (A) Semester System 15 credits; and
 - (B) Quarter System 10 credits;
 - (4) For university or college non-credit courses that meet these CPE standards, CPE credits shall be awarded only for the actual classroom time spent in the non-credit course.
 - (5) Credit is not granted to participants for preparation time.
 - (6) Only the portions of committee or staff meetings that are designed as programs of learning and comply with these standards qualify for CPE credit.

(e**b**) CPE credit for self-study learning activities must be based on a pilot test of the average completion time. A sample of intended professional participants should be selected to test program materials in an environment and manner similar to that in which the program is to be presented. The sample group of at least three individuals must be independent of the program development group and possess the appropriate level of knowledge before taking the program. The sample does not have to ensure statistical validity. CPE credits should be recommended based on the average completion time for the sample. If substantive changes are subsequently made to program materials further pilot tests of the revised program materials should be conducted to affirm or amend, as appropriate, the average completion time. Self-study courses considered for CPE credit must be:

- (1) offered by sponsors registered with NASBA's National Registry of CPE Sponsors; or
- (2) courses offered by the AICPA or other such organizations as determined by the Board.

(e**c**) Instructors or discussion leaders of learning activities should receive CPE credit for both their preparation and presentation time to the extent the activities maintain or improve their professional competence and meet the requirements of these CPE standards.

- (1) Instructors, discussion leaders, or speakers who present a learning activity for the first time should receive CPE credit for actual preparation time up to two times the number of CPE credits to which participants would be entitled, in addition to the time for presentation.
- (2) Instructors of university or college courses can claim a maximum of fifteen (15) CPE credits per college credit hour taught to the extent the preparation required for the course maintains or improves their professional competence.
- (3) For repeat presentations, CPE credit as provided in 10:15-32-5(d)(1) and (2) can be claimed only if it can be demonstrated that the learning activity content was substantially changed and such change required significant additional study or research.

(e**d**) Writers of published articles, books, or CPE programs should receive CPE credit for their research and writing time to the extent it maintains or improves their professional competence. CPE credit from this activity shall be limited to 10 CPE credits per calendar year and will be determined by the Board on a case by case basis. Writing articles, books, or CPE programs for publication is a structured activity that involves a process of learning. CPE credits should be claimed only upon publication.

(e**e**) CPE credits recommended by a CPE program sponsor of independent study must not exceed the time the participant devoted to complete the learning activities specified in the learning contract. The credits to be recommended by an independent study CPE program sponsor should be agreed upon in advance and should be equated to the effort expended to improve professional competence. The credits cannot exceed the time devoted to the learning activities and may be less than the actual time involved.

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SUBCHAPTER 33. PEER REVIEW

10:15-33-5. Effect of consecutive deficient reports

(a) Effective for peer reviews commencing on or before December 31, 2008, a firm, including a succeeding firm, which receives two (2) consecutive modified reports and/or one (1) adverse report, may be required by the Board or its designee to have ~~an accelerated a pre-issuance peer review or team captain revisit~~ within eighteen (18) months from the year end of the firm's last peer review.

(b) If the ~~accelerated pre-issuance review or team captain revisit~~ required by subsection (a) above results in a ~~modified or adverse report continued oversight~~:

(1) The firm may complete any review and audit engagement for which field work has already begun only if:

(A) ~~Prior prior~~ prior to issuance of any report, the engagement is reviewed and approved by a third party reviewer acceptable to the Board or its designee; and,

(B) ~~The engagement is completed within ninety (90) days of the acceptance of the peer review report, letter of comments, and letter of response by the sponsoring organization;~~

(2) The firm shall be referred to the Vice Chair of the Board for enforcement investigation.

(3) A firm may petition the Board for a waiver from the provisions of this rule subsection (b).

(c) Effective for peer reviews commencing on or after January 1, 2009, a firm, including a succeeding firm which receives two (2) consecutive pass with deficiencies reports and/or one (1) fail report, may be required by the Board or its designee to have an accelerated peer review within eighteen (18) months from the year end of the firm's last peer review.

(d) If the accelerated review required by subsection (a) or (c) above results in a deficient report:

(1) The firm may complete any service requiring a peer review for which field work has already begun only if:

(A) Prior to issuance of any report, the engagement is reviewed and approved by a third party reviewer acceptable to the Board or its designee; and

(B) The engagement is completed within ninety (90) days of the acceptance of the peer review report, and letter of response (when applicable) by the sponsoring organization;

(2) The firm shall be referred to the Vice Chair of the Board for enforcement investigation.

(3) A firm may petition the Board for a waiver from the provisions of this rule subsection (d).

10:15-33-7. Peer review oversight committee

(a) The Board shall appoint a Peer Review Oversight Committee for the purpose of:

(1) Monitoring sponsoring organizations to provide reasonable assurance that peer reviews are being conducted and reported on in accordance with peer review minimum standards;

(2) Reviewing the policies and procedures of sponsoring organization applicants as to their conformity with the peer review minimum standards; and

(3) Reporting to the Board on the conclusions and recommendations reached as a result of performing functions in paragraphs (A) and (B) of this subsection.

(b) The Peer Review Oversight Committee shall consist of three (3) members nominated by the Chair and approved by the Board, none of whom is a current member of the Board. Initial appointment of the three (3) committee members shall be as follows: one (1) member appointed for three (3) years; one (1) member appointed for two (2) years; and one member appointed for one (1) year. Subsequent committee members shall serve three (3) year terms. Compensation, if any, of Peer Review Oversight Committee members shall be set by the Board, not to exceed One Hundred Fifty Dollars (\$150.00) per hour. Each member of the Peer Review Oversight Committee must be active in the practice of public accounting at a supervisory level or above in the accounting or auditing function while serving on the committee or any employee involved at a supervisory level or above in an audit function of a state or local government. The member or member's firm must be enrolled in an approved practice/monitoring program and have received an unmodified or pass report on its most recently completed peer review. A majority of the committee members must satisfy the qualifications required of system peer review team captains as established and reported in the AICPA Standards for Performing and Reporting on Peer Reviews.

(1) No more than one Peer Review Oversight Committee member may be from the same firm.

(2) A Peer Review Oversight Committee member may not concurrently serve as a member of the AICPA's or any state's CPA society ethics or peer review committee.

(3) A Peer Review Oversight Committee member may not participate in any discussion or have any vote with respect to a reviewed firm when the committee member lacks independence or has a conflict of interest. The Board may appoint alternate committee member(s) to serve in these situations.

(c) Information concerning a specific firm or reviewer obtained by the Peer Review Oversight Committee during oversight activities shall be confidential, and the firm's or reviewer's identity shall not be reported to the Board. Reports submitted to the Board will not contain information concerning specific registrants, firms or reviewers.

(d) As determined by the Board, the Peer Review Oversight Committee shall make periodic recommendations to the Board, but not less than annually, as to the continuing qualifications of each sponsoring organization as an approved sponsoring organization.

(e) The Peer Review Oversight Committee may:

(1) When necessary in reviewing reports on peer reviews, prescribe actions designed to assure correction of the deficiencies in the reviewed firm's system of quality control policies and procedures and provide such results to the Board;

(2) Monitor the prescribed remedial and corrective actions to determine compliance by the reviewed firm;

- (3) Establish and perform procedures for ensuring that reviews are performed and reported on in accordance with the AICPA Standards for Performing and Reporting on Peer Reviews or other standards as approved by the Board and the rules promulgated herein by the Board;
- (4) Establish a report acceptance process, which facilitates the exchange of viewpoints among committee members and sponsoring organization; and
- (5) Communicate to the governing body of the sponsoring organization on a recurring basis:
 - (A) Problems experienced by the enrolled registrants in their systems of quality control as noted in the peer reviews conducted by the sponsoring organization;
 - (B) Problems experienced in the implementation of the peer review program; and
 - (C) A summary of the historical results of the peer review program.
- (f) Committee members shall become disqualified to serve on Peer Review Oversight Committee if any of the provisions that qualify the committee member no longer exist or by majority vote of the Board.

SUBCHAPTER 35. REINSTATEMENT

10:15-35-1. Application for reinstatement

- (a) Upon application on a form prescribed by the Board an individual may request reinstatement of a canceled, suspended, or revoked certificate or license.
- (b) The applicant shall be of good moral character.
- (c) In addition to the application fee the applicant shall pay the required registration fees and permit fee, if applicable, as well as all costs and fines assessed by the Board which remain unpaid at the date the application is filed.
- (d) Individuals applying for the reinstatement of a certificate or license must meet the requirements to return to active status in 10:15-30-9 if they will be providing any services associated with accounting work.
- (e) Individuals applying for the reinstatement of a certificate or license must show evidence of successful completion of the AICPA ethics examination or its equivalent as determined by the Board.

SUBCHAPTER 37. ENFORCEMENT PROCEDURES

10:15-37-5. Filing of formal complaint

- (a) All formal complaints shall be filed by the Enforcement Committee only with the agreement of the Special Prosecutor.
- (b) The Enforcement Committee, and the Special Prosecutor must concur. In the event they do not, the Vice Chairman will prepare a report for the Board and the Board will determine future action.
- (c) The formal complaint shall be signed by the Special Prosecutor or the Vice Chairman.

- (d) The formal complaint shall include a concise statement of the allegations and particular sections of the Oklahoma Accountancy Act and the rules implementing that Act which are involved.

10:15-37-6. Formal proceedings

- (a) The Chairman shall set a time and place for the hearing of the formal complaint, provided that such hearing shall be set not less than twenty (20) days from service of the complaint and notice of the proceeding to the accused at the last known address in the official records of the Board.
- (b) Notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the specialized knowledge of one (1) or more members of the Board.
- (c) The accused shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise of any material notices, including any staff memoranda or data to be relied on by the Board and the accused shall be afforded an opportunity to contest the material so noticed. The experience, technical competence, and specialized knowledge of the members of the Board may be utilized in the evaluation of the evidence.
- (d) Oral proceedings or any part thereof shall be transcribed upon request of any party. All costs of such transcription shall be paid by the requesting party.
- (e) Hearings will be conducted by one (1) of the following methods, as determined by the Board:
 - (1) By the Board;
 - (2) By any member of the Board or a designee of the Board acting as a hearing examiner or Administrative Law Judge; or
 - (3) By an attorney licensed to practice law in this state appointed by the Board to act as a hearing examiner or Administrative Law Judge.
- (f) The standard of proof in all hearings shall be clear and convincing evidence.
- (g) All orders, whether proposed or final, shall be issued within ninety (90) calendar days of the hearing. Final orders shall state their effective date.
- (h) The Board shall consider past disciplinary action taken against any accused found guilty in any present proceeding. Such past conduct shall not be evidence of guilt in the present proceeding but will be considered only in determining appropriate sanctions to be imposed by the Board in the present proceeding.
 - (i) Unless precluded by law, the accused may waive any right granted in the law and proceed by stipulation, agreed settlement, consent order, or default. No provision of this section shall be construed as prohibiting the Board from suspending, or holding in abeyance, any formal proceeding pending the outcome of informal negotiation or informally agreed upon terms.
 - ~~(j) The investigation files of the Board shall be confidential, except the Board may provide information in the investigation files and hearing record to the following:
 - ~~(4) Any Board of Accountancy or Commission of the District of Columbia, or any other state or territory of the~~~~

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~~United States which exercises disciplinary authority over accountants; and~~

~~(2) Any law enforcement agency which makes a proper showing that such information is necessary to conduct a pending investigation.~~

(kj) Any individual who has filed a complaint may be notified of the final disposition of the matter.

(lk) The hearing record of any formal proceeding shall be open to the public.

(ml) The notice and hearing procedures required for individual proceedings as set forth in the Oklahoma Administrative Procedures Act shall be followed by the Board.

SUBCHAPTER 39. RULES OF PROFESSIONAL CONFLICT

10:15-39-1. Application

(a) To the extent not contradicted by rule herein, a registrant shall conform in fact and in appearance to the AICPA Code of Professional Conduct.

(b) To protect the public interest, the Rules of Professional Conduct are based on the premise that the public and the business community rely on sound financial reporting and on professional competence. This premise is inherent in the authorized use of the titles certified public accountant and public accountant, which imposes on persons registered with the Board certain obligations to the public and to others. These obligations which the Rules of Professional Conduct are intended to enforce, include: the obligation to maintain independence and objectivity of thought and action, to strive continuously to improve professional skills, to observe, where applicable, generally accepted accounting principles, governmental auditing standards, standards as set by the Public Company Auditing Accounting Oversight Board, and generally accepted auditing standards, to promote sound and informative financial reporting, to hold the affairs of clients or employers in confidence, to uphold the standards of the public accounting profession, and to maintain high standards of personal conduct in all matters affecting fitness to practice public accounting.

(c) Acceptance by a registrant of a certificate or license involves a duty to abide by the Rules of Professional Conduct.

(d) The Rules of Professional Conduct are intended to have application to all kinds of professional services performed in the practice of accounting, including, but not limited to, assurance, attest, auditing, accounting, review and compilation services, tax services, management advisory services and personal financial and investment planning, and intended to apply as well to all certificate and license holders, whether or not engaged in the practice of public accounting, except where the wording of one of the Rules of Professional Conduct clearly indicates that the applicability is more limited.

(e) A registrant who is engaged in the practice of public accounting outside the United States is not subject to discipline by the Board for departing, with respect to such foreign practice, from any of the Rules of Professional Conduct, so long as the conduct is in accordance with the Rules of Professional

Conduct applicable to the practice of public accounting in the country in which the registrant is practicing. If the name of a registrant is associated with financial statements in such manner as to imply that the registrant is acting as an independent CPA or PA under circumstances which would entitle the reader to assume that United States practices are followed, the registrant will be expected to comply with auditing standards and accounting principles generally accepted in the United States of America, and other professional standards applicable to the services provided.

(f) In interpreting and enforcing these rules, the Board may give consideration, but not necessarily dispositive weight, to relevant interpretations, rulings and opinions issued by the boards of other jurisdictions, appropriately authorized ethics committees of professional organizations and other federal and state agencies.

10:15-39-9. Professional misconduct

It is professional misconduct for a CPA, PA or a firm to:

(1) violate or attempt to violate the Oklahoma Accountancy Act or the rules implementing that Act, knowingly assist or induce another to do so, or do so through the act of another; or

(2) commit a criminal act that reflects adversely on the CPA's or PA's integrity, trustworthiness or fitness to practice as a CPA or PA; or

(3) commit any act that reflects adversely on the CPA's or PA's fitness to practice public accounting.

(4) engage in conduct involving dishonesty, fraud, deceit, misrepresentation or omission of a known material fact; or

(5) engage in a pattern of repeated offenses, even ones of minor significance including an indifference to the Oklahoma Accountancy Act or the rules implementing that Act; or

(6) state or imply an ability to influence improperly a government agency or official; or

(7) ~~violate the rules and regulations~~ receive a censure, suspension, cancellation, revocation, of other state or federal regulatory agencies which results in the censure or suspension, cancellation, revocation, or withdrawal of registration or by a state or federal agency concerning the right of the registrant to practice by such before a state or federal agency, as a result of whether by a hearing, consent agreement, court order, or other administrative proceedings.

SUBCHAPTER 43. AUDITS PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

10:15-43-7. Disqualification

At any time the firm's registration or permit to practice public accounting in Oklahoma is revoked, cancelled, dissolved or suspended, the firm's registration under this subchapter shall be disqualified and the firm's name shall be

automatically removed from the list of Registrants Performing Governmental Audits in Accordance with Government Auditing Standards.

10:15-43-8. Reinstatement

After disqualification, reinstatement shall only be granted upon the filing of the form prescribed by the Board and proof of the firm's qualification.

[OAR Docket #09-853; filed 5-7-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 13. FUEL ALCOHOL**

[OAR Docket #09-842]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Chapter 13. Fuel Alcohol
- 35:13-1-1 [AMENDED]
- 35:13-1-2 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 2-18, 11-20 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

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April 15, 2009

Effective:

July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

The Distilled Spirits for Fuel Use regulations found in Title 27 of the Code of Federal Regulations (CFR) (~~2006~~2008 Revision).

Incorporating rules:

- 35:13-1-1 [AMENDED]
- 35:13-1-2 [AMENDED]

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298, 405-522-4576

ANALYSIS:

The proposed rules incorporate the date for the most recent version of the Code of Federal Regulations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry, (405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

35:13-1-1. Incorporation by reference of federal distilled spirits for fuel use regulations

The Distilled Spirits for Fuel Use regulations found in Title 27 of the Code of Federal Regulations (CFR) (~~2006~~ 2008 Revision), Part 19.901 et seq. for the United States Department of the Treasury, Alcohol and Tobacco Tax and Trade Bureau, as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:13-1-2.

35:13-1-2. Deleted regulations

The following sections of the Code of Federal Regulations governing distilled spirits for fuel use of the United States Department of the Treasury, Alcohol and Tobacco Tax and Trade Bureau incorporated by reference under 35:13-1-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 27 CFR §§ 19.905, 19.906, 19.955, 19.956, 19.957, 19.958, and 19.959 (~~2006~~ 2008 Revision).

[OAR Docket #09-842; filed 5-6-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 15. ANIMAL INDUSTRY**

[OAR Docket #09-858]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 5. Biological Products and Laboratories
- 35:15-5-1 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture and the Oklahoma Agricultural Code; 2 O.S. §§ 2-4, 6-2, and 6-135; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

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March 12, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on April 23, 2009

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July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The proposed rules require all biological products distributed, sold, offered for sale, or used in Oklahoma to be registered with the Department. The rule requires annual registration of the products with an annual registration fee and other requirements for registration.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry
(405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 5. BIOLOGICAL PRODUCTS AND LABORATORIES

35:15-5-1. Biological products

(a) No biological product, including antigens, used to immunize, test, or treat livestock or any other species of animals shall be manufactured, produced, transported, distributed, sold, or offered for sale, or possessed in Oklahoma unless the biological product has been licensed or permitted by and produced in an establishment licensed by the United States Veterinary Biologics Division of the United States Department of Agriculture, and approved by the Oklahoma ~~Board~~ Department of Agriculture, Food, and Forestry. Exemption: Autogenous vaccines and/or bacterins when prepared for use on individual premises or animals may be prepared in laboratories approved by the Board of Agriculture.

(b) John's (Paratuberculosis) vaccine is expressly prohibited in Oklahoma without prior approval of the Department of ~~Agriculture~~. This approval may be obtained only after a written agreement is developed between the producer, attending veterinarian, and state regulatory officials. A plan of herd management, vaccination and any restrictions ~~must~~ shall be a part of this agreement.

(c) Each biological product distributed, sold, offered for sale or used in Oklahoma or delivered for transportation or transported in intrastate or interstate commerce shall be registered with the Department on an annual basis.

(d) Each person registering biological products shall pay an annual registration fee of Two Hundred Dollars (\$200.00) for each biological product registered.

(1) The Department may require the submission of the complete formula of any biological product.

(2) Trade secrets and formulations submitted with the registration shall be kept confidential.

(e) If it appears to the Board that the composition of the biological product is adequate to warrant the proposed claims and if the biological product, its labeling, and other material

required to be submitted comply with the requirements of this section, then the biological product shall be registered.

(f) Registration shall not be required in the case of a biological product shipped from one location within Oklahoma to another location within Oklahoma so long as the location is operated by the same person.

(g) All biological product registrations shall expire on March 20 of each year.

(h) It shall be a violation of these rules if the renewal application is not received by March 20.

(i) The term "Biological Product" shall mean any substance or mixture of substances, including but not limited to vaccines, autogenous bacterins, and antigens, used to immunize, test or treat livestock, poultry or any other species of animals, but shall not include any product identified and regulated as a pesticide by the Department.

[OAR Docket #09-858; filed 5-7-09]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 15. ANIMAL INDUSTRY

[OAR Docket #09-861]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 16. Contagious Equine Metritis
35:15-16-1 [AMENDED]
Subchapter 36. Scrapie
35:15-36-1 [AMENDED]
35:15-36-2 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture and the Oklahoma Agricultural Code; 2 O.S. §§ 2-4, 6-2, 6-124, 6-131, and 6-152; Article 6, Section 31, Constitution of the State of Oklahoma

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July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

Title 9 CFR 2008 Revision, Section 93-301

Title 9 CFR 2008 Revision, Part 79 et seq. with the exception of the following regulations: 79.6 and 79.7

Incorporating rules:

35:15-16-1
35:15-36-1

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298.

ANALYSIS:

The proposed rules update the incorporation by reference of the Code of Federal Regulations for Contagious Equine Metritis and Scrapie.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 16. CONTAGIOUS EQUINE METRITIS

35:15-16-1. Incorporation by reference

(a) The contagious equine metritis regulation found in Title 9 of the Code of Federal Regulations (CFR) (~~2007~~ 2008 Revision), Section 93-301 for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, is hereby adopted in its entirety.

(b) All words and terms defined or used in the federal regulation incorporated by reference by the Department shall mean the state equivalent or counterpart to those words or terms.

SUBCHAPTER 36. SCRAPIE

35:15-36-1. Incorporation by reference of federal regulations

(a) The Scrapie in Sheep and Goats Regulations found in Title 9 of the Code of Federal Regulations (CFR) ~~2007~~ 2008 Revision, Part 79 et seq. for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:15-36-2.

(b) All words or terms defined or used in the Federal regulations incorporated by reference shall mean the state equivalent or counterpart to those words or terms.

35:15-36-2. Deleted regulations

The following sections of the Federal regulations governing scrapie in sheep and goats (9 CFR, Part 79 et seq.) (~~2007~~ 2008 Revision) of the USDA incorporated by reference under 35:15-36-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 79.6 and 79.7.

[OAR Docket #09-861; filed 5-7-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 15. ANIMAL INDUSTRY**

[OAR Docket #09-859]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 49. Miscellaneous Animal Diseases [NEW]
35:15-49-1 through 35:15-49-5 [NEW]

AUTHORITY:

Oklahoma State Board of Agriculture and the Oklahoma Agricultural Code; 2 O.S. §§ 2-4, 6-2, and 6-131; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

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April 15, 2009

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July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 49. Miscellaneous Animal Diseases [NEW]
Part 1. Malignant Catarrhal Fever [NEW]
35:15-49-1 through 35:15-49-5 [NEW]

Gubernatorial approval:

June 10, 2008

Register publication:

25 Ok Reg 2613

Docket number:

08-1183

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

These rules provide requirements for owners of wildebeest within the state of Oklahoma. Wildebeest carry malignant catarrhal fever that is transmissible to other species when the wildebeest are calving. These rules were previously approved as emergency rules.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 49. MISCELLANEOUS ANIMAL DISEASES

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35:15-49-1. Definitions

The following words or terms, when used in this Subchapter, shall have the following meaning unless the context clearly indicates otherwise:

"Malignant catarrhal fever" means alcelaphine herpesvirus-1 (AHV-1), carried asymptotically by wildebeest.

"Movement" or **"move"** means any transfer of wildebeest from one location to another, and shall include interstate transfer, intrastate transfer, and export.

"Wildebeest" means the animals known as *Connochaetes taurinus*.

35:15-49-2. Movement of wildebeest

(a) No person shall move any wildebeest into Oklahoma without first obtaining an entry permit from the Department.

(b) No person shall move any wildebeest within Oklahoma without obtaining a permit prior to movement that identifies the following:

(1) Name, mailing address, and telephone number of the current owner;

(2) Name, mailing address, and telephone number of the purchaser;

(3) Name, mailing address, and telephone number of the transporter;

(3) Specific legal description of the property where the wildebeest currently are located or premise identification number;

(4) Specific legal description of the destination property or premise identification number;

(5) Identification of the mode of transportation, including any license tag information and business information; and

(6) Any other information the State Veterinarian may request.

(c) No person shall move any wildebeest for export from Oklahoma without obtaining a permit prior to movement.

35:15-49-3. Separation requirements

(a) Any person holding female wildebeest within Oklahoma shall maintain sufficient separation, as determined by the State Veterinarian, of all wildebeest, including male and female, from cervidae, bovidae, giraffidae, and antilocapridae.

(b) In no case shall any person holding wildebeest allow any of the above listed species to be held in any enclosure sharing a common fence with wildebeest.

(c) The requirements of this rule shall not be applicable to any zoological park licensed by USDA APHIS Animal Care.

35:15-49-4. Notification requirements

(a) Any person who owns or possesses wildebeest in Oklahoma shall notify the Department of the following:

(1) Location, including specific legal description, where the wildebeest are held or premise identification number;

(2) Number of head of female wildebeest and number of head of male wildebeest;

(3) Name, mailing address, and telephone number of the owner;

(4) Any other information the State Veterinarian may request.

(b) Any person owning or possessing female wildebeest shall provide biannual notice to the landowner of record for all property adjacent to any location female wildebeest are or may be held.

(1) Notice shall include the following information:

(A) A statement that female wildebeest are or will be held on adjacent property;

(B) The specific legal description where the female wildebeest are or will be held;

(C) A statement that female wildebeest are carriers of malignant catarrhal fever and malignant catarrhal fever is fatal to cattle, but does not spread between cattle;

(D) Contact information, including telephone number and email address, of the office of the State Veterinarian; and

(E) The name, mailing address, and telephone number of the owner of the wildebeest.

(2) Notice shall be sent by certified mail return receipt requested, and the person owning or possessing the wildebeest shall keep records of the certified mailing for three years from the date of mailing.

(c) Any person owning or possessing female wildebeest shall provide publication notice in a newspaper of general circulation in the county where the wildebeest are held on an annual basis, and the notice shall contain the following:

(1) A statement that female wildebeest are or will be held in the county;

(2) The specific legal description of the property where the female wildebeest are or will be held;

(3) A statement that female wildebeest are carriers of malignant catarrhal fever and malignant catarrhal fever is fatal to cattle, but does not spread between cattle;

(4) Contact information, including telephone number and email address, of the office of the State Veterinarian; and

(5) The name, mailing address, and telephone number of the owner of the wildebeest.

(d) Notice to adjacent property and notice by publication shall be given by the owner or possessor of female wildebeest prior to placing wildebeest on the property.

35:15-49-5. Violations

(a) Any person violating any of the provisions of these rules may be subject to administrative, civil, or criminal penalties.

(b) Each day of continuing violation and each wildebeest shall be a separate violation.

[OAR Docket #09-859; filed 5-7-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. CONSUMER PROTECTION**

[OAR Docket #09-863]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 17. Combined Pesticide
Part 6. Pesticidal Product Producing Establishments
35:30-17-13 [AMENDED]
Part 21. Standards for disposal of pesticide and pesticide containers
35:30-17-89.1 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 3-81 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

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April 16, 2009

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July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

Title 40 CFR 2008 Revision, Part 167 et seq. and Part 169 et seq. with the exception of 40 CFR § 167.90; Part 156.140 et seq. and Part 165 et seq.

Incorporating rules:

35:30-17-13
35:30-17-89.1

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298, 405-522-4576

ANALYSIS:

The proposed rules incorporate the date for the most recent version of the Code of Federal Regulations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 17. COMBINED PESTICIDE

PART 6. PESTICIDAL PRODUCT PRODUCING ESTABLISHMENTS

35:30-17-13. Incorporation by reference of federal pesticide producing establishment regulations

(a) The Registration of Pesticide and Active Ingredient Producing Establishments, Submission of Pesticide Reports and Books and Records of Pesticide Production and Distribution Regulations found in Title 40 of the Code of Federal Regulations (CFR) ~~2007~~ 2008 Revision, Part 167 et seq. and Part 169 et seq. for the United States Environmental Protection Agency (EPA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of 40 CFR § 167.90.

(b) All words or terms defined or used in the Federal regulations incorporated by reference shall mean the state equivalent or counterpart to those words or terms.

PART 21. STANDARDS FOR DISPOSAL OF PESTICIDE AND PESTICIDE CONTAINERS

35:30-17-89.1. Incorporation by reference of federal pesticide management and disposal regulations

(a) The Labeling Requirements for Pesticides and Devices, Container Labeling and Pesticide Management and Disposal regulations found in Title 40 of the Code of Federal Regulations (CFR) ~~2007~~ 2008 Revision, Part 156.140 et seq. and Part 165 et seq. for the United States Environmental Protection Agency (EPA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety.

(b) All words or terms defined or used in the federal regulations incorporated by reference shall mean the state equivalent or counterpart to those words or terms.

[OAR Docket #09-863; filed 5-7-09]

**TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY
CHAPTER 30. CONSUMER PROTECTION**

[OAR Docket #09-860]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 17. Combined Pesticide
Part 21. Standards for disposal of pesticide and pesticide containers
35:30-17-92 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 3-81 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

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N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The proposed rules ensure that all pesticide spills, both wet and dry, that are of a specific amount are reported to the Oklahoma Department of Environmental Quality and the Oklahoma Department of Agriculture, Food, and Forestry in a timely manner. The proposed rule changes also provide clean up to the existing rules.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 17. COMBINED PESTICIDE

PART 21. STANDARDS FOR DISPOSAL OF PESTICIDE AND PESTICIDE CONTAINERS

35:30-17-92. Handling spills by commercial applicators

(a) All uncontained spills of more than ten (10) gallons liquid or twenty-five (25) pounds dry weight of pesticide concentrate or fifty (50) gallons of an application mixture (tank mix) shall be reported by a commercial applicator within 24 hours by telephone and by written notice within three (3) days to ~~Waste Management~~, Oklahoma Department of Environmental Quality, (405-702-5100) or 800-522-0206, P.O. Box 1677, Oklahoma City, Oklahoma 73101-1677 and ~~Pest Management Pesticide~~ Section, Oklahoma Department of Agriculture, Food, and Forestry, (405-521-3864), P.O. Box 528804, Oklahoma City, Oklahoma 73152-8804.

(b) ~~Commercial applicators~~ Any person shall be responsible for the all costs of associated with cleanups resulting from pesticide spills in their operations that person's operation.

[OAR Docket #09-860; filed 5-7-09]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 37. FOOD SAFETY

[OAR Docket #09-862]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Meat Inspection

Part 1. General Provisions

35:37-3-1 [AMENDED]

35:37-3-3 [AMENDED]

Subchapter 5. Poultry Products Inspection

Part 1. General Provisions

35:37-5-1 [AMENDED]

35:37-5-2 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4, 6-181 et seq.; 6-251 et seq.; 6-280-1 et seq., and 6-290.1 et seq.; Article 6, Section 31, Constitution of the State of Oklahoma

DATES:**Comment period:**

January 2, 2009 through February 4, 2009

Public hearing:

February 4, 2009

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February 18, 2009

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February 19, 2009

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February 19, 2009

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February 19, 2009

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March 4, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on April 16, 2009

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April 16, 2009

Effective:

July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:**Incorporated standards:**

Mandatory Meat Inspection Regulations, Title 9, Code of Federal Regulations (CFR) (2008 Revision)

Incorporating rules:

35:37-3-1 and 35:37-3-3

35:37-5-1 and 35:37-5-2

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at the Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105-4298, 405-522-4576

ANALYSIS:

The proposed rule changes update the incorporation by reference of Code of Federal Regulations citations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry, (405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 3. MEAT INSPECTION

PART 1. GENERAL PROVISIONS

35:37-3-1. Incorporation by reference of federal meat inspection regulations

The Mandatory Meat Inspection Regulations found in Title 9 of the Code of Federal Regulations (CFR) (~~2007~~ 2008 Revision), Parts 301 to 391; 416; 417; 424; 430; 441; and 500 for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:37-3-3. Whenever an official mark, form, certificate or seal is designated by federal regulations, the appropriate Oklahoma Department of Agriculture, Food, and Forestry form, certificate or seal shall be substituted.

35:37-3-3. Deleted regulations

The following sections of the Federal regulations governing the mandatory meat inspection of the USDA incorporated by reference under 35:37-3-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 9 CFR 302.2; 303.1(c); 304.1; 304.2(a); 304.2(c); 305.2(b); 307.4; 307.5; 307.6; 316.12; 316.13(c); 317.5; 317.7; 317.9; 317.13; 318.8; 318.12; 321; 322; 327; 329.6; 329.7; 329.8; 329.9; 331; 335; 351; 352; 354; 355; 362; 381; 390; 391; and 590 (~~2007~~ 2008 Revision).

SUBCHAPTER 5. POULTRY PRODUCTS INSPECTION

PART 1. GENERAL PROVISIONS

35:37-5-1. Definitions and incorporation by reference of federal poultry inspection regulations

(a) The Mandatory Poultry Inspection Regulations found in Title 9 of the Code of Federal Regulations (CFR) (~~2007~~ 2008 Revision), Parts 381; 416; 417; 424; 430; 441; and 500 for the United States Department of Agriculture (USDA) as promulgated and amended in the Federal Register, are hereby adopted in their entirety with the exception of the deleted regulations specified in 35:37-5-2. Whenever an official mark, form, certificate or seal is designated by federal regulations, the appropriate Oklahoma Department of Agriculture, Food, and Forestry mark, form, certificate or seal shall be substituted.

(b) All words and terms defined or used in the federal regulations incorporated by reference by the Department shall mean the state equivalent or counterpart to those words or terms.

(c) The following terms, when used in this subchapter, shall have the following meaning unless the context clearly indicates otherwise:

- (1) **"Act"** means the Oklahoma Poultry Products Inspection Act.

- (2) **"Director"** means the Director of Meat Inspection.

- (3) **"Poultry"** means any domesticated bird, whether live or dead, including chickens, turkeys, ducks, geese, guineas, ratites, or squabs (also known as young pigeons from one to about thirty (30) days of age).

- (4) **"Poultry product"** means any poultry carcass, part, or product made wholly or in part from any poultry carcass or part that can be used as human food, except those exempted from definition as a poultry product in Title 9 of the Code of Federal Regulations (CFR), Part 381.15. This term shall not include detached ova.

- (5) **"Poultry byproduct"** means the skin, fat, gizzard, heart, or liver, or any combination of any poultry for cooked, smoked sausage.

35:37-5-2. Deleted regulations and exemptions

(a) The following sections of the Federal regulations governing the mandatory poultry inspection (9 CFR, Part 381 et seq.; 416 et seq.; 417 et seq.; 424 et seq.; 441 et seq.; and 500 et seq.), (~~2007~~ 2008 Revision) of the USDA incorporated by reference under 35:15-27-1 are deleted and are not rules of the Oklahoma Department of Agriculture, Food, and Forestry: 381.6; 381.10(a)(2), (5), (6), and (7); 381.10(b); 381.10(d)(2)(i); 381.13(b); 381.16; 381.17; 381.20; 381.21; 381.37; 381.38; 381.39; 381.96; 381.101; 381.103 through 381.112; 381.123(b)(1) and (4); 381.132(c); 381.133; 381.179; 381.185; 381.186; and 381.195 through 381.225.

(b) The provisions of this Act and rules do not apply to poultry producers who slaughter their own poultry raised on their farm, and each of the following apply:

- (1) The producers slaughter no more than two hundred and fifty (250) turkeys or their equivalent with a ratio of four (4) birds of other species, excluding ratites, to one (1) turkey during a calendar year;

- (2) The producers do not engage in buying or selling poultry products other than those produced from poultry raised on their own farms;

- (3) The poultry and poultry products do not move in commerce. Poultry producers are prohibited from selling or donating uninspected poultry products to retail stores, brokers, meat markets, schools, orphanages, restaurants, nursing homes, and other similar establishments and are prohibited from sales or donation of uninspected poultry through any type of retail market or similar establishment owned or operated by the poultry producer;

- (4) The producers submit a certificate of registration to the Board;

- (5) The poultry is healthy, the poultry is slaughtered and processed under sanitary standards, practices, and procedures that result in the preparation of poultry products that are sound, clean, and fit for human food, and each carcass, part, or poultry product bears a label that lists the customer's name, the producer's name, and the following statement, "This poultry product has not been inspected and passed";

- (6) The poultry is sold directly to the household consumer and transported by either the household consumer or the poultry producer without third-party intervention or

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intervening transfer or storage, and is maintained in a safe and unadulterated condition during transportation; and
(7) The poultry producers, allow an authorized agent of the Board access to their facilities and an opportunity to examine records at all reasonable times upon notice.

[OAR Docket #09-862; filed 5-7-09]

TITLE 35. OKLAHOMA DEPARTMENT OF AGRICULTURE, FOOD, AND FORESTRY CHAPTER 44. AGRICULTURE POLLUTANT DISCHARGE ELIMINATION SYSTEM

[OAR Docket #09-843]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Concentrated Animal Feeding Operations
35:44-3-3 [AMENDED]

AUTHORITY:

Oklahoma State Board of Agriculture; 2 O.S. §§ 2-4(2), 2-18.2, 2A-1 et seq., and 2A-21 et seq.; 27A O.S. § 1-3-101(D); and Article 6, Section 31, Constitution of the State of Oklahoma

DATES:

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January 2, 2009 through February 4, 2009

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February 4, 2009

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February 18, 2009

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February 18, 2009

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February 18, 2009

Submitted to Senate:

February 18, 2009

Gubernatorial approval:

March 2, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on April 15, 2009

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April 15, 2009

Effective:

July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

Incorporated standards:

Title 40 CFR §§ 122.21 (a)-(b), (e) - (f), (i), and (p) (application for permit); §§ 122.23 (concentrated animal feeding operations); §§ 122.28 (General permits); §§ 122.42(e) (Conditions applicable to specified categories of permits).

Title 40 CFR Part 412 (Concentrated Animal Feeding Operations (CAFO) Point Source Category).

Incorporating rules:

35:44-3-3

Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday at Oklahoma Department of Agriculture, Food, and Forestry, 2800 North Lincoln Boulevard, Oklahoma City, OK 73105-4298, 405-522-4576

ANALYSIS:

This rule updates the Code of Regulation Regulations date for the incorporation by reference of the permitting requirements for concentrated animal feeding operations.

CONTACT PERSON:

Teena Gunter, Oklahoma Department of Agriculture, Food, and Forestry (405) 522-4576

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 3. CONCENTRATED ANIMAL FEEDING OPERATIONS

35:44-3-3. Date of federal regulations incorporated

When reference is made to 40 CFR it means, unless otherwise specified, the volume of 40 CFR as published on July 1, ~~2007~~2008.

[OAR Docket #09-843; filed 5-6-09]

TITLE 155. OKLAHOMA CONSERVATION COMMISSION CHAPTER 30. OKLAHOMA CARBON SEQUESTRATION CERTIFICATION PROGRAM

[OAR Docket #09-815]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions [NEW]
155:30-1-1 through 155:30-1-4 [NEW]
Subchapter 3. Verification of Carbon Offsets [NEW]
155:30-3-1 through 155:30-3-5 [NEW]
Subchapter 5. Aggregators and Verifiers [NEW]
155:30-5-1 through 155:30-5-5 [NEW]
Subchapter 7. Carbon Offset Registry [NEW]
155:30-7-1 through 155:30-7-3 [NEW]
Subchapter 9. Soil Carbon Sequestration [NEW]
155:30-9-1 through 155:30-9-5 [NEW]
Subchapter 11. Forest Carbon Sequestration [NEW]
155:30-11-1 through 155:30-11-5 [NEW]
Subchapter 13. Geologic Carbon Sequestration [NEW]
155:30-13-1 through 155:30-13-5 [NEW]

AUTHORITY:

Oklahoma Conservation Commission and the Conservation District Act contained in 27A O.S. 2001 §§ 3-1-101 et seq.; fee language contained at 27A O.S. (Supp 2008) § 3-1-106 (33); and the Oklahoma Carbon Sequestration Enhancement Act contained in 27A O.S. (Supp 2007) §§ 3-4-101 et seq.

DATES:

Comment period:

December 1, 2008 through January 16, 2009

Public hearing:

January 16, 2009

Adoption:

March 2, 2009

Submitted to Governor:

March 4, 2009

Submitted to House:

March 4, 2009

Submitted to Senate:

March 4, 2009

Gubernatorial approval:

March 24, 2009

Legislative approval:

Failure of the Legislature to disapprove the rules resulted in approval on April 29, 2009

Final adoption:
April 29, 2009

Effective:
July 1, 2009

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

- Subchapter 1. General Provisions [NEW]
155:30-1-1 through 155:30-1-9 [NEW]
- Subchapter 3. Soil Carbon Sequestration [NEW]
155:30-3-1 through 155:30-3-7 [NEW]
- Subchapter 5. Forest Carbon Sequestration [NEW]
155:30-5-1 through 155:30-5-7 [NEW]
- Subchapter 7. Geologic Sequestration (Injection and Storage) [NEW]
155:30-7-1 through 155:30-7-4 [NEW]

Gubernatorial approval:

July 3, 2008

Register publication:

25 Ok Reg 2737

Docket number:

08-1201

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The Oklahoma Conservation Commission is implementing the Oklahoma Carbon Sequestration Certification Program pursuant to the Oklahoma Carbon Sequestration Enhancement Act contained in 27A O.S. (Supp 2007) §§ 3-4-101 et seq. The rules provide the structure of the program and set fees; outline the process for verification, certification, and registration of Oklahoma carbon offsets; and, describe the requirements for voluntary participation in the program by carbon offset providers, offset aggregators, offset verifiers, and persons requesting verification of carbon dioxide stored as a result of downhole injection.

CONTACT PERSON:

Stacy Hansen, Director, Oklahoma Carbon Program, Oklahoma Conservation Commission, 2800 N. Lincoln Blvd., Suite 160, Oklahoma City, OK 73152-8804, 405-522-4739

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

155:30-1-1. Purpose and authority

The rules in this Chapter are promulgated for the purpose of establishing and administering the Oklahoma Carbon Sequestration Certification Program, pursuant to the Oklahoma Carbon Sequestration Enhancement Act. These rules describe and establish the requirements for voluntary participation in the Program. The rules define carbon dioxide and an Oklahoma verified carbon offset. The rules also describe how to register Oklahoma carbon offsets on the Oklahoma Carbon Offset Registry. Additionally, the rules describe the process to become recognized as a state approved aggregator or verifier of carbon offsets. These rules are to ensure that each transferable Oklahoma verified offset is a true representation of the quantity of stored greenhouse gas that it is claimed to represent, and that each offset is only claimed once for the purposes of emissions reduction. Such assurance is fundamental to the sale, trade, or transfer of greenhouse gas offsets.

155:30-1-2. Definitions

The following words or terms when used in this chapter shall have the following meaning unless the context clearly indicates otherwise:

"Act" means the Oklahoma Carbon Sequestration Enhancement Act, 27A O.S. § 3-4-101 et seq.

"Aggregator" means an intermediary that serves as the administrative representative between offset sellers and offset buyers for the purpose of pooling or bundling carbon offsets for sale.

"Air quality agency" means the agency with jurisdiction to issue or enforce permits for air emissions.

"Anthropogenic carbon dioxide" or **"Man-Made CO2"** means carbon dioxide that is formed mechanically as opposed to carbon dioxide that naturally occurs or is from natural processes such as respiration and decay. It includes, for example, carbon dioxide from power generation, manufacturing, or other similar sources.

"Applicant" means a person making an application.

"Application" means a petition or any written request for authority, approval, determination, permission, or other Commission action or relief pursuant to these rules. An application also includes the standard state forms for applying for verification of an offset, including any supplemental materials, additions, revisions, or modifications to the forms.

"Carbon dioxide (CO2)" means an inorganic compound containing one carbon atom and two oxygen atoms. Carbon dioxide is an inert, stable, colorless, odorless, non-toxic, incombustible, inorganic gas. It is dissolvable in water and is naturally present in underground locations and in the atmosphere as a trace gas. Carbon dioxide is formed during respiration and exhaled by humans and animals, and is utilized by plants during photosynthesis. Carbon dioxide can be liquefied by compression and cooling, and can be solidified into dry ice. Carbon dioxide is a gas produced when carbon is oxidized by any process. It can be produced through various natural processes or produced mechanically. For the purposes of these rules, only anthropogenic carbon dioxide is considered to be carbon dioxide. Under standard conditions, one short ton (2,000 pounds) of carbon dioxide equals 17.483 mcf (thousand cubic feet) or 0.91 metric tonnes.

"Carbon dioxide equivalent (CO2e)" means a term used to refer to gases other than carbon dioxide that have been converted into the equivalent of carbon dioxide based on their global warming potential. As defined by the U.S. Environmental Protection Agency, Global Warming Potential (GWP) is the cumulative radiative forcing effects of a gas over a specified time horizon resulting from the emission of a unit mass of gas relative to a reference gas. The GWP-weighted emissions of direct greenhouse gases in the U.S. Inventory are presented in terms of equivalent emissions of carbon dioxide (CO2e), using units of teragrams of carbon dioxide equivalents (Tg CO2 Eq.).

"Carbon offset" means the emissions reduction that occurs when a practice or project negates greenhouse gas emissions by sequestering greenhouse gases in a carbon sink with reforestation, afforestation, managed forests, growing agricultural crops, increasing existing vegetated areas, or utilizing geologic storage. An offset may be expressed in standard cubic

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feet of CO₂, metric tonnes of CO₂, tons of CO₂, or tons of CO₂e.

"Carbon offset registry" means the repository of records of Oklahoma carbon offsets certified under this program, and the repository of records of Oklahoma carbon offsets not verified under this program, and collectively maintained by the Commission and made public through an online website where Oklahoma carbon offsets are reported for the purpose of reducing the potential for the offsets to be claimed more than once as an emission reduction credit.

"Carbon sequestration" or **"carbon storage"** means the process of increasing the amount of greenhouse gases held in soil, in plants, underground, in geologic storage, in waterbodies, or in other types of long term storage.

"Certificate" means a document evidencing carbon sequestration occurred and was verified by the Commission or other approved verifier. It is issued by the Commission pursuant to these rules in response to an application and subsequent verification of a specified carbon offset or project that occurred during a specific, defined time period. Any Certificate shall specify the year the offset occurred and the numerical volume or tonnage of the offset. For pooled projects, the certificate shall only apply to the distinct offset or contract verified by this program and shall not be applied to other offsets or contracts held within a pooled project unless the entire pooled project has been verified pursuant to these rules.

"Document" means any kind of printed, recorded, written, graphic, photographic or electronic matter or material, however printed, produced, reproduced, coded or stored.

"EOR reservoir" means a reservoir that is a common source of supply or pool of hydrocarbons, including oil or gas, that may be recovered using enhanced methods.

"Geologic storage" means underground storage or sequestration of carbon dioxide or other greenhouse gas in a reservoir, including an EOR reservoir.

"Greenhouse gas" means any gas that absorbs infrared radiation in the atmosphere. Greenhouse gases include, but are not limited to, water vapor, carbon dioxide (CO₂), methane (CH₄), nitrous oxide (N₂O), chlorofluorocarbons (CFCs), hydrochlorofluorocarbons (HCFCs), ozone (O₃), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), and sulfur hexafluoride (SF₆).

"Governmental entity" means any department, commission, authority, council, board, bureau, committee, legislative body, agency, beneficial public trust, municipality, institution, political subdivision, tribe, or other establishment of the executive, legislative or judicial branch of the United States, the State of Oklahoma, any other state in the United States, the District of Columbia, the Territories of the United States, and any similar entity of any foreign country.

"Landowner" means the person authorized to enter into contract for the lands or vegetation that will provide the carbon offset under Subchapters 3 and 5 of these rules.

"Oklahoma Carbon Program" means the Oklahoma Carbon Sequestration Certification Program pursuant to the Oklahoma Carbon Sequestration Enhancement Act.

"Oklahoma Verified Offset" means a carbon offset verified by the Commission pursuant to the rules of the Oklahoma Carbon Program.

"Operator" means the person permitted by the UIC agency to perform injection of carbon dioxide or other greenhouse gas into a reservoir or storage facility.

"Person" means any institution, individual, public or private corporation, partnership, proprietorship, association, firm, company, limited partnership, limited liability company, joint venture, public trust, joint-stock company, syndicate, trust, organization, estate, governmental entity, tribe, or any other legal entity or an agent, employee, representative, assignee or successor.

"Pooled project" means a project created by the grouping of more than one carbon contract or project.

"Project" means the separate and distinct activity or practices that sequestered carbon dioxide or carbon dioxide equivalent for a defined time period and for which the applicant is making an application for verification and certification under these rules.

"Reserve" means a fund or qualifying carbon offset set aside to compensate for the reversal or loss of greenhouse gas sequestered by an offset or project.

"Reservoir" means a geologic or subsurface sedimentary stratum, formation, aquifer, cavity or void, whether naturally occurring or artificially created, including an EOR reservoir, saline formation, or coal seam.

"Resource Management Plan (RMP)" means a detailed description of the practice, activity, or project, including the method that will sequester carbon dioxide or carbon dioxide equivalent on a specified area of land or in a specified reservoir. For forest carbon sequestration, the Commission shall accept forest management plans that are written using specifications approved by the Director of Forestry Services, Oklahoma Department of Agriculture, Food and Forestry.

"Reversal" means the release, due to natural or human activities, of some or all of the greenhouse gas sequestered by a project.

"Storage facility" means the reservoir, and all underground equipment and surface buildings, facilities and equipment, utilized in the project, excluding all pipelines used to transport greenhouse gases.

"UIC" means the Underground Injection Control program of the U.S. Environmental Protection Agency pursuant to the Safe Drinking Water Act.

"UIC agency" means the state governmental entity(s) having jurisdiction over UIC in Oklahoma.

"UIC permit" means the document issued by the UIC agency authorizing the operator to engage in injection of carbon dioxide or other greenhouse gas into a reservoir or storage facility.

"Verification" means the determination that the sequestration of carbon dioxide or its equivalent is occurring or has occurred in accordance with a specific method or standard. **"Verifier"** means a person, approved by the Commission that confirms the accuracy of information reported for the purposes of verification.

155:30-1-3. Applicability

These rules apply to aggregators and operators who are seeking verification and certification of Oklahoma carbon offsets or carbon sequestration projects through this program; to persons seeking to become state approved aggregators or verifiers of Oklahoma carbon offsets through this program; and to persons seeking to register Oklahoma carbon offsets on the Oklahoma Carbon Offset Registry. The Commission disclaims any express or implied warranties as to the marketability, merchantability, or market value of an offset verified by the Oklahoma Carbon Program.

155:30-1-4. Informal complaint process

(a) Any person may complain to the Commission about any matter regarding this program under the Commission's authority. A complaint shall be in writing, and it shall include the following information:

- (1) The name, address, and telephone number of the person making the complaint;
- (2) The name, address, and telephone number of the organization the person represents, if applicable;
- (3) The name, address, telephone number, and title of any representative of the person filing the complaint;
- (4) A brief, clear description of each charge, problem, or issue that is the basis for the complaint including names, dates, places, and actions;
- (5) The numbers and headings of the laws and rules that may apply;
- (6) The remedy, if any, the person making the complaint seeks;
- (7) The signature of the person making the complaint; and
- (8) The date of the complaint.

(b) If the complaint is repetitive, concerns a matter that has already been resolved, or is a matter outside the Commission's authority, the Executive Director or the Executive Director's designee may reject the complaint.

(c) The Executive Director or the Executive Director's designee may provide other affected persons with written notice of the complaint and give them an opportunity to respond in writing within 15 days. The response shall contain the following information:

- (1) The name, address, and telephone number of the person responding;
- (2) The name, address, and telephone number of the organization the person represents, if applicable;
- (3) The name, address, telephone number, and title of any representative of the person responding;
- (4) A specific admission, denial, or explanation of each charge;
- (5) A brief, clear description of the facts including names, dates, places, and actions;
- (6) A brief, clear explanation of the reasons for the action (or inaction) that is the basis for the complaint if the person admits to any charge;
- (7) The numbers and headings of the laws and rules that may apply;
- (8) The signature of the person responding; and

(9) The date of the response.

(d) The Executive Director or the Executive Director's designee may refer complaints to informal procedures, including but not limited to telephone calls, letters, meetings, mediation, investigations, or other appropriate procedures.

(e) The Executive Director or the Executive Director's designee shall make a decision about a complaint within 60 days after its receipt, unless more time is required. In that case, the Commission shall notify in writing the person filing the complaint and persons filing any responses to the complaint informing the persons that additional time is needed to reach a decision.

SUBCHAPTER 3. VERIFICATION OF CARBON OFFSETS

155:30-3-1. Approval process for applications for carbon offset verification

The process for approval of applications for carbon offset verification pursuant to this program is as follows:

- (1) An applicant shall submit an application requesting verification of a carbon offset or sequestration project to the Commission. The application shall comply with both general requirements of this subchapter and any additional specific requirements contained in subsequent subchapters regarding the different types of carbon offsets.
- (2) Eligible carbon offsets identified in the application will be verified by the Commission or other state approved verifier.
- (3) The Commission will issue a certificate of Oklahoma verified offset if the offset is found to be in accordance with standards pursuant to or accepted by this program.

155:30-3-2. Applications for carbon offset verification

(a) Obtaining an application. An applicant may obtain an application from the Commission.

(b) Contents. Applications shall be submitted on a form provided or in a format designated by the Commission. The application shall contain, at a minimum, the following information:

- (1) The name, address, and phone number of the applicant;
- (2) The name, address, and phone number of the offset aggregator, if an aggregator has been retained;
- (3) The legal description of the physical location of the offset or project;
- (4) The name of the city nearest to the location of the offset or project, and the county in which the offset or project is located;
- (5) The type of offset and start date of the activity or project that created the offset;
- (6) An aerial photo of the land delineating the offset or project area and indicating the number of acres delineated or, in the case of geologic sequestration, an aerial photo,

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topographical map, or graphic depiction of the land area overlaying the reservoir that received the carbon dioxide or carbon dioxide equivalent. If the above are not available, the Commission may accept GPS coordinates of the offset or project.

(7) A statement, signed by an authorized person, that permits and authorizes the Commission or other state approved verifier to conduct verification pursuant to these rules; and

(8) Exhibits as required in the respective subchapter related to the application.

(c) Fees. The application shall be accompanied by payment of fees specified in the respective subchapter related to the application. The fees shall be paid by check, certified check, or United States Postal Money Order.

(d) Guidance and review. The Commission shall provide applicants with guidance, including copies of any additional policies, procedures, and necessary forms for the efficient administration of the program, and shall process applications in a timely manner.

155:30-3-3. Commission action on applications for carbon offset verification

(a) Approval. When the Commission is satisfied that all requirements for verification have been met, then a certificate of verification will be issued to the applicant.

(b) Denial. Any denial of an application shall be in writing and provided to the applicant, along with the reasons that the application was denied. A denial shall also advise the applicant of their right of appeal and of the procedures necessary to exercise those appeal rights.

(c) Timing. A certificate of verification or a denial will be issued by the Commission to the applicant within (90) days after receipt of an application, unless more time is required. In that case, the Commission shall notify the applicant in writing that additional time is needed.

(d) Withdrawal. Any application may be withdrawn by the applicant at any time prior to verification occurring. An applicant may withdraw an application by submitting a written request to the Commission. The applicant's application will be automatically withdrawn upon receipt of the request by the Commission. Any fees paid in connection with any application that is later withdrawn under this section shall not be refunded to the applicant.

155:30-3-4. Verification

(a) The Commission or other approved verifier shall verify carbon offsets using protocols established by or approved by the Commission. Carbon offsets shall be verified to a reasonable level of assurance by the Commission or other state approved verifier.

(b) Verification shall include the calculation of the volume or weight of carbon dioxide or carbon dioxide equivalent sequestered by the project, and will use visual confirmation paired with values from carbon accumulation tables, standard values for each type of carbon offset, or direct measurement

or other verification protocol or document applicable under the respective subchapter related to the application.

155:30-3-5. Restrictions on certification

(a) The Commission reserves the right to transfer a certificate to another person if the applicant is not legally entitled to the certificate.

(b) The Commission shall not determine the market value, if any, of any carbon offset.

(c) The Commission on issues relevant to the project shall not certify a carbon offset that has accidentally, intentionally, or through gross negligence violated the law when such determination is made by a governmental entity having competent jurisdiction. If and when a violation has been cured or remedied to the satisfaction of a governmental entity and documentation of the cure or remedy and satisfaction has been submitted to the Commission, certification will proceed. In addition, the Commission will not certify a carbon offset purported to be created by the intentional disturbance of soil followed by the subsequent replanting of crops or plants for the purpose of creating a carbon offset for monetary gain.

SUBCHAPTER 5. AGGREGATORS AND VERIFIERS

155:30-5-1. Approval process for aggregator and verifier applications

Aggregators seeking to receive verification of carbon offsets and persons seeking to conduct verification of carbon offsets under this program must apply to and be approved by the Commission.

(1) Approval. The Commission shall notify the applicant in writing within ninety (90) days of receipt of an application that they have been approved to participate as an aggregator or verifier in the program.

(2) Denial. Any denial of an application shall be provided to the applicant in writing within ninety (90) days of receipt of an application, along with the reasons that the application was denied. A denial shall also advise the applicant of their right of appeal and of the procedures necessary to exercise those appeal rights.

(3) Withdrawal. Any application may be withdrawn by the applicant at any time prior to approval or denial in response to an application. An applicant may withdraw an application at anytime by submitting a written request to the Commission. The application will be automatically withdrawn upon receipt of the request by the Commission. Any fees paid in connection with any application that is later withdrawn under this section shall not be refunded to the applicant.

155:30-5-2. Applications for aggregators and verifiers

Aggregators seeking to receive verification of carbon offsets and persons seeking to conduct verification of carbon offsets under this program must apply to and be approved by the

Commission. This requirement may be waived for governmental entities that are participating in this program as a verifier under a written agreement with the Commission.

(1) **Obtaining an application.** Applications may be obtained from the Commission.

(2) **Fees.** The application shall be accompanied by payment of the application fee. The fee shall be paid by check, certified check, or United States Postal Money Order.

(A) **Aggregators.** An aggregator shall submit with the application a fee of three hundred dollars (\$300.00). An aggregator shall submit a new application with a fee of three hundred dollars (\$300.00) every three years within the calendar month of the initial application.

(B) **Verifiers.** A verifier shall submit with the application a fee of three hundred dollars (\$300.00). A verifier shall submit a new application with a fee of three hundred dollars (\$300.00) every three years within the calendar month of the initial application.

(3) **Contents.** Applications shall be submitted on a form provided or in a format designated by the Commission. The application shall contain, at a minimum, the following information:

(A) The name, address, and phone number of the applicant; and

(B) Documentation showing that the applicant is an approved aggregator or verifier for a national or international carbon exchange, or documentation showing that the applicant meets equivalent criteria as determined by the Commission.

(4) **Aggregators.** An applicant not affiliated with a national or international carbon exchange shall submit required information on a form provided or in a format designated by the Commission. The information shall include, at a minimum, the following:

(A) Proof of a bond or other financial instrument that is not less than Ten Thousand Dollars (\$10,000.00);

(B) Description of past experience and available resources that demonstrates the ability to manage the marketing and tracking of an offset portfolio and of the capability to be an aggregator of carbon sequestration projects;

(C) Description of safeguards in place to ensure that the risk of reversal is minimized and that, should reversal occur, a mechanism is in place that guarantees that the reductions or removals will be replaced or compensated;

(D) Documentation of insurance or approved reserves of emission reductions, or some other guarantee to replace any unexpected reversals;

(E) A monitoring plan that describes how potential reversals will be discovered, measured, or estimated and compensated in the event they occur; and

(F) A sample copy of the contract that offset sellers will be asked to sign and samples of all supplemental

information provided to the seller as part of the contract

(5) **Verifiers.** An applicant not affiliated with a national or international carbon exchange shall submit on a form provided or in a format approved by the Commission, at a minimum, the following information to the Commission:

(A) A resume;

(B) A description of the applicant's expertise in the area of agriculture, forestry, geologic storage or the oil and gas industry, including specific experience verifying carbon offsets or sequestration in the specified area of expertise. When the applicant is a company, this information shall be provided for each individual person who will conduct verification on behalf of the company;

(C) Information that demonstrates they are qualified and capable of conducting verification of projects in accordance with Commission established and approved verification criteria;

(D) Documentation of any licenses, degrees, certificates, or specific training that qualifies the applicant to verify carbon offsets in the specified area of expertise; and

(E) Documentation of errors and omissions insurance.

(6) **Time to file.** An application may be filed with the Commission at any time.

(7) **Guidance and review.** The Commission shall provide applicants with guidance, including copies of any additional policies, procedures, and necessary forms for the efficient administration of the program, and shall process applications in a timely manner.

155:30-5-3. Commission action on applications for aggregators and verifiers

(a) **Approval.** The Commission shall notify the applicant within ninety (90) days of receipt of an application that they have been approved to participate in the program.

(b) **Denial.** Any denial of an application shall be provided to the applicant in writing within ninety (90) days of receipt of an application, along with the reasons that the application was denied. A denial shall also advise the applicant of their right of appeal and of the procedures necessary to exercise those appeal rights.

(c) **Withdrawal.** An applicant may withdraw an application at anytime by submitting a written request to the Commission. The application will be automatically withdrawn upon receipt of the request by the Commission. Any fees paid in connection with any application that is later withdrawn under this section shall not be refunded to the applicant.

(d) **Revocation.** An approved application and any subsequent authorizations may be revoked for cause by the Commission at anytime.

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155:30-5-4. Performance criteria for state approved verifiers

State approved verifiers shall do the following:

- (1) Have no financial or pecuniary interest in the project they are verifying;
- (2) Perform verification only on project scopes and geographies that they are qualified for and authorized to conduct by the Commission;
- (3) Conduct verification in accordance with verification criteria, standards, protocols, or agreements established or approved by the Commission;
- (4) Certify on forms provided by the Commission that offsets have or have not occurred as claimed;
- (5) Evaluate project reports, documentation, and summary reports as required by the Commission;
- (6) Establish and implement protocols acceptable to the Commission for conducting verification and reporting the results;
- (7) Maintain transparent records on the methods and assumptions used to develop, calculate, and conduct verification of projects to the degree that the methods and assumptions are independently verifiable to other interested persons; and
- (8) Provide copies of all required verification reports and supporting documentation or materials to the Commission in accordance with Commission established and approved procedures.

155:30-5-5. Performance criteria for state approved aggregators

State approved aggregators shall do the following:

- (1) Gather the required information for each offset from participating landowners with whom they are contracted;
- (2) Submit offset documentation to the Commission pursuant to these rules;
- (3) Have verified by this program at least ten percent of the Oklahoma carbon contracts on which the applicant, applicant's company or representative is a contract signatory;
- (4) Maintain a monetary reserve to cover offset buyer losses caused by reversal;
- (5) Utilize safeguards to ensure that the risk of reversal is minimized and that, should any reversal occur, a mechanism is in place that guarantees that the reductions or removals will be replaced or compensated;
- (6) Establish and implement acceptable protocols for landowner contract non-compliance;
- (7) Track project information as required;
- (8) Report offset information to the state carbon offset registry pursuant to these rules;
- (9) Disseminate to the public reliable information about carbon sequestration in Oklahoma;
- (10) Encourage landowners to maintain contracted practices that sequester carbon and that result in the sequestered carbon remaining in place at least through the duration of the contract; and

(11) Include the following information in landowner contracts:

- (A) Length of time the carbon sink shall be maintained;
- (B) Verification requirements;
- (C) Compensation protocol;
- (D) Reserve stipulations;
- (E) Landowner non-compliance stipulations; and
- (F) Clear explanation of who owns the rights to the offset.

SUBCHAPTER 7. CARBON OFFSET REGISTRY

155:30-7-1. Applications for carbon offset registration

(a) **Obtaining an application.** Persons signatory to a contract for, or owning an interest in, a carbon offset, allowance, credit or sequestration project that was not verified by the Oklahoma Carbon Program but who wish to have information related to such offset published to the Oklahoma carbon offset registry may obtain an application from the Commission.

(b) **Contents.** Applications under this subchapter shall be submitted on a form provided or in a format designated by the Commission. The application shall contain, at a minimum, the following information:

- (1) The name, address, and phone number of the applicant;
 - (2) The name, address, and phone number of the offset aggregator, if an aggregator has been retained;
 - (3) The legal description of the physical location of the offset or project;
 - (4) The name of the city nearest to the location of the offset or project, and the county in which the offset or project is located;
 - (5) The type of offset and start date of the activity or project that created the offset;
 - (6) An aerial photo of the land delineating the offset or project area and indicating the number of acres delineated or, in the case of geologic sequestration, an aerial photo, topographical map, or graphic depiction of the land area overlaying the reservoir that received the carbon dioxide or carbon dioxide equivalent. If the above are not available, the Commission may accept GPS coordinates of the offset or project; and
 - (7) A copy of the offset purchase and sale contract or other transfer agreement, or memorandum of a contract or agreement, signed by the seller and buyer.
- (c) **Fee.** A fifty dollar (\$50.00) fee shall accompany an application under this subchapter, and is assessed for the review of an offset that was not verified by this program and to publish offset information to the Oklahoma carbon offset registry. The fee shall be paid by check, certified check, or United States Postal Money Order. Offsets certified by the Oklahoma Carbon Program will be automatically published to the registry free of charge after all fees for verification and certification have been received by the Commission.

(d) **Filing.** An application under this subchapter may be filed with the Commission at any time after the offset is verified or the contract or agreement described in subparagraph (b)(7) above is fully executed. An applicant under this subchapter should be the operator, seller, purchaser, aggregator, verifier, or other person who is a signatory party to the carbon contract or agreement.

(e) **Guidance and review.** The Commission shall provide applicants with guidance including copies of any additional policies, procedures, and necessary forms for the efficient administration of the program.

155:30-7-2. Commission action on applications for carbon offset registration

(a) **Approval.** Offset information for carbon offsets not verified by the Oklahoma Carbon Program will be published to the Oklahoma carbon offset registry within ninety (90) days after the application for registration and fees are received and approved by the Commission. Applicants shall refer to the on-line carbon offset registry to determine application status.

(b) **Denial.** Any denial of an application shall be provided to the applicant in writing within ninety (90) days, along with the reasons that the application was denied. A denial shall also advise the applicant of their right of appeal and of the procedures necessary to exercise those appeal rights.

(c) **Withdrawal.** An applicant may withdraw an application at anytime by submitting a written request to the Commission. The application will be automatically withdrawn upon receipt of the request by the Commission. Any fees paid in connection with any application that is later withdrawn under this section shall not be refunded to the applicant.

155:30-7-3. Carbon offset registry

(a) The carbon offset registry shall be maintained and made publicly available via a website updated by the Commission at least monthly for the purpose of public disclosure.

(b) Information on carbon offsets verified by the Oklahoma Carbon Program will be automatically published to the carbon offset registry after verification is conducted and applicable fees are received by the Commission.

(c) Information on carbon offsets not verified under the Oklahoma Carbon Program will be published to the carbon offset registry after the application for registration accompanied by the fee is received and approved by the Commission.

(d) Each offset reported by an applicant under this subchapter shall be unique; such offset shall not be claimed more than once on any regulatory, voluntary, or off market venue for the purposes of mitigating greenhouse gas emissions.

SUBCHAPTER 9. SOIL CARBON SEQUESTRATION

155:30-9-1. Filing of applications for soil carbon offset verification

A request for verification of a soil carbon offset may be filed during each calendar year of the carbon offset contract.

155:30-9-2. Fees

An applicant filing an application under this subchapter shall pay the following fees and expenses:

(1) **Field verification fee.** Thirty dollars (\$30.00) per hour charged for time spent in the field verifying the offset, including travel time to and from the offset location. An applicant may indicate on the application a request to be contacted prior to verification and to be told the estimated amount of time that will be needed to conduct verification.

(2) **Field verification expenses.** The government rate in effect on the date of travel will be charged to cover travel or lodging costs incurred during travel associated with field verification. An applicant may indicate on the application a request to be contacted prior to verification and to be told the estimated amount of time that will be needed to conduct verification.

(3) **Document verification fee.** Fifty dollars (\$50.00) per hour assessed for the in-office review of documents and preparation of reports that record whether carbon sequestration has occurred.

(4) **State certification fee.** Ten cents (\$.10) per metric ton of carbon dioxide for each ton under and including fifty thousand (50,000) metric tons, and three cents (\$.03) per metric ton of carbon dioxide for each ton over fifty thousand (50,000) tons, is assessed for the preparation and issuance of a certificate and report evidencing that carbon sequestration occurred and was verified by the Oklahoma Conservation Commission or other state approved verifier not to exceed \$10,000 per application. The applicant will be invoiced this fee per application after the Commission has verified the carbon offset.

155:30-9-3. Soil carbon offset verification application requirements

(a) In addition to the requirements in Subchapters 1 and 3 for any application, an application for soil carbon offset verification shall include the following:

(1) Resource management plan with details and explanations of the activities that will increase, or maintain existing, trapped carbon including but not limited to growing of designated crops or use of designated cropping systems that created the offset to be verified;

(2) Crop certification summary from a state or federal agency;

(3) Copy of Conservation Reserve Program (CRP) or Conservation Reserve Enhancement Program (CREP) contracts, or other federal conservation contracts when applicable;

(4) Farm records showing dates and schedules of seeding, grazing, haying, or harvest as applicable and necessary to substantiate the offset; and

(5) Current or previous carbon offset contract that includes any portion of the offset for which the applicant is requesting verification.

(b) The Commission may request additional information.

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155:30-9-4. Commission action on soil carbon offset verification applications

The Commission shall either approve or deny a soil carbon application and shall notify the applicant in writing of the Commission's determination.

155:30-9-5. Soil carbon offsets eligible for verification

(a) Only soil carbon offsets with default or standard sequestration rates determined by research acceptable to the Commission to capture and hold carbon dioxide or its equivalent for a determined or estimated or measurable rate or span of time shall be considered for verification. Types of eligible soil carbon offsets are:

- (1) Conservation tillage, and
- (2) Grassland establishment.

(b) Soil carbon offsets not specifically listed above may be considered by the Commission on a case by case basis.

SUBCHAPTER 11. FOREST CARBON SEQUESTRATION

155:30-11-1. Filing of applications for forestry carbon offset verification

A request for verification of a forestry carbon offset may be filed during the first, third, or fifth or later calendar year of the carbon offset contract. For afforestation or reforestation applicants, the first year means the first year following the planting year.

155:30-11-2. Fees

An applicant filing an application under this subchapter shall pay the following fees and expenses:

- (1) **Field verification fee.** Thirty dollars (\$30.00) per hour charged for time spent in the field verifying the offset, including travel time to and from the offset location. An applicant may indicate on the application a request to be contacted prior to verification and to be told the estimated amount of time that will be needed to conduct verification.
- (2) **Field verification expenses.** The government rate in effect on the date of travel will be charged to cover travel or lodging costs incurred during travel associated with field verification. An applicant may indicate on the application a request to be contacted prior to verification and to be told the estimated amount of time that will be needed to conduct verification.
- (3) **Document verification fee.** Fifty dollars (\$50.00) per hour assessed for the in-office review of documents and preparation of reports that record whether carbon sequestration has occurred.
- (4) **State certification fee.** Ten cents (\$.10) per metric ton of carbon dioxide for each ton under and including fifty thousand (50,000) metric tons, and three cents (\$.03) per metric ton of carbon dioxide for each ton over fifty thousand (50,000) tons, is assessed for the preparation and issuance of a certificate and report evidencing that carbon

sequestration occurred and was verified by the Oklahoma Conservation Commission or other state approved verifier not to exceed \$10,000 per application. The applicant will be invoiced this fee per application after the Commission has verified the carbon offset.

155:30-11-3. Forest carbon offset verification application requirements

In addition to the general requirements in Subchapters 1 and 3 for any application, a forest carbon sequestration verification application shall include a forest management plan written on a form provided or in a format approved by the Oklahoma State Forester, containing the following:

- (1) Details and explanations of the activities that have or will increase, or maintain existing, trapped carbon;
- (2) Clearly stated landowner objectives for the forest management practices that include the sequestration of carbon;
- (3) Description and evaluation of the natural resources present on the area;
- (4) Defined desired future forest condition;
- (5) Description of the forest management practices and activities aimed at reaching the desired forest condition or condition class; and
- (6) Documentation of a timeline for forest management plan implementation that includes the start date of the forest management activities.

155:30-11-4. Commission action on forest carbon offset applications

The Commission shall either approve or deny a forest carbon offset application and shall notify the applicant in writing of the Commission's determination.

155:30-11-5. Forest carbon offsets eligible for verification

(a) Only forest carbon offsets with default or standard sequestration rates determined by research acceptable to the Commission to capture and hold carbon dioxide or its equivalent for a determined or estimated or measurable rate or span of time shall be considered for verification. Types of eligible forestry carbon offsets are:

- (1) **Afforestation.** The establishment of trees on lands that was unforested prior to 1990.
 - (2) **Managed Forests.** The use and management of sustainable silvicultural practices in forests that are also part of a long-term approved forest management plan.
 - (3) **Reforestation.** The establishment of trees on lands previously forested that are also part of a long-term approved forest management plan.
- (b) Forestry carbon offset types not specifically listed above may be considered by the Commission on a case by case basis.

SUBCHAPTER 13. GEOLOGIC CARBON SEQUESTRATION

155:30-13-1. Filing of applications for geologic carbon sequestration verification

A request for verification of geologic carbon sequestration may be filed anytime during the calendar year immediately following the calendar year, or portion thereof, in which sequestration occurred (i.e. applications must be filed on or before December 31, 2011 for any sequestration that occurred during any portion of the calendar year of 2010). Notwithstanding the foregoing, requests for verification of carbon dioxide or its equivalent sequestered prior to the effective date of these rules, but after the effective date of the Act, shall be made on or before December 31, 2010.

155:30-13-2. Fees

An applicant filing an application under this subchapter shall pay the following fees and expenses:

(1) **Document verification fee.** The application shall be accompanied by payment of a fee equivalent to fifteen dollars (\$15.00) per injection well that was utilized during the injection of carbon dioxide or its equivalent for which verification is requested, with a minimum fee of one hundred fifty dollars (\$150.00) per application, as payment for the in-office review of documents and preparation of reports that record whether sequestration of carbon dioxide or its equivalent has occurred.

(2) **Field verification fee.** When applicable, thirty dollars (\$30.00) per hour charged for time spent visiting the project location, including travel time to and from the project location. An applicant may indicate on the application a request to be contacted prior to verification and to be told the estimated amount of time that will be needed to conduct verification.

(3) **Field verification expenses.** The government rate in effect on the date of travel will be charged to cover travel or lodging costs incurred during travel associated with field verification. An applicant may indicate on the application a request to be contacted prior to verification and to be told the estimated amount of time that will be needed to conduct verification.

(4) **State certification fee.** Ten cents (\$.10) per metric ton of carbon dioxide for each ton under and including fifty thousand (50,000) metric tons, and three cents (\$.03) per metric ton of carbon dioxide for each ton over fifty thousand (50,000) metric tons, is assessed for the preparation and issuance of a certificate and report evidencing that carbon sequestration occurred and was verified by the Oklahoma Conservation Commission or other state approved verifier not to exceed \$10,000 per application. The applicant will be invoiced this fee per application after the Commission has verified that carbon sequestration occurred.

155:30-13-3. Geologic sequestration application requirements

(a) In addition to the requirements in Subchapters 1 and 3 for applications, an application for the verification of geologic carbon sequestration shall include the following:

(1) **Resource management plan (RMP).** An applicant shall provide an explanation of the activities that will increase sequestration of, or maintain sequestration of, carbon dioxide or its equivalent in the reservoir, and shall include a brief description of the following:

(A) The source(s) of the carbon dioxide or equivalent that was injected or maintained;

(B) The method used to capture the carbon dioxide or equivalent from the source(s); and

(C) The purity level of the carbon dioxide contained in the stream of gas or in the supercritical fluid injected, and a statement indicating whether the applicant took that purity level into account when calculating the volume or weight of carbon dioxide for which verification is requested in the application.

(2) **UIC agency documents.** An applicant shall provide clear and convincing proof that the project is authorized by and operating and monitored in accordance with applicable state and federal laws that protect underground sources of drinking water by providing written assurance on a designated form that any required UIC documents related to the project have been obtained by the applicant and are on file with the UIC agency. The Commission may also request copies of applicable UIC agency documents, which include the following:

(A) UIC permit documents. These documents include any applicable permits, orders, licenses, exemptions, rights, or registrations.

(B) UIC monitoring documents. These documents include:

(i) **Annual fluid injection report.** This report shows the carbon dioxide or carbon dioxide equivalent volumes and pressures associated with the injection portion of the project were measured and reported in accordance with UIC agency rules. The Commission will request copies or written assurance that there is on file with the UIC agency the annual fluid injection report filed by the operator for each active injection well involved in the project during the calendar year for which verification is requested.

(ii) **Mechanical Integrity Test Report.** This report demonstrates that the injection well(s) associated with the project have sufficient mechanical integrity in accordance with UIC agency rules. The Commission will request a copy or written assurance that there is on file with the UIC agency the most recent Mechanical Integrity Test reports performed before or during the calendar year for which verification is requested.

(3) **Annual carbon dioxide recovery and sequestration report.**

(A) An applicant shall report the amount of carbon dioxide or equivalent sequestered in geologic storage as a result of the project. On a form provided by or in a format approved by the Commission, an applicant shall record the metered volume of carbon dioxide (or its equivalent) injected and the metered volume

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recovered, if any, during any recovery portion of the project.

(B) An applicant shall calculate and record in metric tons the total amount of carbon dioxide or its equivalent that was injected and not recovered by the project during the calendar year for which verification is requested.

(C) The report shall contain an authorized signature.

(4) **List of prior certificates.** An applicant shall include a list of each certificate or certificate number associated with all prior applications for verification submitted to the Commission related to the project.

(5) **Air emissions documents.** When air quality permits are required by the project, an applicant shall provide proof that the project is authorized by and operating in accordance with applicable state and federal laws that protect air quality. The Commission will request written assurance that the applicant has obtained any required permits, orders, licenses, exemptions, rights, or registrations required by law issued to the applicant from the state air quality agency or any other governmental entity having jurisdiction over air emissions pertaining to the project during the calendar year for which verification is requested. The Commission may request copies of the aforementioned documents.

(b) The Commission at its discretion may request additional information, within reason and relevant to the project, before approving an application.

155:30-13-4. Commission action on applications for geologic carbon sequestration verification

Within ninety (90) days of the filing of an application for geologic carbon sequestration verification, the Commission shall either approve or deny the application and shall notify the applicant in writing of the Commission's determination. The Commission shall notify an applicant if more time is needed to make a determination and indicate the approximate date the determination will be made.

155:30-13-5. Geologic carbon sequestration projects eligible for verification

Only geologic carbon sequestration projects utilizing anthropogenic carbon dioxide that are in compliance with all applicable UIC agency requirements, and air quality agency requirements when applicable, shall be considered for verification.

[OAR Docket #09-815; filed 5-1-09]

TITLE 165. CORPORATION COMMISSION CHAPTER 30. MOTOR CARRIERS

[OAR Docket #09-877]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Intrastate Motor Carriers

Part 1. Applying For A License

165:30-3-1. Obtaining a license [AMENDED]

Part 3. License Requirements

165:30-3-11. Insurance [AMENDED]

165:30-3-16. Current address requirement [AMENDED]

Part 9. Violations

165:30-3-71. Loading capacity - Safety compliance [AMENDED]

165:30-3-76. Contempt complaint [AMENDED]

Subchapter 7. Procedural Rules

165:30-7-12. Revocation, suspension or denial of issuance of motor carrier license, permit, certificate or registration [NEW]

165:30-7-13. Disqualification procedure [NEW]

Subchapter 19. Registration Pursuant To The International Registration Plan

165:30-19-12. Supplemental application [AMENDED]

165:30-19-17. Temporary registration [AMENDED]

Subchapter 21. International Fuel Tax Agreement

165:30-21-7. Application processing [AMENDED]

AUTHORITY:

Const., Art. IX, §18, 47 O.S. § 230.32, 165:30

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Failure of the Legislature to disapprove the rules resulted in approval on May 7, 2009.

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SUPERSEDED EMERGENCY ACTIONS:

None

INCORPORATIONS BY REFERENCE:

None

ANALYSIS:

The adopted rules update provisions pertaining to licensing and compliance for intrastate motor carriers, the International Registration Plan and the International Fuel Tax Agreement. They also establish procedures for certain Commission actions and specify fine amounts for rule violations.

CONTACT PERSON:

Kathy Nelson, 522-1638

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S. SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 3. INTRASTATE MOTOR CARRIERS

PART 1. APPLYING FOR A LICENSE

165:30-3-1. Obtaining a license

(a) No intrastate motor carrier shall operate upon any street, road, public highway or dedicated public thoroughfare of this State for the transportation of passengers or property for hire without first obtaining from the Commission a license as provided in this Section. A license issued under this Subchapter shall not include transportation as a motor carrier of household goods. Motor carriers of household goods must comply with Subchapter 13 of this Chapter.

(1) An applicant for a license shall file with the Commission a written application on the appropriate form prescribed by the Commission (TDF 1), and shall tender with the application a filing fee as prescribed by law or by Commission rule.

(2) The application shall be assigned a personal identification number (PIN), which shall be the permanent identification number for all matters relating to authority granted therein. Any application thereafter filed to amend the license by the same applicant shall be filed in the same cause under the original PIN, and otherwise shall be governed by the provisions of this Chapter relating to an application for license. Each subsequent application shall also bear a sub-number in sequence.

(3) A license shall be personal to the holder thereof, and shall be issued only to an individual, a corporation, a limited liability corporation, a partnership or some other legally recognized entity.

(4) The filing of an application for a license does not of itself authorize any motor carrier operations by the applicant. Such operations are prohibited until after all requirements have been met, and a license has been issued. All requirements for compliance with this Chapter shall be met within thirty (30) days from date of receipt of a motor carrier license application by the Commission. Failure to comply will result in dismissal of the application for a license. Licenses issued shall be valid for a maximum of one year and may be renewed after application has been filed as provided by this Chapter.

(5) No license for intrastate operations shall be issued until after the applicant has provided a satisfactory USDOT safety rating or the applicant has demonstrated its ability to conduct operations in a safe and reasonable manner and applicant is in compliance with all applicable rules and laws of the State of Oklahoma; has furnished proper proof of all insurance required by this Chapter and all applicable state statutes; and has purchased an appropriate number of identification devices.

(6) The notarized application shall require the following:

(A) Name, single trade name (if any), mailing address, physical address, telephone number and domicile county of the applicant.

(B) The type of applicant (indicating if sole proprietorship, partnership, corporation or other legal entity), specifying the names of all partners, officers and/or directors listing the addresses of each.

(C) The type of operations the applicant is applying for.

(D) The name and address of the motor carrier's process agent in Oklahoma (if the motor carrier does not maintain its principal place of business or a terminal in Oklahoma).

(E) Declaration of its USDOT number, safety rating and a safety summary report which details its safety program and lists all safety violations identified within the prior twelve (12) months. Motor carriers without a USDOT number must attach a copy of its previously submitted application for a USDOT number. The applicant shall notify the Commission in writing of its USDOT number once issued, unless the USDOT number is issued by the Commission.

(F) A size and weight summary report which details its size and weight compliance program and lists all size and weight violations identified within the prior twelve (12) months.

(G) A listing of all power vehicles and trailers to be used, detailing the model, make and capacity of each vehicle and denoting whether each vehicle is owned or leased.

(H) A description of all terminal and dock facilities.

(I) A declaration that the applicant is in full compliance with all other state laws, rules and regulations.

(J) Any other information the Commission deems pertinent.

(7) Every person operating under the Motor Carrier Act of 1995 and the rules of this Commission shall possess a copy of this Chapter governing the operations of motor carriers.

(8) A motor carrier desiring to modify its license operations shall file a sub application (TDF 1). Sub applications to include hazardous materials must comply with the provisions in this Section. Sub applications to modify other types of operations shall be exempt from (5) and (6)(D)-(H) of this subsection.

(9) A copy of the current license under which a motor carrier operates shall be carried at all times in each power unit by the motor carrier.

(b) A motor carrier engaged in intercorporate hauling shall be subject to this Subchapter.

(c) Motor carrier operations, other than motor carriers of passengers, are exempt from this Subchapter when:

(1) Conducted strictly within a municipality, or

(2) Conducted by a federal, state or local government.

(d) Motor carriers of passengers shall be exempt from this Subchapter when:

~~(1) Utilizing vehicles designed to carry ten (10) or less passengers (including the driver); and,~~

~~(2) Operations are not conducted between two or more cities or towns, when duly licensed by a municipal corporation in which they are doing business.~~

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(1) Operating a taxicab, as defined by 47 O.S. § 1-174, wholly within a municipality, provided the operator of the taxicab is licensed by the municipality in which business is conducted;

(2) Operating a bus, as defined by 47 O.S. § 1-105, not between two or more cities or towns, provided the operator of the bus is licensed by a municipality in which business is conducted.

(e) Applicant may be issued a provisional intrastate license not to exceed ninety (90) days from the date application is filed, provided all other requirements for the intrastate license have been met. Applicant must provide a written request for the provisional intrastate license to the Director of the Transportation Division. If the provisional intrastate license is issued, a copy of the provisional intrastate license must be carried in each vehicle operated by the Applicant.

(f) The Commission may grant or deny the motor carrier license application or may impose conditions, stipulations and limitations on the license. If the Commission deems a hearing on the application to be necessary, the hearing shall be set within 30 days of receipt of a complete application.

(g) No intrastate motor carrier license shall be issued to an applicant until all outstanding fines or judgments due the Commission or other state(s) regulatory agencies have been satisfied.

(h) All proceedings subsequent to the application, shall be governed by applicable provisions of the Commission's Rules of Practice, OAC 165:5.

PART 3. LICENSE REQUIREMENTS

165:30-3-11. Insurance

(a) No intrastate motor carrier whose principal place of business is in Oklahoma shall conduct any operations in this State unless such operations are covered by a valid primary bond or insurance policy issued by an Oklahoma State Insurance Commission authorized provider. No motor carrier shall conduct any operations in this State unless such operations are covered by a valid bond or insurance policy issued by a National Association of Insurance Commissioners (NAIC) certified state insurance commission licensed provider. ~~A self insurance certificate issued by the Oklahoma State Insurance Commission, a state commission certified by NAIC or by the Oklahoma Department of Public Safety pursuant to 47 O.S. § 7-503 may be accepted in lieu of an insurance filing for an intrastate license or household goods certificate.~~ No holder of an authority shall conduct any operations before a proper certificate of insurance(s) has been filed with, and approved by the Commission. A surety bond containing all obligations provided by this Section may be substituted for an insurance policy.

(b) Every motor carrier shall file with, and must be approved by, the Commission a certificate on Form E or G certifying that there is in effect a valid bond or insurance policy covering operations in Oklahoma to protect the public against loss of life, injury, property damage, and including environmental

restoration in minimum amounts, of combined single limits, for bodily injuries to, or death of all persons injured or killed in any accident, and loss or damage in any one accident to property or others (excluding cargo). Minimum liability insurance limits as set forth in 49 CFR Part 387 shall also be applicable to intrastate operations unless otherwise specified in subsections (b)(1)-(4).

(1) Motor carriers of property using vehicles with a gross vehicle weight rating (GVWR) of 10,000 pounds or more:

(A) Transporting non-hazardous commodities or transporting hazardous waste, materials or substances not listed in 49 CFR Part 387.9 - \$750,000.

(B) Transporting hazardous waste, materials, or substances- as required by 49 CFR, Part 387.9.

(2) Motor carriers of property using only vehicles with a GVWR under 10,000 pounds:

(A) Transporting commodities not listed in (B) of this paragraph- \$300,000.

(B) Transporting hazardous waste, materials or substances - as required by 49 CFR Part 387.9.

(3) Motor carriers of the following types of property, materials, and products (also known or identified as restricted property) - \$350,000:

(A) Sand, rock, gravel, rip-rap, aggregate or dirt.

(B) Asphaltic mixtures and similar mixtures and compositions (excluding concrete and concrete mixtures) used in road, highway and other ground surface paving.

(C) Unprocessed forestry products and by products thereof not in a finished state.

(D) Unprocessed agricultural commodities.

(E) Ordinary livestock.

(4) Motor carriers of passengers (seating capacity includes the driver):

(A) Taxicab service utilizing vehicles having a seating capacity of less than 7 passengers not operated on a regular route or between specified points - \$100,000.

(B) Utilizing vehicles having a seating capacity of 15 passengers or less, other than as described in (A) of this paragraph - \$1,000,000.

(C) Utilizing vehicles having a seating capacity of 16 or more passengers - \$5,000,000.

(5) Motor carriers of household goods - \$750,000.

(c) Every intrastate motor carrier of freight, except an intrastate motor carrier of household goods, shall be exempted from filing proof of cargo insurance. Every intrastate motor carrier of household goods shall file with, and be approved by, the Commission an additional certificate on Form H or J that there is in effect a valid bond or insurance policy issued by a State Insurance Commission authorized provider, in the amount of at least Five Thousand (\$5,000) Dollars covering each household goods carrying vehicle operated by the motor carrier for the benefit of all persons who may suffer damage to property while in possession of said motor carrier of household goods.

- (d) Motor carriers of hazardous materials or hazardous waste shall maintain a properly executed Form MCS-82 or MCS-90 in effect as required by 49 CFR 387.
- (e) The Commission may by order grant authority to operate or to continue operating as a motor carrier conditional upon carrying insurance coverage in amounts larger than prescribed by (b) of this Section.
- (f) No certificate of insurance or surety bond filed with the Commission pursuant to this Section shall be cancelled, unless the authorization to conduct operations has been canceled, except after thirty (30) days written notice made to the Commission, on Form K or L, which notice shall be effective only upon actual receipt thereof by the Commission.
- (g) Insurance certificates or surety bonds may be cancelled without the thirty (30) days written notice on Form K or L only when the authorization to operate has previously expired or cancelled, the motor carrier provides an affidavit stating no operations have been conducted and the effective date of the cancellation notice is not before the date the cancellation notice is received in the Commission.
- (h) Insurance certificates or surety bonds not properly cancelled or expired shall be considered expired one year after the motor carrier's authorization to operate has been cancelled or expired.
- (i) Insurance certificates or surety bonds approved by this Commission shall be replaced by more recent insurance certificates or surety bonds. The liability of the retiring insurer or surety shall be terminated as of the effective date of the replacement insurance certificate or surety bond provided the replacement is approved by this Commission.
- (j) No certificate of insurance shall be filed with the Commission which contains a provision to the effect that liability thereunder may be limited or avoided because of the culpability, the recklessness, or the condition of the driver of the vehicle involved or any other restriction relating to the driving or operation of the vehicle.
- (k) Every certificate of insurance filed with the Commission shall provide that the public is protected from damage sustained through operations of any and all vehicles operated by the motor carrier insured, whether or not listed or identified in the policy; and that liability is not limited by the description of any particular vehicle or route which may be traveled by the motor vehicle in transporting passengers or property under the certificate or permit or license.
- (l) Every certificate of insurance filed with the Commission shall be executed by an officer or authorized agent of the insurance company; and if executed by an agent, a copy of his written authority or power of attorney to execute the same shall be attached to the certificate.
- (m) When insurance is provided by more than one insurer in order to aggregate security limits for motor carriers, a separate insurance certificate and endorsement is required of each insurer.
- (n) Every motor carrier shall maintain in force at all times all insurance required by state laws and by this Section. Failure for any cause to maintain any required insurance in force shall automatically and without notice suspend the license, ~~IRC~~ or authority of a motor carrier until proper insurance is filed.

- (o) Whenever the license, ~~IRC~~ or authority of a motor carrier is suspended for failure to maintain in force insurance required by this Section, the carrier must file, within sixty (60) days after commencement of the suspension, proper certificate(s) of insurance as provided in this Section and a sufficient showing, by affidavit or otherwise, that no operations were conducted during the period that insurance was not in force (TDF 18).
- (p) Whenever a motor carrier fails to provide proper certificates of insurance within sixty (60) days after suspension thereof as provided in this Section, the motor carrier's certificate or permit, license, ~~IRC~~, or other authority shall be cancelled by operation of law, and without notice. A certificate or permit, license, ~~IRC~~, or other authority so cancelled shall not be reinstated or otherwise made operative except upon proper showing, at a hearing, that the motor carrier was actually covered by proper insurance during the suspension or cancellation period, and that failure to file with the Commission was not due to the motor carrier's own negligence.
- (q) Any motor carrier conducting operations under a suspended or cancelled authority, shall not be eligible to apply for a new authority for a period of not less than one hundred eighty (180) days. The one hundred eighty (180) day period shall be determined by either the date insurance on file expires or the date a violation is discovered, whichever occurrence is later.
- (r) A person may not require indemnification from a motor carrier as a condition to the following:
 - (1) The transportation of property by the motor carrier.
 - (2) Entrance onto property by the motor carrier for the purpose of loading, unloading or transporting property.
 - (3) Subsection ~~(q)~~(r)(2) of this Section does not apply to a claim arising from damages or losses from the wrongful or negligent act or omission of the motor carrier.
- (s) Insurance filings and cancellation notices required by this Chapter may be accepted electronically as set forth by the Transportation Division. Electronic insurance filings and cancellations shall be held to the same standard and carry the same force and effect as if accepted through traditional paper filings.

165:30-3-16. Current address requirement

- (a) Any notice required by law, the Commission's Rules of Practice, OAC 165:5, or this Chapter to be served upon or mailed to any holder of a certificate, ~~or~~ permit, ~~or~~ license ~~or~~ ~~IRC~~ shall be delivered or mailed to the last known address as reflected by the records of the Commission. It is the duty of every holder of a certificate, ~~or~~ permit, ~~or~~ license ~~or~~ ~~IRC~~ to notify the Transportation Division by specific written request (TDF 17) of any change in the address of the principal place of business and mailing address thereof.
- (b) Any non-resident motor carrier who has not filed a written designation of service agent with the Commission shall be deemed to have designated the Secretary of State of Oklahoma for the purpose of service of process by the Commission.
- (c) Where such notice is required by law, Commission's Rules of Practice, OAC 165:5, or this Chapter is returned undeliverable, it will be grounds for revocation of the certificate, ~~or~~ permit, ~~or~~ license ~~or~~ ~~IRC~~.

PART 9. VIOLATIONS

165:30-3-71. Loading capacity - Safety compliance

- (a) No intrastate motor carrier or private carrier shall operate or allow any employee, agent or any other person to operate a motor vehicle owned or leased to it in violation of the size and weight limits established by the State Statutes. Factors to be considered when an application for suspension or revocation is made are set forth in subsection (d)(1) through ~~(4)~~ (5).
- (b) No person, firm or corporation shall assist in the commission of such overweight violation or cause a motor vehicle to be overloaded.
- (c) No intrastate motor carrier shall operate or allow any employee, agent or any other person to operate a motor vehicle owned or leased to it in violation of the safety standards established by the state statutes.
- (d) A compliance audit may be conducted by the Commission and will be based upon, but not limited to the following:
- (1) Frequency of violations.
 - (2) Pattern of violations.
 - (3) Fleet size.
 - (4) Type of operation.
 - (5) Overweight excess.

165:30-3-76. Contempt complaint

In addition to the procedures set forth in the Oklahoma Statutes and in the Commission's Rules of Practice, OAC 165:5 regarding the procedure in proceedings as for contempt, the following procedures may be followed for violations of this Chapter, and applicable statutes of Title 47 and Title 68:

- (1) An enforcement officer/compliance inspector/rate field agent (hereinafter referred to as "officer") of the Transportation Division may issue in the field a contempt citation for any violation of this Chapter or any applicable state statute. The officer shall furnish a copy of the citation to the person.
- (2) The citation shall be in the form prescribed by the Commission's Transportation Division.
- (3) A person served with a contempt citation may post bond or be released by the complaining officer upon personal recognizance as provided herein. The person shall indicate a plea on the citation, and sign the citation in the presence of the complaining officer. A person served with a citation may elect to change this plea to the citation at any time prior to and including the hearing date before the Administrative Law Judge. Any person electing to plead not guilty shall appear at the time and date set forth on the citation for a hearing on the matter before the Administrative Law Judge and, if not appearing, forfeit the bond posted. All Rules of Practice, OAC 165:5, of the Oklahoma Corporation Commission regarding procedures for hearing shall apply to the hearings provided for herein, except that the Administrative Law Judge may issue either an oral or written recommendation to the Commission en banc on the matter.
 - (A) The Commission shall accept bond payment of a fine in the form of cash, certified check, cashier's

check, certified or guaranteed bank check, postal or commercial money order, guaranteed arrest bond certificate or any other form of payment accepted by the Commission. Such payment shall be in full satisfaction of the violation asserted in the complaint and the allegations and charges therein will be taken as confessed. The guaranteed arrest bond certificate must have been issued by either a trucking services club or surety company, officially authorized to issue such bonds for trucking violations in Oklahoma by the State Insurance Commission, or a trucking association authorized to transact business in Oklahoma by the State Insurance Commission. The guaranteed arrest bond certificate shall be signed by the person to whom it is issued and shall contain a printed statement that such surety company, trucking association or trucking services club guarantees to pay the fine imposed on such person.

(B) Any person may be released by the complaining officer on personal recognizance if the person is unable to post a bond and the person has been issued a valid license to operate the motor vehicle they are operating, by Oklahoma, or by another state jurisdiction within the United States, or by any party jurisdiction of the Nonresident Violator Compact; and the complaining officer is satisfied as to the identity of the person receiving the citation. A person released on personal recognizance shall post a bond with the Commission within ten (10) days of the writing of the citation. Failure to do so may result in detention of equipment or revocation of authority.

(C) The failure to timely appear at the hearing at the time and date set forth on the citation may result in a request for suspension of the person's driver's license in Oklahoma, or in the nonresident's home state pursuant to the Nonresident Violator Compact. The Commission's Transportation Division shall report all such requests for suspension to the Department of Public Safety which shall proceed as provided for by the provisions of Section 1115.5 of Title 22 of the Oklahoma Statutes.

(D) The violations for which fines shall be accepted and amounts thereof shall be as follows:

- (i) Operating as a motor carrier without proper authority:
 - (I) First violation within a 12-month period - \$300.00
 - (II) Second violation within a 12-month period - \$400.00
- (ii) Operating without carrying /producing a valid copy of the authority, permit, vehicle registration, fuel license, oversize or overweight permit, or display of fuel decal or identification device:
 - (I) First violation within a 12-month period - \$125.00
 - (II) Second violation within a 12-month period - \$200.00

- (iii) Operating as a motor carrier carrying or producing an altered or fraudulent authority, over-size or overweight permit, vehicle registration, ~~or fuel license or license plate:~~ ~~-\$500.00~~
 - (I) First violation within a 12-month period - \$1,000.00
 - (II) Second violation within a 12-month period - \$1,500.00
 - (III) Third violation within a 12-month period - \$2,000.00
- (iv) Operating a commercial vehicle in excess of its registered weight by two thousand one (2,001) pounds or more; ~~or violating special permit - amount as specified by state statute.~~
 - (I) First violation within a 12-month period - \$175.00
 - (II) Second violation within a 12-month period - \$250.00
- (v) Transportation of a deleterious substance(s) without a current deleterious substance transport permit:
 - (I) First violation within a 12-month period - \$300.00
 - (II) Second violation within a 12-month period - \$400.00
- (vi) Operating a vehicle without proper registration:
 - (I) First violation within a 12-month period - \$175.00
 - (II) Second or third violation within a 12-month period - the amount as shown in (vi) above plus an amount as reflected in 47 O.S. §1133
- (vii) Operating motor vehicle without proper markings on vehicle:
 - (I) First violation within a 12-month period - \$175.00
 - (II) Second violation within a 12-month period - \$250.00
- (viii) Operating a commercial motor vehicle without a valid fuel permit:
 - (I) First violation within a 12-month period - \$175.00
 - (II) Second violation within a 12-month period - \$250.00
- (ix) Operating motor vehicle without valid lease agreement in vehicle:
 - (I) First violation within a 12-month period - \$125.00
 - (II) Second violation within a 12-month period - \$200.00
- (x) Operating motor vehicle without proper shipping or cargo ownership documentation in vehicle:
 - (I) First violation within a 12-month period - \$125.00
 - (II) Second violation within a 12-month period - \$200.00
- (xi) Failure to yield for inspection:
 - (I) First violation within a 12-month period - \$150.00
 - (II) Second violation within a 12-month period - \$200.00
- (xii) Operating as an interstate motor carrier while placed out of service by a federal agency:
 - (I) First violation within a 12-month period - \$300.00
 - (II) Second violation within a 12-month period - \$400.00
- (xiii) Operating as a transporter of hazardous waste without proper registration/permit:
 - (I) First violation within a 12-month period - \$350.00
 - (II) Second violation within a 12-month period - \$500.00
- (xiv) Operating as an interstate motor carrier, freight forwarder, broker or leasing company without paying the appropriate UCR fee:
 - (I) First violation within a 12-month period - \$300.00
 - (II) ~~Second violation~~ violation within a 12-month period - \$400.00
- (xv) Operating as an interstate motor carrier, freight forwarder, leasing company or broker without an active USDOT number:
 - (I) First violation within a 12-month period - \$300.00
 - (II) ~~Second violation~~ violation within a 12-month period - \$400.00
- (xvi) Operating as an interstate motor carrier, freight forwarder, leasing company or broker without proper federal authority:
 - (I) First violation within a 12-month period - \$300.00
 - (II) ~~Second violation~~ violation within a 12-month period - \$400.00
- (xvii) Operating as motor carrier, carrier, freight forwarder, leasing company or broker without proper insurance on file:
 - (I) First violation within a 12-month period - \$300.00
 - (II) ~~Second violation~~ violation within a 12-month period - \$400.00
- (xviii) Operating oversize without a proper oversize permit; operating as an escort service without proper certification or violating its certification; failure to secure load; or failure to carry or produce a valid insurance security verification form, if required:
 - (I) First violation within a 12-month period - ~~amount as set by state statute~~ \$175.00
 - (II) Second violation within a 12-month period - ~~amount as set by state statute plus \$100.00~~ \$250.00
- (xix) Refusal to weigh vehicle - \$500.00

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- (xx) Operating a commercial vehicle in excess of its legal weight; ~~violating a special permit or a variance permit~~ amount as specified by state statute, or:
- (I) From 700 to 2,000 pounds - \$200.00
 - (II) From 2,001 to 3,000 pounds - \$250.00
 - (III) From 3,001 to 4,000 pounds - \$300.00
 - (IV) From 4,001 to 5,000 pounds - \$350.00
 - (V) From 5,001 to 6,000 pounds - \$400.00
 - (VI) From 6,001 to 7,000 pounds - \$450.00
 - (VII) From 7,001 pounds and above - \$500.00
- (xxi) Violating a special permit or a variance permit - \$100.00
- (xxii) Other violations, unless otherwise specified by the Oklahoma Statutes or by the Oklahoma Bond Schedule:
- (I) First violation within a 12-month period - \$175.00
 - (II) Second violation within a 12-month period - \$250.00
- (~~xxiii~~ xxiii) The third ~~conviction~~ violation within a twelve-month period of units (i) through (xviii) of the subparagraph, unless otherwise specified by the Oklahoma Statutes or the rules of this Subchapter, shall result in a contempt fine of \$500.00. In addition, the Commission may suspend or revoke a motor carrier's authority, registration or permit.
- (E) Every officer is authorized to serve process in motor carrier, private carrier and other Commission related matters.

SUBCHAPTER 7. PROCEDURAL RULES

165:30-7-12. Revocation, suspension or denial of issuance of motor carrier license, permit, certificate or registration

- (a) The Commission may revoke, suspend or deny the issuance of any Commission issued motor carrier or commercial motor vehicle license, permit, certificate or registration issued pursuant to the Commission's jurisdiction for any of the following reasons:
- (1) Violation of applicable state law.
 - (2) Violation of Commission rules.
 - (3) Failure to observe or fulfill the conditions upon which the license, permit, certificate or registration was issued.
 - (4) Nonpayment of any delinquent tax, fee or penalty to the Commission or to the State of Oklahoma.
 - (5) Nonpayment of a uniform base state program delinquent tax, fee or penalty to a state or province participating with the Commission in that program.
- (b) A motor carrier or registrant who wishes to contest a revocation, suspension or denial of issuance of motor carrier license, permit, certificate or registration is entitled to a hearing under the procedures contained in the Commission's Rules of Practice, OAC 165:5.

165:30-7-13. Disqualification procedure

- (a) **General provisions.** Any person may, after notice and an opportunity for hearing, be disqualified from conducting business before the Transportation Division of the Commission if such person:
- (1) Is shown to be incompetent or disreputable;
 - (2) Refuses to comply with rules and regulations;
 - (3) With intent to defraud, in any manner willfully and knowingly deceives, misleads, or threatens any person;
 - (4) Advises a person to file a fraudulent or false report or return;
 - (5) Knowingly prepares or files a false or fraudulent report or return;
 - (6) Assists, aids or abets any person in or by concealing any information pertaining to said person's books, records, reports or returns;
 - (7) Delays proceedings of the Commission by disposing of or concealing information required in the filing of reports or returns under any Commission law or rule, or assisting another in such acts; or
 - (8) Commits any other misconduct determined by the Commission.
- (b) **Complaint and initial investigation.** The Commission may, upon its own initiative, or upon receiving a written complaint filed with the Director of the Transportation Division, cause the complaint to be investigated and a determination made as to whether good cause exists for initiating a disqualification proceeding. If it is determined that none of the conditions in subsection (a) above have been met, or if there is insufficient evidence to support the allegation, the investigation will be terminated. If a determination is made that good cause exists for initiating a disqualification proceeding, such proceeding will be promptly commenced.
- (c) **Commencement, notice, and conduct of hearing.** The commencement of the proceeding, notice to the respondent, and conduct of the hearing shall be held in compliance with the Commission's Rules of Practice, OAC 165:5.
- (d) **Burden of proof.** The Office of the General Counsel shall have the burden of establishing, by a preponderance of the evidence, that a condition in subsection (a) has been met such that respondent should be disqualified from conducting business before the Commission. Notice of the final disposition of the disqualification proceedings will be provided to the respondent.
- (e) **Scope of action.** The respondent may be found qualified to conduct business before the Commission, or may be disqualified from conducting business before the Commission for a stated period of time or indefinitely. The Commission may provide notice of the determination of the disqualification proceeding to other agencies, boards, or Commissions who exercise jurisdiction or regulatory authority over the respondent or the activities involved in the violation. Nothing in this Section shall preclude the Commission from seeking any other remedies or legal proceedings available at law to enforce its orders or rules.

SUBCHAPTER 19. REGISTRATION PURSUANT TO THE INTERNATIONAL REGISTRATION PLAN

165:30-19-12. Supplemental application

- (a) After an original application has been filed, vehicles can be added, deleted, or registration weight increased by filing a supplemental application form.
- (b) Registration fees for supplemental applications are calculated from the date of purchase or lease, unless the vehicle was previously registered in the fleet, then the fees shall be calculated upon an annual rate. For registrants who do not have possession of equipment on the date they purchased it, fees may be calculated from the date the equipment came into possession of the registrant. Registrants who wish to avail themselves of this provision must provide documentation of the receipt date of the equipment to the Transportation Division. In no case should the effective date of the registration be after equipment is placed in service.
- (c) When a supplemental application is filed to add a unit and delete a similar unit, a credit of the registration fees paid on the deleted unit will be given toward registration of the added unit for those states that allow credit. In order for credit to be given on the registration fees, the cab card and license plate for the deleted vehicle must be returned with the supplemental application, or an affidavit of destruction must be submitted with the supplemental application. Under no circumstances can a license plate be transferred from one vehicle to another. No refund for the unused portion will be given for a deleted vehicle.
- (d) If the license plate is lost, an affidavit may be submitted in lieu of the plate.

165:30-19-17. Temporary registration.

New fleet vehicles, or vehicles being added to any existing fleet, must have some form of temporary registration prior to operation if permanent IRP credentials have not been issued. All forms of temporary registration are valid for the period shown and will be honored by all IRP jurisdictions when properly completed and validated.

- (1) **Temporary registration.** Temporary registration may be obtained directly from the IFTA/IRP Section, Transportation Division, Oklahoma Corporation Commission, P.O. Box 52948, Oklahoma City, Oklahoma, 73152-2948. The temporary registration shall be completed in full by the applicant and validated by the IFTA/IRP Section at the time the application and appropriate fees are presented to the section. The temporary registration should be completed as follows:
 - (A) Enter the assigned Oklahoma IRP account number or leave a blank if no previous number has been assigned.
 - (B) Mark the appropriate section indicating the type of application on which the vehicle(s) is listed for registration and the date application was filed.
 - (C) List the vehicles being authorized by license plate number (leave blank if not assigned), equipment

number, year model, make and the vehicle identification number. Unused vehicle listing spaces must be lined out.

- (D) List jurisdictional weights for the vehicles. A separate form must be completed for vehicles which are not to be qualified at identical weights in the same jurisdiction. State with no entry must be lined out.
- (E) Enter the registrant's name and business address as reported on schedule A or C application.
- (F) Jurisdiction and weight information entered on the form must be consistent with those reported on the Schedule A or C form.
- (G) Temporary registration for established accounts may also be obtained directly from any person that has entered into an agreement with Commission for distribution and issuance of temporary registration. This registration must be completed in the same manner described in paragraph (1) of this subsection. Misuse of any temporary registration may result in denial of temporary registration privileges.
- (2) **Required payment of fees.** Temporary registration or credentials may only be issued to new accounts after all required fees are paid.
- (3) **Wires of temporary registration.** Wires of temporary registration may be requested from the IFTA/IRP Section in the following manner:
 - (A) **Where to apply.** Wires of temporary registration may be requested through the IFTA/IRP Section, Transportation Division, Oklahoma Corporation Commission, P.O. Box 52948, Oklahoma City, Oklahoma, 73152-2948, during normal business hours, Monday through Friday.
 - (B) **Application procedure.** A properly completed and signed Schedule C application must be mailed to the IFTA/IRP Section, Transportation Division, Oklahoma Corporation Commission, P.O. Box 52948, Oklahoma City, Oklahoma, 73152-2948, prior to issuance of the wire request. The applicant must contact the appropriate wire service agency to determine the proper amount of fees due and the location to remit the fees.
- (4) **Self-issue temporary registration.** Self-issue temporary registrations are available only to established Oklahoma-based IRP registrants, and may be used for vehicle(s) added to the fleet, duplicate cab cards, substitute license plates, state add and weight increase applications to the registrant's account. Self-issue temporary registrations may not be used for renewal vehicles. Self-issue temporary registrations may not be issued by a registrant to another registrant or to an applicant or potential applicant for Oklahoma proportional registration.
 - (A) **Self-issue temporary registration.** Self-issue temporary registrations or authorizations may be issued up to a maximum of twenty-five percent (25%) of the registrant's fleet. Any registrant with a fleet of less than six (6) vehicles may be assigned one (1) self-issue temporary registration.

(B) **Application procedure.** Properly completed temporary registrations allow for immediate temporary registration for vehicles added to the fleet, duplicate cab cards, substitute license plates, state add and weight increase applications. Upon issuance, ~~the original a copy of the~~ temporary registration should be placed in the vehicle, and one copy mailed immediately to the IFTA/IRP Section, Transportation Division, Oklahoma Corporation Commission, P.O. Box 52948, Oklahoma City, Oklahoma, 73152-2948. Within fifteen (15) days of issuance, another copy of the temporary registration must be submitted, along with a completed Schedule C.

(C) **Violations.** Misuse of the temporary registration or failure to maintain proper accountability may result in the Prorate Section's refusal to issue the registrant self-issue temporary registrations.

(5) **Issuance of temporary registration.**

(A) The issuance of temporary registration creates a debt to the State of Oklahoma who is then indebted to the participating jurisdictions of the International Registration Plan. Registrants must pay registration fees for the remainder of the registration year for which a temporary registration is issued. The fees shall be calculated beginning with the effective date of the temporary registration, or the date determined by the Transportation Division, if earlier, and continue through the end of the registration year.

(B) In addition to collection actions, failure to pay the fees described in (A) above will cause the loss of apportioned registration privileges.

(C) The Transportation Division may withhold issuance of future temporary registration, to those registrants who have failed to timely file a registration application, or pay the registration fees associated with any vehicle, for which a temporary registration authorized by 47 O.S. § 1124.1 has been issued.

(D) The Transportation Division may revoke previously issued registration credentials and/or deny future registration privileges to registrants who use temporary registration issued under 47 O.S. § 1124.1 without paying registration fees.

(b) The Transportation Division may withhold issuing requested decals if fulfilling the request would result in the licensee having over 25% more decals in their possession than their fleet size. If the Division withholds decals under this provision, it will only withhold that portion of the decal request that causes the licensee's decal inventory to exceed the 25% figure.

(c) IFTA licensees are required to account for all decals issued to them under the IFTA program. Licensees must ensure that decals are assigned only to vehicles that are subject to the fuel and distance requirements of the IFTA program of the licensee. Decals, not issued to vehicles subject to fuel and distance requirements, must be produced for inspection upon request of the Transportation Division. Failure to adequately account for decals, or produce decals for inspection, may subject the licensee to penalty of \$250 per decal.

[OAR Docket #09-877; filed 5-8-09]

TITLE 175. STATE BOARD OF COSMETOLOGY CHAPTER 10. LICENSURE OF COSMETOLOGISTS, SCHOOLS AND RELATED ESTABLISHMENTS

[OAR Docket #09-792]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 7. Sanitation and Safety Standards for Cosmetology Establishments, Salons and Schools
175:10-7-25 [AMENDED]
175:10-7-29 [NEW]
175:10-7-30 [NEW]

AUTHORITY:

59 O.S., 1991, § 199.3 (A); State Board of Cosmetology

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Failure of the Legislature to disapprove the rules resulted in approval on April 23, 2009

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The amendments to 175:10-7-25 prohibit fish pedicures or other cosmetology procedures using fish or animals. This is a procedure which

SUBCHAPTER 21. INTERNATIONAL FUEL TAX AGREEMENT

165:30-21-7. Application processing

(a) Upon receipt of an IFTA fuel tax license application from a new or renewing applicant, the Commission shall check all entries on the application to ensure that they are complete. If the Commission feels more information is required, the licensee should immediately be contacted requesting the required information. Upon being satisfied that the application is correct and all fees prescribed by law or Commission rule have been paid, the Commission shall issue the fuel tax credentials for the fleet.

involves the use of certain species of fish to nibble or suck dead skin from the feet of the customer. 175:10-7-29 (new) establishes that the use of exfoliating substances or devices that affect more than the outermost layer of skin cells to be prohibited and is beyond the scope of practice of licensees. It ensures that licensees are not performing medical procedures. 175:10-7-30 (new) establishes specific procedures for cleaning and disinfecting pedicure equipment after each client use in order to prevent the spread of potentially dangerous and infectious diseases and disorders that may be contracted by the public from unclean, undisinfecting and unsanitized pedicure equipment.

CONTACT PERSON:

Jennifer McRee, Principal Assistant, Oklahoma State Board of Cosmetology, 2401 NW 23rd Street, Suite 84, Oklahoma City, OK 73107, 405-522-7616.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOIWNNG RULES ARE CONSIDRED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 7. SANITATION AND SAFETY STANDARDS FOR COSMETOLOGY ESTABLISHMENTS, SALONS AND SCHOOLS

175:10-7-25. Animals, birds, pets prohibited in cosmetology schools and related establishments

Animals, birds, and/or other pets shall be prohibited in a cosmetology establishment or school, unless otherwise provided by law. The use of fish or other animals in performing a cosmetology service in a cosmetology establishment or school, including but not limited to fish pedicures is prohibited.

175:10-7-29. Facial procedures, devices and equipment

(a) Licensees are prohibited from performing facial procedures using cosmetic exfoliating substances or devices that effect more than the top layer (stratum corneum) or outer most layer of dead cells on the skin. Procedures which use any cosmetic exfoliation substance or device to remove viable (living) skin below the stratum corneum are deemed beyond the scope of practice of persons and establishments licensed by the Board of Cosmetology.

(b) Cosmetic exfoliating substances may include alpha hydroxyl acids (glycolic and lactic acids), beta hydroxyl acids, salicylic acid, Jessner's solutions, resorcinol and other substances intended to affect no more than the stratum corneum.

(c) Cosmetic exfoliating devices may include FDA (U.S. Food and Drug Administration) registered and/or approved devices, provided that such devices affect no more than the stratum corneum.

175:10-7-30. Pedicure equipment and procedures for cleaning and disinfecting after each client use

Pedicure equipment is a unit that holds water for a pedicure service, including whirlpool spas, 'pipe-less' units, foot-baths, basins, tubs, sinks and bowls which shall be cleaned by scrubbing surface with a brush, using an enzymatic or surfactant detergent (soap) and water. After cleaning, pedicure equipment, tools and implements shall be disinfected by using an EPA-registered disinfectant as prescribed in Board rule 175:10-7-6. Board rules regarding the cleaning and sanitizing of cosmetology tools and implements apply to all tools and implements used for pedicures. The Board recommends the use of NIC approved 'Cleaning and Disinfecting of Circulating and Non Circulating Tubs and Spa's For All Industry Modalities'.

[OAR Docket #09-792; filed 4-28-09]

**TITLE 180. OKLAHOMA STATE CREDIT UNION BOARD
CHAPTER 1. GENERAL PROVISIONS, DUTIES, DEFINITIONS, PROCEDURAL RULES, AND PUBLIC RECORDS ADMINISTRATIVE OPERATIONS**

[OAR Docket #09-825]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 1. General Provisions
- 180:1-1-2. Definitions [AMENDED]
- 180:1-1-4. ~~Public records~~Requests for Information [AMENDED]
- Subchapter 3. ~~Rules for Proceedings Before the Board~~Procedural Rules
- 180:1-3-1. Board's principal offices and alternate locations [AMENDED]
- 180:1-3-2. General procedures before the Board [AMENDED]
- 180:1-3-3. Filing pleadings and papers [AMENDED]
- 180:1-3-4. Record of proceedings [AMENDED]
- 180:1-3-5. Service of pleadings [AMENDED]
- 180:1-3-6. Commencement of proceeding; intervention; consolidation [AMENDED]
- 180:1-3-7. Notice of hearing [AMENDED]
- 180:1-3-9. Depositions and discovery [AMENDED]
- 180:1-3-10. Examiner testimony [AMENDED]
- 180:1-3-15. Party's attendance required at hearing [AMENDED]
- 180:1-3-16. Complaint Procedure [NEW]
- 180:1-3-17. Petitions for rulemaking [NEW]
- 180:1-3-18. Declaratory Rulings [NEW]

AUTHORITY:

State Credit Union Board; 6 O.S. § 2001.2(A)(3) and 75 O.S. §§ 302(A), 305, and 307.

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N/A

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N/A

ANALYSIS:

The rule changes are a result of a review of all rules in Chapter 1 and Chapter 10 of Title 180 in the Oklahoma Administrative Code. The circumstances that created the need for the new and amended rules are (1) the lack of certain rules required under the Administrative Procedures Act, and (2) a need to update certain rules to reflect the current operation of the Banking Department (the "Department") and statutory changes in the Oklahoma Credit Union Act (Title 6 O.S. section 2001 *et seq.*, the "Act") occurring since the last complete review of these rules. The intended effect of the new and amended rules is to bring the provisions of Chapter 1 of Title 180 into conformity with statutory requirements and to update Chapter 1 of Title 180 to reflect the current operation of the Department. Several amendments are suggested with respect to typographical issues or clarification of language, with no substantive change intended.

Subchapter 1. In Subchapter 1, obsolete definitions have been deleted and other terms have been defined. For example, definitions for specific types of deposit accounts offered by credit unions (such as "regular share," "share certificate," and "share draft/checking account") have been deleted from the definitions in section 180:1-1-2 because those terms are not used in Chapter 1 of Title 180. A definition of the term "complaint," has been added for clarity in Chapter 1 and to correspond to new rule 180:1-3-16.

Rule 180:1-1-4 is amended to provide clarity and instruction with regard to how the public may make requests for public records. The rule also deletes an obsolete reference to Oklahoma statutes regarding those credit union records that are open for public inspection. The statute addressing public records is found at title 6 O.S. § 2027. The amended rule also describes how credit unions are to handle examination reports in their possession.

Subchapter 3. In Subchapter 3, changes are made to update the rules of practice with regard to formal and informal proceedings before the Banking Commissioner (the "Commissioner") and the State Credit Union Board (the "Board"). For example, the complaint procedure has been removed from the formal proceedings before the Board and is now described in detail in new rule 180:1-3-16 as a matter to be decided by the Commissioner or his designee. On the other hand, appeals to the Board from certain decisions of the Commissioner are added to rule 180:1-3-6 as a type of formal proceeding that follows the other procedural rules of Subchapter 3.

Rules 180:1-3-17 (Petitions for rulemaking) and 180:1-3-18 (Declaratory rulings), are new rules added to more fully describe the procedure relating to petitioning the Board for rulemaking and for a declaratory ruling. These topics were addressed very briefly in rule 180:1-3-2 but that reference did not provide sufficient guidance to either the public or the Department with respect how these matters should be handled. The new rules are intended to comply with the requirements of sections 305 and 307 of the Oklahoma Administrative Procedures Act (Title 75 O.S. section 250 *et seq.*). Rule 180:1-3-16 (Complaint procedure) is a new rule that describes how complaints against credit unions will be handled by the Department and the type of relief that the Department may provide to a complaining party.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

180:1-1-2. Definitions

The following words or terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise. Any term used in this chapter but not otherwise defined in this chapter shall have the meaning provided for such term in the Act, unless the context clearly indicates otherwise.

"**Act**" means the Oklahoma Credit Union Act (6 O.S., §2001 *et seq.*).

~~"Adjustable rate mortgage loan" means a mortgage loan secured by a first lien on residential real property which permits the periodic adjustment of the rate of interest on the loan in response to the movement of an index which was agreed upon in advance by the borrower and the credit union.~~

"**Administrative Procedures Act**" means the Administrative Procedures Act of Oklahoma (75 O.S. § 301 *et seq.*).

"**Applicant**" means a party commencing a proceeding either in the form of an Application or Complaint; and includes the terms "plaintiff", ~~"complainant"~~ "appellant" and "petitioner".

"**Attorney**" means a licensed attorney currently admitted to practice before the Supreme Court of Oklahoma, or an attorney currently licensed to practice in another state who is granted permission to appear in a proceeding in this state. No attorney who is not currently licensed to practice in Oklahoma shall be permitted to appear except in association with an attorney so licensed to practice in Oklahoma who shall also appear in the proceeding. An attorney licensed to practice in a state permitting attorneys of this state to practice before its state courts without local counsel may appear without association of local counsel.

"**Board**" means the Oklahoma State Credit Union Board.

~~"Capital", as referred to in the Oklahoma Credit Union Act and in the rules of this chapter shall consist of the shares and deposits held by state chartered credit unions.~~

"**Certificate of deposit account**" means an account represented by a Certificate of Deposit as defined in this section.

~~"Certificate of deposit" or "Share certificate" means a written instrument or special account in a given amount for a given period of time with a specified rate of interest. Certificates of Deposit and share certificates shall be considered a part of the capital.~~

"**Commissioner**" means the Oklahoma Bank Commissioner, who presides as Chairman of the Board.

"**Complaint**" means a notice to the Commissioner regarding an alleged violation of state or federal law committed by an institution, company, or person under the jurisdiction of the Department.

"**Credit union**" means a credit union organized under the laws of Oklahoma.

"**Department**" means the Oklahoma State Banking Department.

"**Intervenor**" means a party not an applicant or named respondent who obtains permission to enter the proceeding. An intervenor opposing an application will thereafter be deemed a respondent.

"Minimum balance share or Deposit account" means an account which requires the owner to maintain a specific balance in the account for the entire dividend period.

"Net earnings" means the balance after deducting from the gross income a credit union actually receives during a dividend period, all expenses paid or payable during such period, dividends on shares, interest on deposits, statutory reserves and any losses sustained therein for which no specific reserve has been set aside, or for those credit unions on an accrual basis, net earnings shall mean the balance after deducting from the gross income a credit union actually receives or accrues during a dividend period, all expenses paid or payable, all interest accrued, dividend on shares, interest on deposits, statutory reserves during such period and any losses sustained therein for which no specific reserve has been set aside.

"Notice share or Deposit account" means an account which may require the owner to give written notice of the intent to withdraw, in addition to any notice as may be required in credit union bylaws.

"Order" means that which is required or ordered to be done, or not to be done and shall be generally reserved for the requirement or directive portion of an official order or decisions of a proceeding; or the promulgation of rules, regulations, and requirements in matters in which the Board or Commissioner acts.

"Party", as used in this chapter, means a party of record and every other party having interest in the subject matter, and entitled to appear therein as a party of record.

"Party of record" means any party named a party in a pleading, or who makes formal appearance either in person or by an attorney at any stage of the proceeding, whether or not seeking affirmative relief.

"Protestant" means a party who, upon grounds of private or public interest, resists an application or any relief sought thereby. A protestant is governed by the rules applicable to a respondent.

"Record" or **"Formal record"** of any proceeding shall consist of the following, where offered at the hearing, whether or not received:

- (A) Preliminary exhibits, including pertinent pleadings, notices and proof of publication.
- (B) Transcript of proceedings at all hearings.
- (C) Depositions, stipulations, interrogatories and answers, written testimony, offers of proof, and similar matters.
- (D) Exhibits, together with attachments, appendices and amendments thereto.
- (E) Exceptions and motions subsequent to the hearing.
- (F) Orders or Recommendations recommendations of the Board or Commissioner, together with findings of fact and conclusions of law.
- (G) The Any other instruments or matters relevant to the issues that the Board or Commissioner may order included in the record ~~any other instruments or matters relevant to the issues.~~

"Regular share or Deposit account" means an account which does not require the owner to maintain a minimum balance greater than the par value of a share except a nominal minimum relating to the cost of maintaining an account, or to give notice of intent to withdraw, except as may be required in credit union bylaws.

"Respondent" means a party against whom relief is sought in a proceeding, or who appears in opposition to relief sought by the applicant, and includes the term "Defendant". An institution, company, or person named in a complaint shall also be considered a respondent for purposes of the complaint.

"Share certificate account" means an account that will earn dividends at a particular rate (subject to conditions) if held to maturity and on which a penalty may be assessed for withdrawal of all or any portion of the principal amount prior to maturity, with certain exceptions.

"Share draft/Checking account" means a regular share or deposit account, set separate and aside from all other accounts, upon which the owner is permitted to draw drafts as provided for in 180:10-5-5.

"Surplus" ~~means the credit balance of the undivided earnings account on the given date after all losses have been provided for and net earnings or net losses have been added thereto or deducted therefrom, as the case may be. Regular reserves as defined in 6 O.S. §2011 shall not be considered as a part of the surplus.~~

"Trusteed and custodial pension fund share, deposit or share certificate account" means an account which qualifies as an individual retirement account for a member pursuant to 26 U.S.C., Section 408, or Keogh (HR-10) Plan as established pursuant to 26 U.S.C., Section 401.

"Variable rate loan" ~~means any loan other than an adjustable rate mortgage loan defined in this section which permits adjustment of the interest rate on the loan in response to the movement of an index.~~

180:1-1-4. Public records Requests for information

- (a) ~~The Board makes available for public inspection and copying, upon request,~~
 - (1) ~~the Act,~~
 - (2) ~~the Administrative Procedures Act,~~
 - (3) ~~this Title,~~
 - (4) ~~statements of policy and interpretations of the Board, and~~
 - (5) ~~a record of the official actions of the Board.~~
- (b) ~~The public may make submissions or requests to the Commissioner at the office of the Board either orally or in writing. Where the request is for materials of which copies are not available and reproduction is required, such service will be provided upon payment of the costs involved.~~
- (c) ~~Requests for documents other than those expressly made public records pursuant to (a) of this Section, shall be governed by the provisions of 6 O.S. §208.~~
- (a) The records of the Department are subject to review only as provided in the Act, rules of the Board, and the Oklahoma

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Open Records Act. Requests for information shall be accompanied by a Request for Records form prescribed by the Commissioner, which shall identify the name, address and telephone number of the person requesting the information and the specific information or types of information requested. The person requesting to inspect or receive copies of records shall state whether the records are being viewed or requested for a personal, business or commercial reason.

(b) Examination reports are the property of the regulatory agencies that generate them and no part of such reports shall ever be considered public record. Copies are furnished to credit unions for their confidential use. Under no circumstances shall a credit union or any of its directors, officers or employees disclose or make public in any manner the report or any portion thereof. If a subpoena or other legal process is received calling for production of an examination report, the Department must be notified immediately.

(c) All requests for information must be submitted to the principal office of the Department. Records of the Department will be available to the public for inspection only during regular office hours.

(d) No original records shall be removed from the Department. A charge for copies may be made in accordance with the Open Records Act and the provisions of this title or the Act.

SUBCHAPTER 3. RULES FOR PROCEEDING BEFORE THE BOARD PROCEDURAL RULES

180:1-3-1. Board's principal offices and alternate locations

The principal office of the ~~Oklahoma State Credit Union~~ Board shall be located in the main office of the Oklahoma State Banking Department, which shall be at 2900 North Lincoln Boulevard, Oklahoma City, Oklahoma, 73105. The Board, or any official exercising its authority, may meet and exercise its official powers and functions at any location in the State of Oklahoma.

180:1-3-2. General procedures before the Board

(a) The adoption, amendment, or repeal of any rule shall be in accordance with the provisions of ~~§303~~ of the Administrative Procedures Act. (~~75 O.S. §301, et seq.~~)

~~(b) An interested person may petition the Board requesting the promulgation, amendment or repeal of a rule. The petition shall be in writing and shall be in the form of a request submitted to the Board stating the petitioner's interest in the subject matter and the reasons why the petition should be granted. The Board shall consider and act upon said petition within a reasonable time.~~

~~(c) An interested person may petition the Board for declaratory rulings as to the applicability of any rule or order of the Board. The petition shall be in writing setting forth the petitioner's interest in the subject matter and the reasons why the petition should be granted. The petition shall be filed at the~~

~~office of the Board and the Board shall consider and act upon the petition promptly.~~

~~(b) The conduct of an individual proceeding as defined by §301 of the Administrative Procedures Act shall be in accordance with the provisions of §309 of the Administrative Procedures Act. The Board may admit evidence and shall allow cross-examination and right to counsel as provided by §310 of the Administrative Procedures Act.~~

~~(c) The Board shall have power to require the furnishing of such information, the attendance of such witnesses and the production of such books, records, papers or other objects as may be necessary and proper for the purposes of any proceeding in accordance with the provisions of §315 of the Administrative Procedures Act.~~

180:1-3-3. Filing pleadings and papers

Every communication in writing to the Board shall be addressed to the Commissioner at the principal office, unless the Board directs otherwise. Every pleading and other document tendered for official filing shall be deposited with or mailed to the Commissioner at the principal office, and shall be deemed received only upon actual delivery at the office of the Commissioner. Filing of any instrument shall not be complete except upon payment of all applicable fees required by law ~~or by these rules.~~

180:1-3-4. Record of proceedings

The Commissioner may, in his discretion, ~~or shall at the request of a party,~~ cause a record to be made of an individual proceeding before the Board or Commissioner. ~~A If the Commissioner chooses not to cause a record to be made, other than audio recording of a proceeding, a record may be made by any party to a proceeding. If a party chooses to cause a record to be made of an individual proceeding,~~ a transcript of proceedings will be made at the request and expense of any party ordering it; however, two copies shall be furnished to the Department at Appellant's expense in cases in which the Commissioner's or Board's decision is appealed.

180:1-3-5. Service of pleadings

(a) **Service of an initial pleading.** Every application in which a party is named a respondent, ~~and every complaint,~~ shall be served by the State Banking Department on each respondent named therein by mail accompanied by a notice of hearing stating the date on which the cause is set for hearing, which shall be no less than ten (10) days after notice is mailed. Service hereunder shall be required in addition to provisions of this Chapter requiring service by publication.

(b) **Service of subsequent pleadings.** Every pleading after the initial pleading shall be served by the party filing it by regular mail upon all parties of record. Parties of record shall include the applicant, all named respondents, and all persons having theretofore entered an appearance in the cause, in person or by an attorney.

(c) **Certificate of service.** Every pleading required to be served by regular mail shall contain a list of persons served and the certificate of a party or his attorney, that on the date stated a

copy of the pleading was mailed, postage prepaid, or delivered, to each person listed. Any pleading required to be served by regular mail may be served by leaving a copy thereof at the principal office of the party, or of the attorney for the party.

(d) **Service not jurisdictional.** Service prescribed by this Chapter shall not be jurisdictional except where so provided by the Constitution or by ~~Statute~~ statute. Failure to comply with the provisions of this ~~Section~~ section as to mailing and service notice shall not deprive the Board or Commissioner of jurisdiction of the proceeding, but shall be grounds for appropriate relief as the Commissioner may order.

180:1-3-6. Commencement of proceeding; intervention; consolidation

(a) Every proceeding shall be commenced by an initial pleading which shall be:

- (1) an application, which shall include any request for authority, approval, determination, permission or other action or relief whether or not directed against a named respondent;
- (2) ~~a complaint an appeal of a decision of the Commissioner, which decision is entitled to be appealed to the Board, or~~
- (3) an order of the Board or Commissioner commencing a proceeding.

(b) ~~An application shall include any request for authority, approval, determination, permission or other Board action or relief whether or not directed against a named respondent. A complaint shall include every form of request for enforcement of an order, rule or regulation of the Board or Commissioner or for relief against a named respondent based upon an alleged violation of law or of a rule, regulation or order of the Board or Commissioner.~~

(c) Any interested person may intervene in a proceeding before the Board or Commissioner upon making timely application and showing that he may be aggrieved by the decision. Two or more proceedings or matters may be consolidated if there is no prejudice to any person affected by such consolidation.

180:1-3-7. Notice of hearing

(a) The Commissioner shall determine the names of all interested persons who might be directly aggrieved by the determination of the Board or the Commissioner at such hearings.

(b) The Commissioner shall give written notice of hearing to such persons at least ten (10) days prior to the hearing. Any party may waive such notice of hearing, and will be considered to have waived such notice by attending the hearing in person or by representative, unless such appearance is for the sole purpose of protesting the lack of timely notice.

(c) The Commissioner shall give any additional notice required by law and may give additional notice where he deems it advisable.

180:1-3-9. Depositions and discovery

(a) **Depositions.**

(1) Deposition of a witness may be taken pursuant to a subpoena or by agreement of the parties involved. The deposition of a witness may be taken inside or outside the State of Oklahoma with the requesting party bearing the cost of the court reporter.

(2) The manner of taking deposition and the use thereof shall otherwise be governed by the laws relating to taking of depositions for use in the District Courts of Oklahoma.

(b) **Production of documents.**

(1) Upon application of a party, or upon the Commissioner's own motion, with or without notice, the Commissioner may make an ~~Order~~ order requiring a party to produce designated documents or tangible objects for inspection by parties to the proceeding, or for copying at the expense of the applicant, or to be offered in evidence. The ~~Order~~ order shall direct production thereof at the hearing, or at a pre-hearing conference and production shall be at the principal office of the Board, unless some other place is stated in the order. An order hereunder may be directed to a party not yet a party of record, conditioned that such party appears at the hearing, the ~~Order~~ order thereupon will be complied with.

(2) The party applying therefore shall mail a copy of the ~~Order~~ order by regular mail on each party of record at least seven (7) days prior to the date upon which production is required.

(3) An ~~Order~~ order pursuant to this ~~Section~~ section may require production of any document not privileged which constitutes or contains evidence relevant to the subject matter of the proceeding, or may reasonably lead to such evidence. Business records shall not be deemed privileged as such; but confidential business records and information will be protected from disclosure except where directly relevant to the issues in the proceedings.

(4) The ~~Order~~ order shall identify the document or object to be produced individually or by categories, with sufficient particularity to permit easy identification thereof by the party ordered to make production.

(5) An exact photographic copy of a document may be substituted for the original, at the expense of the person requesting the instrument.

(c) **Interrogatories.** Interrogatories may be submitted to a party in an individual proceeding under the same restrictions and procedures as set forth in the Oklahoma ~~Statutes~~ statutes governing discovery in civil cases.

180:1-3-10. Examiner testimony

(a) ~~Oklahoma State Banking~~ Department examiners are prohibited from giving testimony which would disclose information obtained from confidential records, as defined in ~~6 O.S. §208~~ the Oklahoma Banking Code, the Act, or rule of the Board, or information obtained in the process of developing confidential records, without the express permission in writing of the Commissioner.

(b) Litigants seeking to subpoena ~~banking~~ department ~~Department~~ examiners for depositions or hearings shall serve one copy of the subpoena upon the examiner and shall timely furnish one copy of each subpoena to the Department.

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180:1-3-15. Party's attendance required at hearing

A representative of a credit union seeking affirmative relief must be present at the Board meeting where the Board will hear the request, unless such attendance is waived by the presiding officer.

180:1-3-16. Complaint procedure

(a) The primary purpose of the complaint procedure is to assist consumers in obtaining a formal response from an institution or company under the jurisdiction of the Department (the respondent). If the undisputed facts indicate that a respondent has violated state or federal law with respect to the complaining party, the Commissioner may notify both the complaining party and the respondent and recommend a resolution to the complaint. The Commissioner may take other action against the respondent if the activity or violation identified in the complaint, and verified by the Commissioner, indicates a threat to the safety and soundness of the respondent or a violation of law enforced by the Department.

(b) All complaints shall be on a form prescribed by the Commissioner. All complaints shall be answered by the Commissioner or the Commissioner's designee, without proceedings before the Board.

(c) Unless determined by the Commissioner to be frivolous or not including facts that may entitle the complaining party to relief under applicable law, the Commissioner shall forward each complaint to the respondent named in the complaint. The respondent shall have 20 days to respond in writing to the complaint, unless such time is extended by the Commissioner for good cause.

(d) The Commissioner shall not have jurisdiction to decide questions of fact raised by the parties to a complaint nor shall the Commissioner have authority to enforce, interpret, or avoid the provisions of a contract between the parties to a complaint. However, the Commissioner may inform the complaining party and respondent that a contract provision is contrary to established law. (e) Although a complaint may include a request for relief against a named respondent, a complaint will not result in adversary or other proceedings as described in these rules. Decisions of the Commissioner with respect to complaints shall be final as to the administrative process and no appeal or other proceedings shall be held before the Commissioner or Board with respect to complaints. Provided, however, decisions of the Commissioner shall not preclude, endorse, or otherwise affect the rights of any person to pursue civil relief in a court of competent jurisdiction with respect to the issues presented in a complaint.

180:1-3-17. Petitions for rulemaking

(a) Any interested person may file a petition requesting the promulgation, amendment, or repeal of a rule in this title. The petition shall:

- (1) be in writing;
- (2) refer to the statutory section that authorizes the rulemaking action requested;

(3) refer to the need for the rulemaking action requested, including the consequences of not approving the rulemaking action requested;

(4) state the exact language for the rulemaking action requested;

(5) state the purpose of the rule sought;

(6) state a fact situation to which the rule sought will apply; and

(7) list the name and address of the person requesting the rule.

(b) Upon receipt of a petition as described in subsection (a) of this section, the Commissioner may initiate a study of the requested change through whatever means deemed appropriate. If the Commissioner formally acts upon the petition, the petitioner will be advised of the action in writing as specified by the Commissioner. In accordance with 75 O.S. § 305, if the Department has not initiated rulemaking proceedings within 30 calendar days after the submission of a petition, the petition shall be deemed to have been denied.

(c) No petition for emergency rulemaking will be accepted or acted on by the Commissioner.

180:1-3-18. Declaratory rulings

(a) Any interested person may file a petition for a declaratory ruling as to the applicability of any rule or order of the Department. An official ruling will only be given if it is shown that an actual case, controversy, or issue is in contemplation on the fact situation presented and that unreasonable hardship, loss, or delay would result if the matter were not determined in advance.

(b) A petition for a declaratory ruling shall:

(1) be in writing;

(2) refer to the rule or order involved;

(3) state the nature and purpose of the declaratory ruling sought;

(4) state the fact situation with respect to which the declaratory ruling is sought;

(5) provide citations to, and a summary of, authorities (whether controlling or not) relating to the issues presented by the petition; and

(6) list the name and address of the person requesting the ruling.

(c) The Commissioner may require any petitioner to provide additional information. A petition is not considered final until all requested information has been submitted. The failure to provide additional information shall be considered a withdrawal of the petition.

(d) Official declaratory rulings may be made by and at the discretion of the Commissioner as to the applicability of any rule or order. Alternatively, the Commissioner may submit the final petition to the Board for review and declaratory ruling.

(e) A declaratory ruling, or refusal to issue such a ruling, shall be issued by the Commissioner or the Board within 90 days from receipt of the final petition, and shall be subject to review in accordance with the Administrative Procedures Act. The Commissioner or Board may deny the petition if it is repetitive, concerns a matter that in the Commissioner's or Board's

judgment is inappropriate for a declaratory ruling, or concerns a matter beyond the Commissioner or Board's authority.

(f) The Commissioner may provide others with written notice of the request for a declaratory ruling and give them an opportunity to respond in writing.

(g) Nothing in this rule shall be interpreted as limiting the right of the Commissioner to issue, on his own motion or upon request, interpretive statements as allowed by the Act.

[OAR Docket #09-825; filed 5-4-09]

**TITLE 180. OKLAHOMA STATE CREDIT
UNION BOARD
CHAPTER 10. SUPERVISION,
REGULATION AND ADMINISTRATION**

[OAR Docket #09-826]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 1. Department and Board Requirements
 - 180:10-1-2. Definitions [AMENDED]
 - 180:10-1-3. Description of forms and instructions [AMENDED]
 - 180:10-1-4. Change in name [AMENDED]
 - 180:10-1-5. Bond requirements; schedule [AMENDED]
 - 180:10-1-6. Approved auditors [AMENDED]
 - 180:10-1-7. Bylaw amendments [AMENDED]
 - 180:10-1-8. Corporate central credit union organization and operation [AMENDED]
 - 180:10-1-11. Records and retention [AMENDED]
 - 180:10-1-12. Reporting changes in executive officers, directors and committee members [AMENDED]
 - 180:10-1-13. Prohibition against credit unions employing, electing or appointing certain individuals and Credit Union Board's power to enforce [AMENDED]
 - 180:10-1-14. Assessments [AMENDED]
 - 180:10-1-15. Fees [AMENDED]
 - 180:10-1-16. Suspicious Activity Reports [NEW]
 - 180:10-1-17. Credit Union Branches [NEW]
- Subchapter 3. New Credit Unions, Mergers, Conversions, and Field of Membership
 - 180:10-3-1. New credit union; organization [AMENDED]
 - 180:10-3-3. Conversion requirements [AMENDED]
 - 180:10-3-5. Community field of membership [AMENDED]
 - 180:10-3-6. Multiple common bond field of membership [AMENDED]
 - 180:10-3-7. Single common bond field of membership [AMENDED]
 - 180:10-3-8. Field of membership list [AMENDED]
 - 180:10-3-9. Field of membership disaffiliation [REVOKED]
- Subchapter 5. Guidelines and Restrictions
 - 180:10-5-1. Deposits [AMENDED]
 - 180:10-5-2. Dividends and interest paid [AMENDED]
 - 180:10-5-3. Investment and deposits [AMENDED]
 - 180:10-5-4. Rental or purchase of property [AMENDED]
 - 180:10-5-5. Share drafts, checking accounts or other instruments and accounts [AMENDED]
 - 180:10-5-6. Issuance of accounts [REVOKED]
 - 180:10-5-8. Safe deposit boxes [AMENDED]
 - 180:10-5-9. Prohibited acts and practices [AMENDED]

AUTHORITY:

State Credit Union Board; 6 O.S. § 2001.2(A)(3) and (9)

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N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

Subchapter 1. The primary revisions to subchapter 1 are found in section 180:10-1-2 relating to definitions. Many definitions were deleted from Chapter 10 because such terms are defined in Chapter 1 of Title 180 and such terms are used exclusively in Chapter 1, rather than Chapter 10. For example, the terms "attorney," "intervenor," "party," "party of record," and "protestant," are defined in Chapter 1 and are used in Chapter 1 with respect to formal proceedings before the Banking Department (the "Department") and State Credit Union Board (the "Board"). Those terms need not also be defined in Chapter 10. Therefore, they are deleted. The term "rural service area" is deleted because it is no longer authorized as a type of community field of membership pursuant to changes to proposed rule 180:10-3-5. The term "Oklahoma Metropolitan Statistical Area" is amended to remove the specific counties comprising the various MSAs in order to accommodate future changes to the MSAs. Definitions for specific types of deposit accounts offered by credit unions (such as "regular share," "share certificate," and "share draft/checking account") have been deleted because proposed revisions to rule 180:10-5-5 provide broad authorization for accounts rather than only those defined in the rules. Definitions for "financial institution" and "federally insured" are moved from rules 180:10-1-12 and 180:10-1-13 to rule 180:10-1-2.

Rule 180:10-1-4 (Change in name) has been amended to impose the duty on the credit union to search state and federal governmental records regarding whether a new name is eligible for use and not infringing on another company's name. The new rule also removes the duty of the Banking Commissioner (the "Commissioner") to file the credit union's amended certificate of incorporation with the Secretary of State and requires the credit union to file its amended certificate. The amendment also removes the Department's application fee associated with the name change.

Rule 180:10-1-5 (Bond requirements) is amended to require the same minimum coverages that are required for federal credit unions.

Rule 180:10-1-6 (Approved auditors) is amended to require the Board to review its list of approved auditors at least once per calendar year.

Amendments to rule 180:10-1-11 (Records and retention) remove the lengthy and detailed record retention schedule for numerous types of documents. The lengthy retention schedule is replaced by a proposed retention schedule that refers to other state or federal laws that already prescribe a retention schedule for certain documents (such as consumer disclosure documents). The amended rule also refers to statute of limitation laws when no state or federal law prescribes a retention period for specific records. The amended rule allows the Commissioner to issue rulings, with the approval of the Board, that require credit unions to retain certain records for a longer period of time than may be required under the general rule.

Rule 180:10-1-14 (Assessments) is amended so that the payment deadline is changed from January 31 to February 5. The Credit Union Act already imposes a February 5th deadline in Title 6 O.S. § 2001.2.

Rule 180:10-1-16 (Suspicious activity reports) is a new rule that requires credit unions to file with the Department a copy of each suspicious activity report that it files with the federal government.

Rule 180:10-1-17 (Credit union branches) is a new rule relating to branch locations established by credit unions. The new rule requires credit unions to file an application with the Department and pay a \$400 fee. Department policy has required credit unions to file branch applications with the Department and receive approval from the Commissioner since 2005. The fee associated with the applications is new and is intended to defray the Department's

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personnel costs associated with processing, review, and analysis of the branch application. This fee is authorized by Title 6 O.S. 2001.2(A)(9).

Subchapter 3. In rule 180:10-3-1, it is clarified that a new credit union must have share insurance from the National Credit Union Administration ("NCUA") before it can be approved by the Board. In rule 180:10-3-3, the procedure for converting from a state-chartered credit union to a mutual savings bank is set forth - with an emphasis on federal law (*i.e.*, NCUA rules).

Rule 180:10-3-5 (Community field of membership) is amended to remove references to "rural service area" as a type of authorized community. Changes are also made to rule 180:10-3-5 to address the situation where the boundaries of a credit union's community (metropolitan statistical area) have been adjusted based on the latest census data.

Rule 180:10-3-8 (Field of membership list) is amended to remove the requirement to notify the Department of periodic changes to a credit union's list of select groups in its field of membership. Annual notification is still required.

Rule 180:10-3-9 (Field of membership disaffiliation) is revoked as obsolete.

Subchapter 5. The primary changes to Subchapter 5 are to allow credit unions to offer any instruments and accounts authorized by the Act and to offer such other instruments and accounts as shall be approved by the NCUA for federally chartered credit unions. Rule 180:10-5-6 (Issuance of Accounts) is revoked because it limited the types of accounts that credit unions could offer. Changes are made to Rule 180:10-5-1 regarding the circumstances for imposing dormant account fees. Also, the amount of the dormant account fee was removed.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 1. DEPARTMENT AND BOARD REQUIREMENTS

180:10-1-2. Definitions

The following words or terms, when used in this chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Act" means the Oklahoma Credit Union Act (6 O.S., §2001 et seq.).

"Adjustable rate mortgage loan" means a mortgage loan secured by a ~~first~~ lien on residential real property which permits the periodic adjustment of the rate of interest on the loan in response to the movement of an index which was agreed upon in advance by the borrower and the credit union.

"Administrative Procedures Act" means the Administrative Procedures Act of Oklahoma (75 O.S., §301, et seq.).

"Applicant" means a party commencing a proceeding either in the form of an Application or Complaint; and includes the terms "plaintiff", "complainant" and "petitioner".

"Attorney" means a licensed attorney currently admitted to practice before the Supreme Court of Oklahoma, or an attorney currently licensed to practice in another state who is granted permission to appear in a proceeding in this state. No attorney who is not currently licensed to practice in Oklahoma

~~shall be permitted to appear except in association with an attorney so licensed to practice in Oklahoma who shall also appear in the proceeding. An attorney licensed to practice in a state permitting attorneys of this state to practice before its state courts without local counsel may appear without association of local counsel.~~

"Board" means the Oklahoma State Credit Union Board.

"Branch" means any place of business owned or leased by the credit union, other than the credit union's main office location, at which deposits are received, checks paid, and money loaned.

"Capital", as referred to in the ~~Oklahoma Credit Union Act~~ and in the rules of this chapter shall consist of the shares and deposits plus post-closing undivided earnings held by state-chartered credit unions.

"Certificate of deposit account" means an account represented by a ~~Certificate of Deposit~~ certificate of deposit as defined in this section.

"Certificate of deposit" or **"Share certificate"** means a written instrument or special account in a given amount for a given period of time ~~with a specified rate of interest. that will earn interest or dividends at a particular rate (subject to conditions) if held to maturity and on which a penalty may be assessed for withdrawal of all or any portion of the principal amount prior to maturity, with certain exceptions.~~ Certificates of ~~Deposit~~ deposit and share certificates shall be considered a part of the capital.

"Commissioner" means the Oklahoma Bank Commissioner, who presides as Chairman of the Board.

"Community Credit Union" means a credit union that has as its field of membership one of the following:

- (A) a political subdivision;
- ~~(B) a rural service area;~~
- ~~(C)~~ (B) an Oklahoma Metropolitan Statistical Area; or
- ~~(D)~~ (D) such non-standard community as the Board shall approve.

"Credit union" means a credit union organized under the laws of Oklahoma.

"Department" means the Oklahoma State Banking Department.

"Financial institution" shall mean a credit union, trust company, bank, savings bank or savings and loan association.

"Federally insured" shall mean that the institution's deposits are insured by the Federal Deposit Insurance Corporation or National Credit Union Administration, or any successor agency thereof.

"Intervenor" means a party not an applicant or named respondent who obtains permission to enter the proceeding. An intervenor opposing an application will thereafter be deemed a respondent.

"Metropolitan Statistical Area" or **"MSA"** means an area designated by the Federal Office of Management and Budget which consists of a county or group of adjoining counties that contain at least one urbanized area of 50,000 inhabitants or more.

"Minimum balance share or Deposit account" means an account which requires the owner to maintain a specific balance in the account for the entire dividend period.

"Multiple common bond" shall mean a credit union that has as its field of membership select employee groups and/or select associational groups, and which groups have, as to each individual group, a common bond of occupation or association, but, as to all groups, need not have the same common bond of occupation or association as other groups within the credit union.

"NCUA" means the National Credit Union Administration.

"Net earnings" means the balance after deducting from the gross income a credit union actually receives during a dividend period, all expenses paid or payable during such period, dividends on shares, interest on deposits, statutory reserves and any losses sustained therein for which no specific reserve has been set aside, or for those credit unions on an accrual basis, net earnings shall mean the balance after deducting from the gross income a credit union actually receives or accrues during a dividend period, all expenses paid or payable, all interest accrued, dividend on shares, interest on deposits, statutory reserves during such period and any losses sustained therein for which no specific reserve has been set aside.

"Non-standard community" shall mean a well-defined community, neighborhood, or rural district whose residents have common interests or interact. An OMSA, or political subdivision, and rural service area shall not be considered a non-standard community.

"Notice share or Deposit account" means an account which may require the owner to give written notice of the intent to withdraw, in addition to any notice as may be required in credit union bylaws.

"Oklahoma Metropolitan Statistical Area" or **"OMSA"** means any one of the ~~four~~ areas, located entirely within the state of Oklahoma, designated by the Federal Office of Management and Budget as a Metropolitan Statistical Area, as amended from time to time. The four OMSAs and the county/counties of which they are comprised are as follows:

- (A) "Enid OMSA," comprised of Garfield county;
- (B) "Lawton OMSA," comprised of Comanche county;
- (C) "Tulsa OMSA," comprised of Osage, Creek, Rogers, Wagoner, and Tulsa counties; and
- (D) "Oklahoma City OMSA," comprised of McClain, Cleveland, Pottawatomie, Oklahoma, Canadian, and Logan counties.

"Order" means that which is required or ordered to be done, or not to be done and shall be generally reserved for the requirement or directive portion of an official order or decisions of a proceeding; or the promulgation of rules, regulations, and requirements in matters in which the Board or Commissioner acts.

"Party", as used in this chapter, means a party of record and every other party having interest in the subject matter, and entitled to appear therein as a party of record.

"Party of record" means any party named a party in a pleading, or who makes formal appearance either in person or

by an attorney at any stage of the proceeding, whether or not seeking affirmative relief.

"Political subdivision" means a county, city, town or other municipal corporation, a public authority, and any other publicly owned entity which is an instrumentality of a state of the United States or a municipal corporation.

"Primary member" means an individual who is directly eligible for credit union membership because of the individual's employment, group association, or community relationship. ~~An individual whose eligibility relies on his or her status as a family member to a primary member is considered a secondary member.~~

"Protestant" ~~means a party who, upon grounds of private or public interest, resists an application or any relief sought thereby. A protestant is governed by the rules applicable to a respondent.~~

"Record" or **"Formal record"** of any proceeding shall consist of the following, where offered at the hearing, whether or not received:

- (A) Preliminary exhibits, including pertinent pleadings, notices and proof of publication.
- (B) Transcript of proceedings at all hearings.
- (C) Depositions, stipulations, interrogatories and answers, written testimony, offers of proof, and similar matters.
- (D) Exhibits, together with attachments, appendices and amendments thereto.
- (E) Exceptions and motions subsequent to the hearing.
- (F) Orders or Recommendations of the Board or Commissioner, together with findings of fact and conclusions of law.
- (G) ~~The Board or Commissioner may order included in the record any other instruments or matters relevant to issues.~~

"Regular share" or **"Deposit account"** means an account which does not require the owner to maintain a minimum balance greater than the par value of a share except a nominal minimum relating to the cost of maintaining an account, or to give notice of intent to withdraw, except as may be required in credit union bylaws.

"Respondent" means a party against whom relief is sought in a proceeding, or who appears in opposition to relief sought by the applicant, and includes the term "Defendant".

"Rural Service Area" means any one of the following six geographic areas, comprised of contiguous counties, designated by the Oklahoma Department of Community Development:

- (A) "Southeast Oklahoma," comprised of Latimer, Haskell, McCurtain, Choctaw, Pushmataha, Pittsburg, Atoka, Bryan, Coal, Hughes and LeFlore counties;
- (B) "North Central Oklahoma," comprised of Alfalfa, Major, Blaine, Kingfisher, Grant, Kay, Noble, Pawnee, Lincoln, and Payne counties.
- (C) "Southwest Oklahoma," comprised of Beckham, Washita, Caddo, Cotton, Tillman, Jackson, Harmon, Greer, and Kiowa counties.

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~~(D) "South Central Oklahoma," comprised of Grady, Stephens, Jefferson, Garvin, Murray, Carter, Love, Seminole, Pontotoc, Johnston, and Marshall counties.~~

~~(E) "Northeast Oklahoma," comprised of Muskogee, McIntosh, Okfuskee, Washington, Nowata, Craig, Ottawa, Delaware, Adair, Sequoyah, Mayes, Cherokee, and Okmulgee counties.~~

~~(F) "Northwest Oklahoma," comprised of Woods, Ellis, Beaver, Cimarron, Harper, Roger Mills, Custer, Texas, and Woodward counties.~~

"**Select associational group**" means a group whose members participate in activities developing common loyalties, mutual benefits, and mutual interests. A select associational group shall not include a political subdivision, OMSA, rural service area, or any association formed only to qualify for membership in a credit union.

"**Select employee group**" means a group whose members are employed by the same legal entity or such entity's affiliates. For purposes of this definition, the term "affiliate" shall mean any company that controls, is controlled by, or is under common control with, the legal entity.

"**Share certificate account**" means an account that will earn dividends at a particular rate (subject to conditions) if held to maturity and on which a penalty may be assessed for withdrawal of all or any portion of the principal amount prior to maturity, with certain exceptions.

"**Share draft/Checking account**" means a Regular Share or deposit account, set separate and aside from all other accounts, upon which the owner is permitted to draw drafts as provided for in 180:10-5-5.

"**Single common bond**" shall mean a credit union that has as its field of membership select employee groups or select associational groups with a single common bond among all groups.

"**Surplus**" means the credit balance of the undivided earnings account on the given date after all losses have been provided for and net earnings or net losses have been added thereto or deducted therefrom, as the case may be.

"**Trusteed and custodial pension fund share, deposit or share certificate account**" means an account which qualifies as an individual retirement account for a member pursuant to 26 U.S.C., Section 408, or Keogh (HR 10) Plan as established pursuant to 26 U.S.C., Section 401.

"**Variable rate loan**" means any loan other than an adjustable rate mortgage loan defined in this section which permits adjustment of the interest rate on the loan in response to the movement of an index.

180:10-1-3. Description of forms and instructions

(a) The Department may develop forms for use by credit unions in conducting various activities and requirements and may accept, in lieu of its own forms, forms prescribed by the NCUA relating to the same or similar subject matter. Included among the forms that the Department may develop are the following:

(a 1) The form of an application to engage in business as a credit union shall be prescribed in 180:10-3-1-;

~~(b 2) The form of bylaws of that may be used by a credit union shall be prepared by the Board, consistent with the Act, which may be used by the credit union and shall be supplied upon request.;~~

~~(e 3) The form of an oath to be administered and signed by all directors of each state credit union on an annual basis.;~~

~~(d 4) The form to be used by a group to request affiliation with a credit union.;~~

~~(e 5) The form on which a report of condition must be made. (Call Reports); and~~

~~(f 6) The form for annual listing of Small Employee Groups select groups within a credit union field of membership at the end of each fiscal year.;~~

(g b) Other forms and instructions used by may be developed and prescribed by the Commissioner or the Board and shall be available at the office of the Board and shall be furnished to any interested party upon request.

180:10-1-4. Change in name

~~(a) **Board of Directors vote.** The credit union desiring to change its name shall furnish to the Board evidence of an affirmative majority vote of the petitioning credit union's Board of Directors approving the name.~~

~~(b) **Board review of name.** Upon receipt of the resolution, the Board shall review the names of credit unions in the community, and shall review the files of the Secretary of State to determine that the proposed name is not similar to any other corporation in the community, or having been in the community.~~

~~(c) **Board determination.** With this review, the Board shall make the sole determination as to the proposed name being the same, deceptive or misleading, and shall so notify the credit union.~~

~~(d) **Amended articles of incorporation.** The Board shall furnish two (2) copies of the necessary forms to be used for amending the credit union's Articles of Incorporation. The credit union shall complete the forms and return both sets to the Commissioner's office, together with two (2) certified copies of the resolution adopted by a majority of the Board of Directors which resolution appears in the minutes of their meeting, in connection with the change of name. These amended articles shall be accompanied by two (2) checks, one made payable to the State Bank Commissioner in the amount of Ten Dollars (\$10.00), for approving the documents, and one check, in blank, made payable to the Secretary of State for his fees due in connection with filing.~~

~~(e) **Amended articles filed; filing fee; effective date.** Immediately upon receiving the properly executed documents from the credit union, the Commissioner shall file the documents with the Secretary of State, after which he will return a certified copy to the credit union and the required number to the National Credit Union Administration. One (1) set will be retained for the Department's files. The blank check will be filled in by the office of the Secretary of State when the filing fee has been determined. The change in name shall not be effective until the Secretary of State has approved the articles.~~

(a) A credit union desiring to change its name shall furnish the following to the Commissioner:

(1) a resolution by the board of directors approving the new name, which resolution appears in the minutes of their meeting; and

(2) proposed amended corporate documents evidencing the new name;

(b) After the credit union has been notified of the Commissioner's approval of its new name, it must file the necessary corporate documents with the Oklahoma Secretary of State and must submit certified copies of such filed documents to the Department and to the National Credit Union Administration.

(c) It shall be the credit union's responsibility to review governmental records with respect to the availability for use of the new name as well as whether the new name or mark used in connection with the new name will violate or infringe on some other company's name or mark. Any approval provided by the Commissioner will not be taken to mean that such new name or mark is available or eligible for use in any community nor will it mean that such new name or mark does not infringe on the rights of any other company.

(d) In advance of obtaining the Commissioner's approval of its new name, the credit union may take action necessary to reserve the proposed name at the office of the Oklahoma Secretary of State.

180:10-1-5. Bond requirements; schedule

(a) The following schedule shall be deemed as the minimum amount fixed by the State Credit Union Board for the bond provided in Title 6 O.S. Section 2010(B).

<u>Assets</u>	<u>Minimum Coverage</u>
<u>\$0,000 to \$10,000</u>	<u>coverage equal to amount of assets</u>
<u>\$10,001 to \$1,000,000</u>	<u>\$10,000 for each \$100,000 increment or fraction thereof</u>
<u>\$1,000,001 to \$50,000,000</u>	<u>\$100,000 plus \$50,000 for each million or fraction over a million</u>
<u>\$50,000,001 to \$295,000,000</u>	<u>\$2,550,000 plus \$10,000 for each million or fraction thereof over \$50,000,000</u>
<u>over \$295,000,000</u>	<u>\$5,000,000</u>

(1) Assets of \$0 through \$10,000; Minimum coverage equal to amount of assets.

(2) Assets of \$10,001 through \$4,000,000; Minimum coverage equal to the lesser of total assets or \$250,000.

(3) Assets of \$4,000,001 through \$50,000,000; Minimum coverage equal to \$100,000 plus \$50,000 for each million or fraction thereof over \$4,000,000.

(4) Assets of \$50,000,001 through \$500,000,000; Minimum coverage equal to \$2,550,000 plus \$10,000 for each million or fraction thereof over \$50,000,000, to a maximum of \$5,000,000.

(5) Assets over \$500,000,000; Minimum coverage equal to one percent (1%) of assets, rounded to the nearest one hundred million, to a maximum of \$9,000,000.

(b) No deductible may exceed 10% of the credit union's regular reserve unless the credit union creates a special segregated contingency reserve in the amount of the excess. Valuation allowance accounts (allowance for loan losses) may not be considered part of the reserve when determining the maximum deductible.

180:10-1-6. Approved auditors

(a) The supervisory committee, with the approval of the board of directors, may further employ any auditor, licensed public accountant, or any certified public accountant licensed public accountant or certified public accountant authorized to practice in Oklahoma.

(b) The supervisory committee, with the approval of the board of directors, may further employ any auditor listed in the office of the State Bank Commissioner on the official approved list of auditors, which list may be changed from time to time by the State Credit Union Board.

(c) Each auditor, other than licensed public accountants and certified public accountants licensed public accountants or certified public accountants authorized to practice in Oklahoma, seeking approval, shall make application on a form prescribed by the Commissioner, prior to their approval, and indicate thereon their qualifications. Their approval shall be at the sole discretion of the Oklahoma State Credit Union Board. Upon its own motion, the State Credit Union Board may remove any previously approved auditor. The Board shall review the list of approved auditors no less than once per calendar year.

180:10-1-7. Bylaw amendments

(a) Requests for approval of amendments to a credit union's bylaws must be submitted in writing [an original and one copy] at least two (2) weeks in advance of the State Credit Union Board's regularly scheduled meeting.

(b) The form of the requested amendment for which approval is requested should be as follows:

(1) For each amendment requested, the provisions as currently contained in the bylaws should be typed in their present form.

(2) These should then be lightly crossed out and immediately below should be the requested bylaw language change.

(c) The amendment is to be accompanied by a detailed explanation as to reason and effect, and other pertinent data, if requested by the Department.

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180:10-1-8. Corporate central credit union organization and operation

(a) **Scope.** This ~~Section~~ section sets forth provisions relating to the organization and operation of a corporate central credit union in Oklahoma pursuant to the provisions of Title 6 O.S. § 2007. The provisions of this ~~Section~~ section are intended to implement and carry out the laws of this state for the organization and operation of a corporate central credit union to serve other credit unions wherein such organization and operation may differ from the organization and operation of any other credit union, and shall supersede any conflicting provisions of other rules promulgated by the Board insofar as such other rules may pertain to a corporate central credit union.

(b) **Definition.** A corporate central credit union is a central credit union organized under the laws of Oklahoma ~~(6 O.S. § 2007)~~ to which other credit unions organized under the laws of this state and of the United States may belong, whose primary purpose is to serve other credit unions, and to which only a limited number of natural persons and other incorporated and unincorporated organizations may be elected to membership as may be provided in its bylaws.

(c) **Organization.** The ~~Articles of Incorporation certificate of incorporation~~ of a corporate central credit union shall contain the words "Corporate Credit Union" in its name and shall be approved by the Board. No credit union other than a corporate central credit union shall use the word "corporate" in its name. The bylaws of a corporate central credit union shall conform to the provisions of this ~~Section~~ section and shall be approved by the Board.

(d) **Powers.** A corporate central credit union shall have all the powers of a credit union under the provisions of Title 6 O.S. § 2006, including but not limited to the following powers as hereinafter specifically limited, all of which are deemed by the Board to be incidental, necessary and requisite for the purpose of primarily serving other credit unions:

(1) To make loans to its corporate members or invest its funds in loans exclusively to its corporate members. No loans shall be made to a natural person member. A corporate central credit union, organized primarily to serve other credit unions, is not subject to any limitation upon the total amount of loans to other credit unions which have been duly elected to membership, except as may be specifically prescribed by rule or regulation of the Board.

(2) To receive from its corporate member payments on shares and deposits and to require such notice for withdrawal of shares and deposits as the bylaws may provide. The bylaws shall limit the payments on shares and deposits of any natural person member to a relatively nominal amount. A corporate central credit union, organized primarily to serve other credit unions, is hereby approved by the Board as a depository for other credit unions and no limitation shall apply to the investment of funds of other credit unions in shares of and deposits to a corporate central credit union, except as may be specifically prescribed by rule or regulation of the Board.

(3) To invest its funds in the shares or deposits of other credit unions in a total amount not exceeding twenty-five percent (25%) of the paid-in or unimpaired capital and

surplus of the corporate central credit union, provided that such limitation shall not apply to an investment in the shares or deposits of other credit unions approved by the Board as a depository under Title 6 O.S. § 2006(9).

(e) **Accounts.** The board of directors of a corporate central credit union, by resolution, may establish ~~Share accounts with varying dividend rates and periods, Share Certificate accounts with varying dividend rates, periods and maturities, Deposit accounts with varying interest rates, periods and maturities, share draft accounts, and money market accounts~~ as the board of directors may from time to time determine, subject to the following terms and conditions:

(1) Provision shall first be made for such reserves as may be required by law and by the bylaws of the corporate central credit union;

(2) Dividends declared and interest paid ~~may exceed seven percent (7%) but shall in no event exceed available earnings; provided, however, that the board of directors may determine that adequate earnings are available through projections thereof.~~ surplus;

(3) ~~Share Certificate~~ certificate accounts and ~~Certificate Deposit~~ certificate of deposit accounts may be evidenced by book entries without the issuance of a written certificate; and

(4) Penalty provisions required by law for withdrawal of all or any portion of an account without notice or before maturity may be disclosed to corporate members by and through a written statement of policies adopted by the board of directors and delivered to the corporate members.

180:10-1-11. Records and retention

~~(a) If the retention period required by any state or federal laws or regulations, whether now in effect or hereafter enacted, differs from the retention period required by this Section, compliance with such other state or federal laws or regulations shall be deemed to constitute compliance with this Section.~~

~~(1) Regulatory communication.~~

- ~~(A) Annual report to regulator—Permanent~~
- ~~(B) Reports of Examination—Permanent~~
- ~~(C) Call Reports—Permanent~~
- ~~(D) Certificate of License to operate under various government programs—Dependent on duration of license~~
- ~~(E) Specific authorizational or directive correspondence with regulator (i.e., Cease and Desist Orders, Letters of Understanding, recurring financial reports, etc.)—Permanent~~
- ~~(F) Manuals, circulars, official instructions—Permanent~~

~~(2) Administrative records.~~

- ~~(A) Certificate of Organization (Charter)—Permanent~~
- ~~(B) Bylaws and amendments—Permanent~~
- ~~(C) Minutes of membership meetings—Permanent~~
- ~~(D) Minutes of Directors meetings—Permanent~~
- ~~(E) Supervisory Committee minutes, reports, attachments—Permanent~~
- ~~(F) Credit Committee minutes—Permanent~~

- (G) Reports of loan officers—Permanent
 - (H) Reports of Credit Manager—Permanent
 - (I) Miscellaneous committee reports—Permanent
 - (J) New and closed account reports—6 years
 - (K) Monthly financial/statistical reports—6 years
 - (L) Annual financial/statistical report before and after closing—Permanent
 - (M) Escheating of accounts reports—Permanent
 - (N) Records of record destruction—Permanent
 - (O) Delinquent loan reports—6 years
 - (P) Membership register—Permanent
- (3) **Member account evidence and activity.**
- (A) Agreements/application for closed membership and signature cards—Permanent after account
 - (B) Agreements/applications for trust accounts—6 years after account closed
 - (C) Agreements/applications for specialized accounts—6 years after account closed
 - (D) Joint account agreements—6 years after account closed
 - (E) Certificates of deposit or share certificates—5 years after redeemed
 - (F) Payroll deduction authorization—Dependent on duration or until replaced by subsequent document
 - (G) Third party payment authorization—Dependent on duration or until replaced by subsequent document
 - (H) Transaction records of international "transfer of funds" of \$10,000 or more—5 years
 - (I) Form 4790 report of international transactions of currency or monetary instruments (\$5,000 or more)—5 years
 - (J) Transaction records of currency transactions of \$10,000 or more/Form 4789 Currency Transaction Report—5 years
 - (K) Each deposit slip or credit ticket for each transaction over \$100—5 years
 - (L) TIN, name and address for each certificate of deposit or share certificate sold or redeemed—5 years
 - (M) Each document granting signature authority over each deposit or share account—5 years
 - (N) Each statement, ledger/card or other record showing each transaction in, or with respect to a deposit or share account—5 years
 - (O) Each item over \$100 which is a debit to a member's account, EXCEPT charges or periodic charges made under agreement with a member—5 years
 - (P) Designation of Beneficiary Cards—6 years after account closed
 - (Q) Individual share, deposit, loan ledgers (non EDP credit unions)—Permanent
 - (R) Member account statements—Permanent
 - (S) Court orders, judgments, garnishments, inquiries of credit union held member accounts—10 years
 - (T) Specialized agreements or instructions on credit union held member accounts—6 years after account closed
 - (U) Documentation concerning death, disability or other insurance claims involving member accounts—6 years
 - (V) Evidence of compliance with requirements of Consumer Leasing Act—2 years
 - (W) Evidence of compliance with requirements of Regulation E (Electronic Funds Transfer Act)—2 years
 - (X) Evidence of compliance with checkhold regulations (funds availability disclosures)—5 years
 - (Y) Member account transfer authorization—6 years
 - (Z) Cash withdrawal authorizations—6 years
 - (AA) Loan transfer summaries—6 years
 - (BB) Daily report of overdrafts—Dependent, may be destroyed after transfer to month end or annual report
 - (CC) Undelivered statements—5 years
 - (DD) Liens and/or levys—5 years
- (4) **Financial operations.**
- (A) General ledger—Permanent
 - (B) Journal or cash record—Permanent
 - (C) Subsidiary ledgers—Permanent
 - (D) Cancelled/voided checks or drafts—Permanent, may be microfilmed
 - (E) Certified checks—Permanent
 - (F) Money orders and register—5 years
 - (G) Credit union depository statements—Permanent
 - (H) Cash reconciliation—Permanent
 - (I) Cash receipts—6 years
 - (J) Cash disbursement vouchers—6 years
 - (K) Journal vouchers—6 years
 - (L) Payroll deduction detail—6 years
 - (M) Proof tapes of individual share and loan ledgers (if applicable)—2 years
 - (N) Dividend, interest refund, calculation and payment records—6 years
 - (O) Paid bill and invoices—6 years
 - (P) CPA Reports—Permanent
 - (Q) Documentation/agreements relating to the investment of credit union funds—6 years after expiration of agreement
 - (R) Documentation/agreements relating to credit union borrowed funds—6 years after expiration of agreement
- (5) **Lending documentation.**
- (A) Required loan disclosures, paid notes and supporting loan documentation (i.e., extension agreements, co-maker statements, waivers, etc.)—2 years after loan is repaid
 - (B) A record of each extension of credit over \$10,000—5 years
 - (C) Evidence of performance of required actions (i.e., handling billing disputes, etc.)—2 years
 - (D) Loan application rejected, withdrawn, incomplete—25 months

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- (E) Loan application—approved—2 years after loan is repaid
 - (F) Written or recorded information used in credit evaluation—25 months
 - (G) Written notification of action taken on the application or any Memorandum or notation or oral action—25 months
 - (H) Adverse Action Notice—25 months
 - (I) Written statement to credit union by applicant alleging discrimination under Equal Credit Opportunity Act—25 months
 - (J) Any compliance monitoring—5 years
 - (K) Uniform Settlement Statement (Form) HUD-1, Good Faith Estimates, and Right of Rescission Disclosure—5 years from settlement date Mortgage
 - (L) Loan Disclosure Statements (Form HMDA-1)—5 years
 - (M) Real estate lending by Census Tract Report—5 years
 - (N) Lienholder notices on items requiring collateral insurance—6 years
 - (O) "Intent to repossess" correspondence—6 years
 - (P) Documentation concerning liquidation of reposed collateral—6 years
 - (Q) Torrens certificates—Dependent on duration of loan
 - (R) Title insurance/opinions, appraisals, etc.—Dependent on duration of loan
 - (S) Flood insurance information/disclosures—Dependent on duration of loan
 - (T) FHA (or similar) insurance claim documentation—6 years
 - (U) Closed collection files—2 years after close
 - (V) Delinquent loan schedule—7 years, may be microfilmed
- (6) **Data processing reports.**
- (A) Trial balances (month end)—2 years
 - (B) Trial balances (other)—Examination to examination
 - (C) Transaction registers/activity edits—2 years
 - (D) Management reports (i.e., new member, closed accounts, new loans, paid loans, overdrawn accounts, etc.)—Examination to examination
 - (E) Delinquency reports—6 years
 - (F) Dividend and interest payments (reports/calculations)—6 years
 - (G) ACH transaction edit—Optional
 - (H) Master file changes—Examination to examination
 - (I) Share draft exceptions/Transmission Reports—Examination to examination
 - (J) Member statements—Permanent (may be microfilmed after audit and examination)
 - (K) Member 1099 information—6 years
 - (L) Payroll registers—Optional
- (7) **Personnel.**
- (A) General employment records (i.e., promotions, demotions, employee rebuttals/ responses, transfers, layoffs, terminations, etc.)—1 year
 - (B) Earnings records—4 years
 - (C) Test papers of employment tests—1 year
 - (D) Results of physical examinations—1 year
 - (E) Advertising for hiring personnel—1 year
 - (F) Employment eligibility—3 years
 - (G) Verification (Form I-9)—1 year after employment ends
 - (H) EEO-1 Reports (Equal Employment Opportunity) Note: 100 employees or more—Indefinite
 - (I) Written affirmative action plans—Unspecified
 - (J) Records of occupational injury, illness—3 years
 - (K) Records of Retirement Plan Note: plan descriptions, annual reports ERISA—6 years after initial filing
 - (L) Records of employment complaints and action taken—1 year
 - (M) Employees payroll/earnings records—4 years
 - (N) Earnings records (time cards, rate tables, work schedules)—2 years
 - (O) Records of additions to or deductions from wages paid—2 years
 - (P) Certificate of Age—Dependent on duration of employment
 - (Q) Written training agreements—Dependent on program duration
 - (R) Job orders to employment agencies—1 year
 - (S) Collective bargaining agreements—6 years
 - (T) Employment contracts (group or individual)—1 year after expiration date
 - (U) Performance evaluations, written warnings, employee grievances—6 years
 - (V) Written allegations—3 years
 - (W) Rejected employment application—3 years
 - (X) Employment applications—6 years after cessation of employment
 - (Y) Employee's name and home address; occupation and rate of pay; amount paid each day and week, including starting and ending hours each day with morning and afternoon designations—3 years
- (8) **General operations.**
- (A) Insurance policies/endorsements for credit union (fire and casualty, liability, etc.)—6 years after contract expires
 - (B) Chattel lien non-filing insurance record (repaid loans)—6 years after loan is repaid
 - (C) Master contracts member group insurance (i.e., life savings, loan protection)—6 years after contract expires
 - (D) Claim documentation (member and credit union coverage)—6 years
 - (E) Bonding claim notifications, bonding agreements and endorsements—6 years
 - (F) Documentation covering credit union owned property (i.e., deeds, abstracts, titles, etc.)—Permanent

- (G) Major equipment warranties maintenance agreements—Dependent on duration of agreement
- (H) Contracts with professional service or product providers—6 years after contract expires
- (I) Specific legal opinions (permissive)—Dependent Note: Consult issuing attorney
- (J) Documentation of legal actions of which credit union is a party—Dependent Note: Consult attorney representing credit union
- (K) Registered mail (Incoming and outgoing)—6 years
- (L) Investments Note: Records help formulate—Permanent investment policies

(9) **Tax reporting.**

- (A) Form 990 return or organization exempt from income tax—6 years from date tax was due or paid, whichever is later
- (B) Form 990T unrelated business income reporting—6 years from date tax was due or paid, whichever is later
- (C) IRS Tax Exemption approval letter (original form)—Permanent
- (D) Federal Tax Identification number assignment—Permanent
- (E) IRS approval letter concerning qualified pensions, retirements, etc. (annual)—6 years after expiration of program
- (F) Form 941 employer's quarterly federal tax return (and records of monthly deposits if required)—4 years
- (G) Form 940 employer's annual federal return—4 years
- (H) Form W 2 employee's wage and tax statement—4 years
- (I) Form W 3 reconciliation of income tax withheld from wages—4 years
- (J) Form W 4 employee's withholding certificate—4 years after cessation of employment
- (K) Form W 8 certification of foreign tax status (member) Permanent (accounts opened after 12-31-83)
- (L) Form W 9 (or similar) tax identification number certification (member) Permanent (accounts opened after 12-31-83)
- (M) Federal and state tax reports concerning member accounts (i.e., 1099s, 1098s, 1096s, IRA reports etc.)—6 years

(b) Except as otherwise expressly required by applicable state or federal laws or regulations, the preservation or retention of accurate reproductions of original documents shall constitute full compliance with this Section. As used in this Section, "reproduction" shall mean a reproduction of an original document or any durable medium for making a reproduction of an original document obtained by means of any photographic, photostatic, optical disc or other reliable process or technology which accurately reproduces or forms a durable medium for reproducing original documents.

(a) When any law of the state of Oklahoma or federal law requires the retention of a specific record or a specific class, type or category of records for a certain period of time, a credit union shall retain its records falling within such class, type or category for the time period required by such law. If no Oklahoma state law or federal law prescribes a retention period for a specific record or a specific class, type or category of records, a credit union must retain such records for the period of time that would be necessary to prosecute or defend an action for which such records would be required in the prosecution or defense of the action.

(b) The Commissioner may issue orders from time to time, with the approval of the Board, that require credit unions to retain certain records or a certain class, type or category of records for a period of time that is longer than may be required under subsection (a) of this section.

(c) Any credit union may dispose of any record which has been retained for the prescribed period and shall, after it has disposed of a record, thereafter be under no duty to produce such record in any action or proceeding.

(d) In lieu of retention of the original records, any credit union may cause any, or all, of its records to be photographed and/or stored by electronic imaging or other reliable process or technology that accurately reproduces or forms a durable medium for reproducing the original records. Any such photograph, imaged document, or other reproduction shall have the same force and effect as the original thereof and be admitted in evidence equally with the original.

180:10-1-12. Reporting changes in executive officers, directors and committee members

(a) Every credit union shall report to the Commissioner promptly within 30 days any change for whatever reason in the credit union's executive officers, directors and committee members and as part of such report, shall provide the name, home and business addresses (no P.O. Boxes), current occupation or business and shall indicate whether they have previously or are now serving on the board of or have been employed by a federally insured or state chartered financial institution and if so, shall identify by name and location (city and state) each such institution.

(b) ~~In the event a Notice of Proposed Change in Official or Executive Officer notice of change~~ is to be submitted to the National Credit Union Administration ("NCUA") NCUA pursuant to Section 212 the requirements of the Federal Credit Union Act, 12 U.S.C. §1791, copies of the same shall at the same time as they are provided to the NCUA, be provided to the Commissioner.

(c) Definitions for the following terms as used in this Section are:

(1) "Committee members" shall mean those members of the committees identified in Title 6 O.S. §2010(D)&(E), as members of the credit committee and supervisory committee.

(2) "Executive officers" ~~are identified by 6 O.S. §2010(B) as executive officers of the credit union and in addition, shall include an officer in charge of operations whatever his/her title, as likewise identified in §2010(B)~~

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all board members, the manager of the credit union (whatever his/her title), the secretary, the treasurer, the credit manager, and any other officer in charge of credit union operations.

~~(3) "Financial institution" shall mean a credit union, trust company, bank, savings bank or savings and loan association.~~

~~(4) "Federally insured" shall mean that the institution's deposits are insured by the Federal Deposit Insurance Corporation or National Credit Union Administration, or any successor agency thereof.~~

180:10-1-13. Prohibition against credit unions employing, electing or appointing certain individuals and Credit Union Board's power to enforce

(a) A person may not serve and a credit union may not employ, appoint or elect a person as an officer, director, or committee member of a credit union if after notice and opportunity for hearing before the Board pursuant to the Oklahoma Administrative Procedures Act, the Board determines that he/she:

(1) Has been convicted of or plead guilty to a felony in any state or of a criminal offense involving dishonesty, a breach of trust, or fraud;

(2) As an officer, director, committee member, or employee of any federally insured or state chartered financial institution, has been suspended, removed from service with a federally insured or state chartered financial institution by a federal or state regulatory body or has resigned from such an institution as a result of regulatory or civil proceedings for his/her removal or suspension from such institution;

(3) Is unfit to serve in such a capacity or unfit to participate in the conduct of the affairs of a credit union, as determined by the Board pursuant to Rule 180:10-5-9;

(4) Has failed to obey an ~~Order~~ order of the ~~State Credit Union Board or Bank-Commissioner~~ without legal justification therefor.

(5) Fails to obtain a surety bond for protection of the credit union against his/her fraud or dishonesty as required by ~~6 O.S. Supp. 1992 §2010(b) the Act and Rule 180:10-1-5.~~

~~(6) Has been prohibited by an Order of the Board or of the National Credit Union Administration from participating in the affairs of a credit union.~~

(b) Provided, any person or credit union described in (a) of this Section ~~shall may~~ obtain an exception to this ~~Section section~~ from the Board upon a showing of good cause for the grant of such an exception.

(c) ~~Definitions for the following terms as used in this section are:~~

~~(1) "Financial institution" shall mean a credit union, trust company, bank, savings bank or savings and loan association.~~

~~(2) "Federally insured" shall mean that the institution's deposits are insured by the Federal Deposit Insurance Corporation or National Credit Union Administration, or any successor agency thereof.~~

180:10-1-14. Assessments

The Commissioner shall charge and collect an assessment from each state chartered credit union on each One Thousand Dollars (\$1,000.00) of assets, or major fraction thereof, at a rate prescribed by the Board. The assessment shall be based on the total assets of the credit union as of December 31 of each calendar year. Payment of the assessment shall be submitted by each credit union along with a form prescribed by the Commissioner no later than the following ~~January 31~~ February 5 of each calendar year.

180:10-1-15. Fees

(a) The following applications shall be accompanied by a ~~check made payable~~ payment to the ~~Commissioner~~ Department in an amount as prescribed below:

(1) Applications for merger or acquisition when the surviving credit union will be a state chartered credit union shall be accompanied by a fee of \$1,000 and a copy of the merger agreement or agreement of purchase. The ~~Credit Union~~ Board may waive the fee when the merger is required at the direction of a state or federal regulatory agency.

(2) Applications for merger or acquisition when the surviving credit union will be a federally chartered credit union shall be accompanied by a fee of \$800 and a copy of the merger agreement or agreement of purchase. The ~~Credit Union~~ Board may waive the fee when the merger is required at the direction of a state or federal regulatory agency.

(3) Applications for conversion from a state chartered credit union to a federally chartered credit union or other form of financial institution shall be accompanied by a fee of \$800.

(4) Applications for conversion from a federally chartered credit union to a state chartered credit union shall be accompanied by a fee of \$1,000. The applicant shall also pay the costs and fees associated with the special exam of the converting credit union.

(5) Applications for amendment to bylaws shall be accompanied by a fee of \$400.

(6) Applications to be heard by the Board to add a select associational group or select employee group shall be accompanied by a fee of \$400.

(7) Applications for a change to the credit union's field of membership shall be accompanied by a fee of \$800.

(8) Applications for an expansion of the credit union's investment powers shall be accompanied by a fee of \$800.

(9) Applications for an increase in the credit union's investment percentage in real estate, buildings, fixtures, furniture, and equipment shall be accompanied by a fee of \$800.

- (10) Applications for expansion of powers other than those listed in paragraphs (8) and (9) of this subsection shall be accompanied by a fee of \$800.
- (b) Other application fees may be charged to applicants based on other provisions of this Title or the Act.

180:10-1-16. Suspicious activity reports

Whenever a credit union submits a suspicious activity report to any federal regulatory authority pursuant to the requirements of the federal Bank Secrecy Act, the credit union must immediately submit a copy of the suspicious activity report to the Department. Provided, if the Department has electronic access to suspicious activity reports after they are submitted to a federal regulatory authority, the credit union need not submit an additional copy to the Department.

180:10-1-17. Credit union branches

- (a) No credit union shall be permitted to establish and operate a branch, or relocate a branch, except upon application to, and approval by, the Commissioner. A credit union's branch must be located on real property owned or leased by the credit union.
- (b) A credit union desiring to establish or relocate a branch shall submit to the Commissioner the original and one copy of an application on a form prescribed by the Commissioner. The application shall be executed by the applicant's managing officer. An application fee of \$400 must accompany each application.
- (c) The Commissioner may request additional information from the applicant and conduct such investigation as is considered appropriate.
- (d) If the Commissioner determines that the application should not be approved, the applicant may appeal the Commissioner's decision to the Board. In lieu of making the initial decision, the Commissioner shall have the absolute discretion to defer ruling on any application thereby allowing such application to be heard before the Board for approval or disapproval.

SUBCHAPTER 3. NEW CREDIT UNIONS, MERGERS, CONVERSIONS AND FIELD OF MEMBERSHIP

180:10-3-1. New credit union; organization

- (a) A credit union shall only be permitted to engage in business upon ~~authority of approval by the State Credit Union Board.~~ The request to establish a credit union shall be set forth in an application form and filed with the ~~Bank~~ Commissioner. The form of such application shall be prescribed by the ~~State Credit Union Board~~ Commissioner.
- (b) The application shall contain the following information:
- (1) Name of the proposed credit union;
 - (2) Statement of purpose;
 - (3) Place of business;

- (4) Declaration of field of membership, which shall be single common bond, multiple common bond, or community ~~credit union;~~
- (5) Term of existence, which shall be perpetual;
- (6) Number of directors;
- (7) Par value of shares;
- (8) Capital stock;
- (9) List of proposed directors, their addresses, and biographical information; and
- (10) Such other information as may from time to time be required by the ~~Bank~~ Commissioner or the ~~State Credit Union~~ Board.
- (c) No application shall be given favorable consideration by the ~~State Credit Union~~ Board unless it contains a provision that the credit union will obtain share/deposit insurance from the NCUA before accepting accounts.
- (d) No application shall receive favorable consideration by the ~~State Credit Union~~ Board that does not have a minimum of five hundred (500) prospective members.
- (e) An application must disclose to the Board the existence of any known overlap (other than community overlap) between the proposed field of membership of ~~Applicant~~ the applicant and any other credit union operating within the State of Oklahoma.
- (f) Copies of the notice of the ~~Application~~ application must be mailed by Applicant to all Oklahoma credit unions at least ten (10) days prior to the hearing.
- (g) ~~Application~~ An application fee in the amount of Five Hundred Dollars (\$500.00) shall be paid to the Department.
- (h) The Board may deny an application if the applicant does not appear to have satisfactory managing officers or sufficient capital to support its operations, or other conditions exist that indicate the proposed credit union cannot operate in a safe and sound manner.

180:10-3-3. Conversion requirements

- (a) To effect a conversion of charter, a credit union must comply with all requirements of the authority under which it was originally chartered and the requirements of the ~~State Credit Union~~ Board and file proof of such compliance with the ~~State Credit Union~~ Board.
- (1) ~~When converting~~ Conversion from a state-chartered credit union to a federally-chartered credit union.
- (A) Upon approval of the proposition to convert to a federal credit union by a majority of the board of directors, it shall set a date for a meeting of membership, at which the individual members shall have the option to vote on the proposition, either in person at the meeting, or by written ballot to be filed on or before the date of the meeting. The board of directors promptly shall notify the ~~State Bank~~ Commissioner, in writing, of its approval of the proposition to convert to a federal credit union and the date set for the meeting of the members.
- (B) Written notice of the meeting shall be delivered in person to such members, or ~~mailed to each member~~ sent to members in a format or medium

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by which members have agreed to receive account statements, at the address for such member appearing on the records of the credit union, not more than thirty (30) days nor less than seven (7) days prior to the date set for the meeting.

(C) In addition to setting forth the proposition for conversion and the date, time, and place of the meeting, the written notice of the meeting shall:

- (i) inform the members of the opportunity to vote by written ballot and when, where, and how (on or before the date of the meeting) such written ballot shall be filed, which may include filing by electronic means;
- (ii) contain a form of written ballot for the use of those members who will vote thereby instead of in person at the meeting; and
- (iii) set forth, for the advance consideration of the members, a brief and accurate statement of reasons for and against the proposed conversion, including the effect, if any, it will have upon share holdings and obligations of members, and the policies and practices of the credit union.

(D) A copy of the ~~written notice of the meeting notice~~, verified by the affidavit of the secretary of the credit union, shall be delivered to the ~~State Bank~~ Commissioner at the same time, in advance of the meeting, that ~~it~~ is delivered to the members.

(E) In order for the proposition for conversion to be approved and acted upon further by the credit union, it must receive the affirmative vote of a majority of the members voting.

~~(E)~~ A statement of the results of the member vote, verified by the affidavits of the president or vice president, and the secretary, shall be filed with the ~~State Bank~~ Commissioner within ten (10) days after the vote is taken.

~~(F) In order for the proposition for conversion to be approved and acted upon further by the credit union, it must receive the affirmative vote of a majority of the members voting.~~

(G) Within 30 days after receiving the statement of the results of the member vote, the Commissioner shall notify the credit union, in writing, of any findings, including the reasons therefor, that adversely affect the validity of the attempted conversion. If the requirements of this section have not been satisfied, the attempted conversion shall be ineffective and the credit union shall continue to be a state credit union, subject to the provisions of the Act, to the same extent as though the conversion had not been attempted.

~~(G)~~ H) If the proposition for conversion is approved by the affirmative vote of a majority of all the members voting, the board of directors, promptly and in no event later than ninety (90) days after such approval, shall take such action on behalf of the credit union as may be necessary under the applicable federal law for the conversion of a state credit union to the federal

~~credit union, to convert~~ the credit union to a federally-chartered credit union. In addition, the board of directors promptly shall inform the ~~State Bank~~ Commissioner of the action so taken and, from time to time, of the progress of such action.

(I) Within ten (10) days after the credit union receives a federal credit union charter, it shall file a copy thereof with the ~~State Bank~~ Commissioner. The ~~State Bank~~ Commissioner promptly shall notify the credit union, in writing, of the receipt of the national charter. The credit union shall cease to be a state-chartered credit union as of the close of business on the date such copy is received by the ~~State Bank~~ Commissioner, unless the credit union has been notified in writing or is notified in writing to the contrary, pursuant to ~~(H)~~ subparagraph (G) of this paragraph, or such later date as specified by the approval of the conversion by the NCUA. Upon ceasing to be a state credit union, such credit union shall no longer be subject to any of the provisions of the ~~State Credit Union Act~~, shall surrender its original charter certificate to the Commissioner, and shall file all appropriate documents with the Oklahoma Secretary of State necessary to reflect the conversion to a federal charter and the cessation of the credit union's state chartered organization. The successor federal credit union shall be vested with all the assets and shall continue to be responsible for all of the obligations of the state credit union to the same extent as though the conversion had not taken place.

~~(I) Notwithstanding the provisions of (H) of this paragraph, if the requirements of this Section have not been satisfied, the attempted conversion shall be ineffective and the credit union shall continue to be a state credit union, subject to the provisions of the Oklahoma Credit Union Act, to the same extent as though the conversion had not been attempted. The State Bank Commissioner promptly shall notify the credit union, in writing, either before or after the copy of the federal charter is filed with the State Bank Commissioner, of any findings, including the reasons therefor, which adversely affect the validity of the attempted conversion.~~

(2) ~~When converting~~ Conversion from a federally-chartered credit union to a state-chartered credit union.

(A) Any federal credit union may convert to a state credit union by:

- (i) complying with all of the requirements of the federal law applicable for conversion to a state credit union, if any, or to cease being a federal credit union;
- (ii) filing with the Commissioner proof of such compliance satisfactory to the ~~Bank~~ Commissioner;
- (iii) filing with the ~~Bank~~ Commissioner an organization certificate as required by ~~him~~ the Act; and

- (iv) filing with the ~~Bank~~ Commissioner satisfactory proof satisfactory to him that all requirements of the ~~State Credit Union Act~~ and this Title have been complied with.
- (B) Any federal credit union that desires to convert to a state credit union may, after approval of its board of directors, and prior to taking the steps prescribed above, file with the Commissioner a preliminary application for conversion.
- (C) Such preliminary application shall be on a form prescribed by the ~~State Bank~~ Commissioner.
- (D) The preliminary application for conversion shall be filed with the ~~State Bank~~ Commissioner and it shall authorize ~~him~~ the Commissioner to make an examination of ~~it's~~ the applicant's books and records, subject to the special examination fee set forth in the Act and contain an undertaking to pay the examination fee therefor.
- (E) The preliminary application shall:
 - (i) be accompanied by a current financial statement;
 - (ii) be certified by the treasurer as being correct;
 - (iii) be verified by the president or vice president of the credit union;
 - (iv) be accompanied by a statement of the credit union's policies and procedures with respect to loans to members, including interest rates and charges incident to making loans, maturities of loans, unsecured loan limit, types of securities accepted, and requirements for amortization;
 - (v) list all outstanding unsecured loans with unpaid balances;
 - (vi) list all outstanding loans with maturities in excess of five (5) years;
 - (vii) list a schedule of all loans which are delinquent two (2) months or more;
 - (viii) provide a statement of the kinds of accounts (share, savings, deposit, or other) which members are required or permitted to maintain;
 - (ix) provide a description of its real property holdings;
 - (x) provide a description of investments other than loans to members, ~~loans to other credit unions, United States bonds, and deposits in savings and loan associations and shares or accounts in mutual savings banks insured by the FDIC;~~
 - (xi) state the names and locations of depositories of its funds;
 - (xii) provide a description of any services rendered to or on behalf of members or the public other than accepting and maintaining accounts of members and making loans to members;
 - (xiii) provide a statement as to the field of membership to which the credit union intends to offer services, which shall be single common bond, multiple common bond, or community credit union. If the credit union intends to be a community credit

- union, it shall submit an application for a community charter field of membership which describes its proposed community; ~~and~~
- (xiv) be accompanied also by a preliminary plan which shall show what the credit union ~~proposed~~ proposes to do about any of its policies, procedures, practices, assets, and liabilities, which do not comply with the Act, or this Title, if its conversion to a state credit union should be approved; ~~and~~
- (xv) be accompanied by a proposed certificate of incorporation and bylaws.
- (F) The Board shall have the sole discretion as to approval of the preliminary application and shall disapprove the application if it determines that the credit union is unable to comply with all of the requirements of the Act and this Title.
- (G) Upon the ~~conditioned~~ conditional approval of a preliminary application for a conversion into a state credit union, the credit union shall proceed promptly to comply with all of the requirements of the federal law applicable for conversion to a state credit union. The credit union may also pursue compliance with federal law requirements while concurrently seeking approval from the Board of its preliminary application.
- (H) Upon Within 90 days after compliance with all of the requirements of the federal law applicable for conversion to a state credit union and ~~upon~~ compliance with all of the conditions prescribed in the conditional approval, the credit union ~~may~~ shall file with the Commissioner an ~~organization executed~~ certificate of incorporation, together with ~~the proposed~~ its approved bylaws, as required by the Act, which shall constitute its formal application for conversion to a state credit union. Such ~~organization~~ certificate shall be accompanied by evidence satisfactory to the Commissioner, showing compliance by the credit union, with all requirements of the federal law applicable for conversion to a state credit union. For good cause, the Commissioner may extend the time period during which the credit union must submit the documents described in this paragraph.
- (I) Upon approval of the organization's certificate by the ~~Board~~ Commissioner, the credit union shall become a state credit union as of the later of (i) the date it ceases to be a federal credit union, as designated by the NCUA, and (ii) the date its certificate of incorporation is filed with the Oklahoma Secretary of State. It shall be vested with all of the assets and shall continue responsibility for all of the obligations of the federal credit union to the same extent as though conversion had not taken place. All directors and credit committee members holding office at the time the credit union becomes a state credit union shall hold office in accordance with the previous election.

(3) Conversion from a state-chartered credit union to a mutual savings bank.

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(A) Except as provided in subparagraph (B), a state-chartered credit union may rely on Title 6 O.S. § 2023 for authority to convert to a mutual savings bank or savings association. The provisions of federal law and regulations will control the internal governance issues in the conversion. A copy of all notices submitted to the NCUA must also be provided to the Department at the same time such notice is submitted to the NCUA. A copy of all notices to, and communications with, the converting credit union's members must also be provided to the Department at the same time such notice or communication is provided to the members.

(B) Notwithstanding approval by the NCUA of the methods by which the membership vote was taken for conversion of the credit union to a mutual savings bank, the Board must separately approve the membership vote. After the vote of the credit union members that approves the conversion, the credit union must submit the results of the vote to the Board and request its review of the notices provided to the members and the procedure followed with respect to the membership vote. The Board may disapprove of the vote and the conversion if it determines that either:

- (i) notice to the members did not comply with the credit union's bylaws or NCUA requirements;
- or
- (ii) the membership vote for conversion was not the product of deliberate and informed consent by the voting members.

180:10-3-5. Community field of membership

(a) The Board must approve the field of membership of a community credit union. If an existing credit union desires to become a community credit union, the credit union must file with the Board a request for amendment to its bylaws and an application for community field of membership. The bylaw amendment must include a declaration that the credit union is a community credit union and designate the community which the credit union desires as its field of membership. The credit union's designated community must comply with subsection (b) of this section.

(b) A community credit union's field of membership may include individuals who reside, work, worship, or attend school in a designated community, which shall be limited to one of the following:

- (1) a single Oklahoma Metropolitan Statistical Area;
- ~~(2) a single rural service area;~~
- ~~(3) a political subdivision; or~~
- ~~(4) a non-standard community.~~

(c) The application to the Board for community field of membership must contain:

- (1) the name and the address of the credit union;
- (2) a designation of the community which the credit union intends to serve;
- (3) if the proposed community is non-standard,
 - (A) a map of the geographic boundaries of the proposed community;

(B) locations of the credit union's service facilities within the proposed community;

(C) a description of daily or weekly newspapers serving the proposed community;

(D) a description of characteristics within the proposed community which show that members of the community share a common interest or otherwise interact. Evidence of common interests and interaction may include shared common facilities for education, fire and police protection, medical facilities, school districts, water services and taxing authority; and

(4) such other information as the Board or Commissioner may request.

(d) A community credit union may designate as its community the same community, or a community that includes a smaller community, also served by any other credit union. The Board shall not disapprove of a credit union's designated community on the basis of overlapping membership. Members of a single common bond or multiple common bond credit union may qualify for membership in a community credit union if such members otherwise qualify for membership in the community credit union.

(e) If a multiple common bond or single common bond credit union amends its bylaws to declare itself a community credit union, after such amendment the community credit union may retain in its membership individuals existing in its select associational groups and select employee groups prior to such amendment. The community credit union may also accept as members individuals who join such select associational groups and select employee groups after the amendment. A community credit union may not add new select employee groups or select associational groups after declaring itself to be a community credit union.

(f) If a community credit union desires to serve members of another community, it must amend its bylaws to designate such other community as its field of membership. A community credit union may serve only one designated community. Provided, however, if a credit union with a community field of membership merges with another credit union with a community field of membership, both communities may continue to be served by the surviving credit union so long as the surviving credit union retains a full-service facility in each community.

(g) If a community credit union designates a new community as its field of membership, it may add a member of its former community only if the member also qualifies for membership in the new community. However, the community credit union may continue to ~~service~~ serve existing members even if they do not reside, worship, work, or attend school in the new designated community.

(h) If a community credit union has specified the counties of an OMSA as its field of membership, when the boundaries of an OMSA change, the credit union serving the changed OMSA must amend its bylaws before serving any additional counties. A credit union that has identified its field of membership as a specific OMSA without identifying the specific counties, may serve any additional counties of a changed OMSA.

180:10-3-6. Multiple common bond field of membership

(a) ~~The Board must approve~~ A credit union must obtain Board approval of select employee group and select associational group additions to the field of membership of a multiple common bond credit union, except when the credit union has a composite CAMEL rating of 1 or 2 as of the credit union's last examination and seeks to add a group whose potential primary members do not exceed 500 or 10% of the credit union's existing membership, whichever is less.

(b) If Board approval of a select associational group or select employee group is required, the credit union must submit to the Board an ~~Application for Field of Membership Expansion~~. Such application ~~that~~ must contain: ~~name and address of the credit union;~~

- (1) ~~the~~ name and address of the credit union;
- (2) ~~the~~ name and address of the proposed group;
- (3) if an associational group, a copy of the association's organizational certificate, bylaws, or other equivalent organizational documentation;
- (4) the number of potential primary members;
- (5) the distance of the group from the nearest credit union service facility and the address of the facility;
- (6) the primary method by which the credit union anticipates ~~servicing~~ servicing the group (for example, through a branch, ATM, internet, *etc.*)
- (7) information regarding overlaps with other credit unions;
- (8) a letter from a representative of the proposed group which requests membership with the credit union and explains:
 - (A) whether the group has available to it another credit union's services;
 - (B) the number of persons in the group and the group's address; and
 - (C) the group's proximity to the credit union's nearest service facility; and
- (9) such other information as the Board ~~or Commissioner~~ shall request from the applicant.

(c) If Board approval of a select associational group or select employee group is not required, the credit union must complete and retain an ~~Application for Field of Membership Expansion~~, ~~which~~ application ~~that~~ shall contain the same information as described in subsection (b) of this section.

- (1) ~~name and address of the credit union;~~
- (2) ~~name and address of the proposed group;~~
- (3) ~~if an associational group, a copy of the association's organizational certificate, bylaws, or other equivalent or organizational documentation;~~
- (4) ~~the number of potential primary members;~~
- (5) ~~the distance of the group from the nearest credit union service facility and the address of the facility;~~
- (6) ~~the primary method by which the credit union anticipates servicing the group (for example, through a branch, ATM, internet, etc.)~~
- (7) a letter from a representative of the proposed group which requests membership with the credit union and explains:

- (A) ~~the number of persons in the group and the group's address;~~
- (B) ~~the group's proximity to the credit union's nearest service facility; and~~
- (8) ~~such other information as the Commissioner shall request from the applicant.~~

(d) A multiple common bond credit union may not add to its field of membership an OMSA, or political subdivision, ~~or rural service area.~~

(e) The Board may not disapprove of the addition of a select associational group and select employee group solely on the basis of the distance between such group and the credit union's nearest service facility.

(f) A community credit union that amends its bylaws and declares itself to be a multiple common bond credit union may retain all existing members and may add new members that otherwise qualify for membership in the credit union by being a member of a select employee group or select associational group being duly ~~serviced~~ served by the credit union.

(g) For purposes of this section, the term "service facility" shall include shared branches, automated teller machines, and such other facilities, whether structural or electronic, which the Board may recognize.

180:10-3-7. Single common bond field of membership

(a) ~~The Board must approve~~ A credit union must obtain Board approval of select employee group and select associational group additions to the field of membership of a single common bond credit union, except when the credit union has a composite CAMEL rating of 1 or 2 as of the credit union's last examination and seeks to add a group whose potential primary members do not exceed 500 or 10% of the credit union's existing membership, whichever is less.

(b) If Board approval of a select associational group or select employee group is required, the credit union must submit to the Board an Application for Field of Membership Expansion. Such application must contain:

- (1) the name and address of the credit union;
- (2) the name and address of the proposed group;
- (3) if an associational group, a copy of the association's organizational certificate, bylaws, or other equivalent organizational documentation;
- (4) the number of potential primary members;
- (5) information regarding overlaps with other credit unions;
- (6) a letter from a representative of the proposed group which requests membership with the credit union and explains:
 - (A) whether the group has available to it another credit union's services;
 - (B) the number of persons in the group and the group's address; and
 - (C) how the group shares the occupational or associational common bond; and
- (7) such other information as the Board shall request from the applicant.

(c) If Board approval of a select associational group or select employee group is not required, the credit union must complete

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and retain an Application for Field of Membership Expansion, which application that shall contain the same information as described in subsection (b) of this section.

- (1) ~~name and address of the credit union;~~
 - (2) ~~name and address of the proposed group;~~
 - (3) ~~if an associational group, a copy of the association's organizational certificate, bylaws, or other equivalent or organizational documentation;~~
 - (4) ~~the number of potential primary members;~~
 - (5) ~~a letter from a representative of the proposed group which requests membership with the credit union and explains:~~
 - (A) ~~the number of persons in the group and the group's address;~~
 - (B) ~~how the group shares the occupational or associational common bond, and~~
 - (6) ~~such other information as the Commissioner shall request from the applicant.~~
- (d) A single common bond credit union may not add to its field of membership an OMSA, or political subdivision, ~~or rural service area.~~
- (e) A community credit union or multiple common bond credit union that amends its bylaws and declares itself to be a single common bond credit union may retain all existing members and may add new members that otherwise qualify for membership in the credit union by being a member of the select employee group or select associational group being duly serviced by the credit union.

180:10-3-8. Field of membership list

By January 31 of each year, each single common bond and multiple common bond credit union shall file with the ~~State Banking~~ Department a master list of all select associational groups and select employee groups within its field of membership. ~~Each such credit union shall file, on or before the 10th day of each month following the date the credit union became aware of the change, amendments to the list to reflect changes to the list, including addition of groups, name changes, mergers, and group bankruptcies.~~ The ~~State Banking~~ Department shall make the master lists available for inspection by other credit unions but the list shall otherwise be confidential and not subject to public inspection.

180:10-3-9. Field of membership disaffiliation [REVOKED]

- (a) ~~Upon application by a select associational group or select employee group, the State Credit Union Board may allow the group to disaffiliate from a credit union. In making its decision, the Board may consider the following factors:~~
- (1) ~~The length of time the group has been within the credit union's field of membership;~~
 - (2) ~~The number of primary members within the group who are currently members of the credit union;~~
 - (3) ~~The total number of eligible primary members in the group;~~
 - (4) ~~The impact the release of the group would have on the credit union; and~~

(5) ~~The number of group members favoring the request.~~

(b) ~~A credit union may voluntarily allow a select associational group or select employee group to disaffiliate without Board approval.~~

SUBCHAPTER 5. GUIDELINES AND RESTRICTIONS

180:10-5-1. Deposits

(a) Each holding of property by a credit union for a member on deposit creates a debtor-creditor relationship as provided in the agreement between the credit union and the member. Such agreement is a contractual relationship which may be established by ~~the membership card signed~~ a record authenticated only by the member.

(1) ~~The membership card of a member of a credit union is a contract between the credit union and the member.~~

(2) Reasonable fees as determined by the policy of the credit union's board may be charged by a credit union for any account and safe keeping services even if the specific terms of the contract between the credit union and the member are silent with regard to service charges.

(3) ~~Specifically, on~~ On inactive or dormant accounts of \$25.00 ~~or less~~ a credit union may impose a service charge of ~~not more than \$25.00 per year.~~ A credit union may determine by policy when an account is considered "dormant" and such policy may determine an account is dormant even though it may not be considered abandoned or unclaimed under applicable law.

(4) Interest on a deposit may or may not be paid on a dormant account as determined by the policy of the credit union's board even if the specific terms of the contract between the credit union and the customer are silent with regard to interest.

(5) No state government agency, except the Department, shall examine any accounts or safe keeping records of any credit union without fifteen (15) days prior written notification of the scope of such examination to the ~~State Banking~~ Commissioner. No charge may be assessed the credit union for any such examination by any such governmental agency and the credit union is entitled to be paid the costs of producing and copying records pursuant to the Oklahoma Financial Privacy Act.

180:10-5-2. Dividends and interest paid

A state-chartered credit union is hereby expressly authorized and permitted to pay dividends on accounts ~~as defined in 180:10-1-2~~ and interest ~~on~~ deposits at a rate ~~in excess of seven percent (7%) per annum as long as rates determined by the credit union's board of directors shall have first adopted a resolution.~~ The credit union's board of directors shall consider the following when establishing such rates:

- (1) ~~establishing the rate of dividend or interest to be paid and the period to which such rate shall be applicable,~~
- (2) ~~specifying the type(s) of account to which such rate shall be applicable,~~

- (3) ~~determining that whether~~ the available earnings of the credit union are sufficient to pay dividends/interest at the specified rate, provided, however the board of directors may determine that adequate earnings are available through protection thereof, and
- (4) ~~determining that whether~~ the payment of dividends/interest at such rate for such period will not impair the credit union's ability to meet such other financial commitments as it may have or to comply with such liquidity or other legal requirements to which it may be subject.

180:10-5-3. Investment and deposits

- (a) Each credit union must obtain and keep in file the most recent financial statement of any depository at which the credit union maintains a deposit in excess of the insured limit. It is the responsibility of the credit union to review said financial statement before making a deposit which would include uninsured funds.
- (b) No national or state bank or trust company shall be approved as a depository for a given credit union if that credit union's deposit in that bank or trust company exceeds twenty percent (20%) of the bank or trust company's capital, surplus, and undivided profits (exclusive of their reserves and debentures).
- (c) No savings ~~and loan association~~ shall be approved as a depository for a given credit union if that credit union's deposit in that savings ~~and loan~~ association exceeds twenty percent (20%) of the savings ~~and loan~~ association's net worth.
- (d) ~~Except for the U.S. Central Credit Union, no No~~ bank, trust company, savings ~~and loan~~ association, or credit union, will be approved as a depository unless ~~said bank, trust company, savings and loan association, or credit union is its deposits or shares are~~ insured by an agency of the ~~Federal Government~~ federal government.

180:10-5-4. Rental or purchase of property

A state-chartered credit union shall have the authority to rent or purchase property necessary or incidental to its operations. A credit union may plan for future growth by acquiring additional space if ~~they have it~~ has valid projections for ~~their~~ its need for the additional space within a reasonable time. A credit union may not purchase property only for the purpose of renting the same, except that ~~they it~~ it may rent the extra space ~~they it~~ it reasonably ~~expect~~ expects to use for expanded credit union service from the time of acquisition until the space is actually needed by the credit union. A credit union does not have authority to purchase property with the expectation to make a profit from rental activity or resale.

180:10-5-5. Share drafts, checking accounts or other instruments and accounts

Credit unions are expressly authorized to offer ~~share drafts, checking accounts, share certificates, money market certificates, IRA/Keogh accounts and to issue certified cashier's or guaranteed checks and such other instruments~~ any instruments and accounts authorized by the Act and to offer such other instruments and accounts as shall be approved by

the ~~National Credit Union Administration~~ NCUA for federally chartered credit unions.

180:10-5-6. Issuance of accounts [REVOKED]

- (a) ~~The board of directors, by resolution, may establish accounts as follows, all subject to the provisions of 180:10-5-5 where applicable:~~
 - (1) ~~Regular or Deposit accounts, Notice Share or Deposit accounts, Minimum Balance Share or Deposit accounts, and Share Draft accounts at varying dividend checking rates which are not inconsistent with the requirements of the Oklahoma Credit Union Act or the Rules and Regulations of the Oklahoma State Credit Union Board, which accounts contain penalties for failure to comply with any minimum balance or notice requirements or any additional terms and conditions;~~
 - (2) ~~Share Certificate accounts at varying dividend rates which are not inconsistent with the requirements of the Oklahoma Credit Union Act or Rules and Regulations of the Oklahoma State Credit Union Board;~~
 - (3) ~~Trusteed and Custodial Pension Plan Share, Deposit or Share Certificate accounts which comply as an individual retirement account for a member pursuant to 26 U.S.C., Section 408 or Keogh (HR 10) Plan established pursuant to 26 U.S.C., Section 401;~~
 - (4) ~~Certificate of Deposit accounts at varying interest rates which are not inconsistent with the requirements of the Oklahoma Credit Union Act; and~~
 - (5) ~~Any account authorized by the Oklahoma Credit Union Act or the rules of this Board not specifically defined in this Section.~~
- (b) ~~State chartered credit unions shall accurately represent the terms or conditions of its accounts in all advertising, disclosures, or agreements, whether written or oral.~~

180:10-5-8. Safe deposit boxes

Each credit union ~~which that~~ provides safe deposit box services for its members shall:

- (1) Maintain a record as to the lessee(s) of each box rented.
- (2) Maintain a record as to the person or persons permitted to enter the box.
- (3) Maintain a record with minimum data consisting of names of entries into the box and dates of entry.
- (4) Establish other precautionary procedures as may be deemed advisable by the institution's ~~Board of Directors~~ board of directors to insure adequate safety to the lessees with a minimum of liability on the credit union.

180:10-5-9. Prohibited acts and practices

The following is a list of acts which, if after notice and opportunity for hearing before the Board, pursuant to the Administrative Procedures Act, the Board determines that one or more such acts were committed by a credit union officer, employee, agent, director, or committee member, shall constitute acts rendering the individual unfit to participate in the conduct of the affairs of any credit union:

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- (1) To knowingly receive or possess any property of a credit union otherwise than in payment of a just demand or otherwise than as authorized by such credit union, and, with intent to deceive or defraud, to omit to make or cause an omission of a full and true entry thereof in its books and accounts, or concur in omitting to make any material entry thereof;
- (2) To embezzle, abstract, or knowingly misapply any money, property, or thing of value of the credit union, with the intent to deceive or defraud the credit union;
- (3) To knowingly make any false entry in any book, report, or statement of such credit union, or with the intent to deceive the Commissioner, any other regulatory agency, any auditor or any authorized representative appointed to examine the affairs of such credit union;
- (4) To commit any unsafe or unsound practice which causes loss to a credit union or exposes the credit union to potential loss, which loss or potential loss threatens the safety and soundness of the credit union;
- (5) ~~Refuses To refuse~~ or willfully ~~fails fail~~ to deliver or disclose to the Commissioner, his employees or appointed representative any examination report, report of condition, report of income and expenses, internal audit, account, statement, or document known by him to be fraudulent or false as to any material matter;
- (6) To execute, or attempt to execute, any scheme or artifice to defraud a credit union to obtain credit, money, assets, securities, or other property owned by, or under the custody or control of a credit union;
- (7) To willfully deny access to, or to fail to provide upon written request, information or documents required by the laws of Oklahoma or of the United States of America, to the Commissioner or his appointed representative.
- (8) To engage in a pattern of conduct which constitutes a breach of the particular person's fiduciary duty to the credit union or credit union members.
- (9) Any other act which after notice and hearing before the Board, is determined by the Board to have jeopardized the safety or soundness of the credit union.

[OAR Docket #09-826; filed 5-4-09]

TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES

[OAR Docket #09-874]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 9. Lifelong Learning
210:10-9-1. General provisions [AMENDED]
210:10-9-2. Adult basic education [AMENDED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

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210:10-9-2. Adult basic education [AMENDED]

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N/A

ANALYSIS:

The proposed rule amendments bring Adult Basic Education into compliance with federal guidelines. The amendments establish state policies for adult education income, student assessment, student goal setting, state and federal fund allocation, teacher and director qualifications, administrative cost limits, state performance measures, and data collection.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 9. LIFELONG LEARNING

210:10-9-1. General provisions

(a) **Purpose.** The rules of this subchapter have been adopted for the purpose of establishing standards, guidelines, allocation of funds, development of projects and applications, and the implementation of Adult Education, and Literacy, Workplace Literacy, English Literacy, Adult Homeless, Battered Women, and Community Education Projects, and Integrated English Literacy/Civics. These projects provide educational programs to educationally disadvantaged adults and community needs.

(b) **Definitions.** The following words and terms, when used in this Subchapter, shall have the following meaning unless the context clearly indicates otherwise:

(1) **"Act"** means the Adult Education Act, and Family Literacy Act, Title II of the Workforce Investment Act of 1998 (P.L. 105-330).

(2) **"Adult"** means an individual who has attained 16 years of age or who is beyond the age of compulsory school attendance under State law who is not enrolled in secondary school; who lacks sufficient mastery of basic educational skills to enable him/her to function effectively in society or who does not have a ~~certificate of graduation from a school providing secondary education~~ secondary school diploma or its recognized equivalent and who has not achieved an equivalent level of education; ~~who is not currently required to be enrolled in school;~~ and whose lack of mastery of basic skills results in an inability to speak, read, or write the English language.

(3) **"Adult education"** means services or instruction below the college level for educationally disadvantaged adults.

(4) **"Adult education program"** means a local education agency, postsecondary institution, community-based organization, corrections education agency or faith-based organization responsible for locally administering the Adult Education and Family Literacy Act grant.

(5) **"Community-based organization" (CBO)** means a private nonprofit organization which is representative of a community or significant segments of a community and which provides education, vocational education or rehabilitation, job training, or internship services and programs and includes neighborhood groups and organizations, community action agencies, community development corporations, union related organizations, employer-related organizations, tribal governments, and organizations serving Native Alaskans and Indians. The term 'private industry council' means the private industry council established under section 102 of the Job Training Partnership Act.

~~"Community school"~~ means a public elementary school, secondary school, community junior college, or vocational technical ~~career technology school that has accepted the responsibility for stimulating community access to public facilities and equipment by providing leadership personnel; procedures for ensuring citizen involvement; processes for involving existing public and private agencies; and access to a wide range of programs for people of all ages.~~

(6) **"Cooperative"** means that the board of education of two or more school districts may enter into cooperative agreements and maintain joint programs including but not limited to, courses of instruction for handicapped children, courses of instruction in music and other subjects, practical instruction for trades and vocations, practical instruction in driver training courses, and health programs including visual care by persons legally licensed for such purpose, without favoritism as to either profession.

(7) **"Disadvantaged Adult"** means an adult who demonstrates basic skills equivalent to or below that of students at the fifth grade level.

(8) **"General Educational Development" (GED)** means a high school equivalency credential.

~~"Individual of limited English proficiency" (LEP)~~ means an adult or out of school youth who has

~~limited ability in speaking, reading, writing, or understanding the English language.~~

(9) **"Local educational agency" (LEA)** means a public board of education or other public authority legally constituted within elementary or secondary schools in a city, county, township, school district, or other political subdivision of a state, or such combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or secondary schools, except that, if there is a separate board of other legally constituted local authority having administrative control and direction of adult education in public schools therein, such term means such other board or authority.

~~"Rural" means a school district with an ADA of 800 or less.~~

(10) **"State educational agency" (SEA)** means the Oklahoma State Department of Education.

210:10-9-2. Adult basic education

(a) Programs, services and activities funded in accordance with uses specified in ~~section 322~~ sections 203 and 231 of the Act are designed to expand or improve the quality of adult education programs, including priority programs for educationally disadvantaged adults (including first those adults with less than a 5th-grade achievement level, and second, those adults with a 6th-8th grade achievement level), adults with limited English speaking ability, ~~handicapped adults, adults with disabilities, institutionalized adults and GED preparation.~~

~~(b) The SEA will use not less than 10% of the funds granted to the state for corrections education and education for other institutionalized adults under section 326 of the Act. The SEA shall use not less than 15% for special experimental demonstration projects and teacher training projects under section 353 of the Act, with two thirds of the 15% to be used for teacher training.~~

~~(c) The SEA may use not more than 20% of the funds granted to the state under the Act for programs of equivalency for a certificate of graduation from secondary school.~~

~~(d) Adults enrolled in Adult Basic Education programs will not be charged tuition, fees, or any other charges, or be required to purchase any books or any other materials that are needed for participation in the program.~~

~~(e) The SEA will use Federal funds granted to the state under the Act to supplement, and not supplant, the amount of state and local funds available for uses specified in the Act.~~

~~(f) The SEA will provide such fiscal control and accounting procedures as may be necessary to ensure proper disbursement of, and accounting for, Federal funds paid to the state (including such funds paid by the state to eligible recipients under the Act).~~

~~(g) The SEA has instituted policies and procedures to ensure that copies of the state plan and amendments, all statements of general policy, rules, regulations, and procedures will be made available to the public.~~

(b) Adult education programs governed by the Act shall make every effort to provide free classes to students. Adult education programs may charge necessary and reasonable fees for consumable materials and work-based classes. Adult

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education programs that wish to implement fees must develop a fee policy that has been approved by the adult learning center's local governing board. The fee policy must be reasonable and may not restrict access to services.

(c) The Act permits local adult education programs to generate income. The purpose of income is not to make a profit, but rather to expand services. Income and donations received must be reinvested in the adult education program. Any income must be accounted for in records and reported to the state Lifelong Learning office for National Reporting System Financial Reports.

(d) Adult education programs governed by the Act must follow the state adult education Assessment Policy per federal guidelines.

(e) Adult education programs governed by the Act must follow the state adult education Student Goal Setting Policy per federal guidelines.

(hf) For each year covered by the plan, the fiscal effort per student from nonfederal sources available for expenditure by the state for adult education, during the second preceding fiscal year must not be less than the fiscal effort per student from nonfederal sources during the third preceding fiscal year in order to meet the maintenance of effort requirement.

(i) The SEA will plan and implement a program of literacy training and basic skills remediation for adult homeless individuals within the state.

(j) Directors of adult education located in the 40 adult learning centers funded by the state under the Act, shall have a valid Oklahoma Teacher's Certificate and shall be responsible for administering this plan.

(g) Teachers of adult education located in the adult learning centers funded by the state under the Act, shall have a valid Oklahoma Teacher's Certificate. Directors of adult education located in the adult learning centers shall have a valid Oklahoma Teacher's Certificate or a graduate degree.

(kh) For fiscal control, the obligation basis of accounting is used; expenditures will be supported by copies of paid claims and invoices and will be audited following accepted auditing procedures.

(l) The State Review Committee, using the annual evaluation reports and needs assessment from the Adult Education directors, and the latest census figures from the State Employment Securities Commission, reviews the overall program and makes recommendations of service priorities to the State Superintendent based on the above information. Further, the State Review Committee is encouraged to provide input and comments to assist in the planning of the program.

(i) Federal funds for adult education programs operating under a grant extension will be allocated according to local program data, program performance, and participation in state and national initiatives. Seventy percent of federal funds will be allocated according to the number of students with a pre-assessment and 12 hours of instruction as reported in National Reporting System (NRS) data. Twenty percent of federal funds will be allocated according to whether federal and state indicators of performance were met. Ten percent of funds will be

allocated for participation in state and national initiatives. Allocations for the current fiscal year will be based on National Reporting System data from the second preceding fiscal year.

(j) State funds for adult education programs operating under a grant extension will be allocated according to program data. Fifty percent of state funds will be divided evenly among all programs to establish a funding base. The remaining fifty percent of state funds will be allocated according to the number of students enrolled. Allocations for the current fiscal year will be based on National Reporting System data from the second preceding fiscal year.

~~(mk)~~ The SEA and the 40 local education agencies serving as the adult learning centers (ALCs) adult education programs participating in the plan shall enter into cooperative arrangements, when feasible and appropriate, with such entities as other state agencies, community based organizations, community action agencies, ~~vo techs-career technology schools,~~ churches, businesses, etc. in order to carry out the general purpose of the Act.

~~(nl)~~ The SEA and the 40 local education agencies serving as the ALCs adult education programs will expend 95% of the funding for adult education activities and 5% will be used for ~~administration, administrative costs,~~ however if the administrative cost limits would be insufficient for adequate planning and administration of the program, the state agency may negotiate with the local grant recipient in order to determine an adequate level of funds to be used for noninstructional purposes. Negotiated administrative cost limits are indicated in the Adult Education and Literacy State Plan/State Plan Amendments.

~~(o)~~ Facilities for adult education classes are identified as to the number of persons each can accommodate, the geographic location, cost, if any, and time availability. Lists of curriculum materials for adult education classes which have proven to be effective are available for program use.

~~(p)~~ Bilingual adult education classes will be established in areas where high concentration of non-English speaking or limited-English proficient adults exist. The program of instruction will be designed to teach the adult English language skills and, if necessary, the native language skills as determined by the needs assessment.

~~(q)~~ The SEA will provide direct and equitable access to and will review annual applications from public/private and profit/non-profit agencies and organizations if these entities can make a significant contribution to obtaining the objectives of the Act, and can provide equivalent education services at a lesser cost, or can provide services not available in public institutions. Assurance that the services are coordinated with and are not duplicative services under other Federal, State and local programs must be documented to the SEA to show that consultation and guidance on the development of the services has been obtained by the applicable LEA. The comments of the LEA and responses thereto shall be attached to the application when it is forwarded to the state.

~~(r)~~ Funds shall be allocated on the basis of an application and shall be paid on the number of students enrolled in each adult class. Funds will be matched on the ratio specified by the Adult Education Act regulations in existence for the current fiscal program year.

(s) Applications for adult education funds will be submitted to the 40 LEAs serving as ALCs and shall address the needs of the districts' adult population to be served as reflected in the local needs assessment. Further, the applicant shall state the adult standardized test to be used to assess the adult population when they enroll in adult education classes. Finally, the applicant shall address the methods used to annually gather data to determine the extent to which the adult students are achieving the goals set forth in the plan.

(t) ~~The SEA will accept bids from eligible applicants to conduct adult basic education teacher training workshops with funds available for above mentioned training under section 353 of the Act, for the purpose of improving teaching techniques which have proven to be effective with the target population.~~

(u) ~~The SEA shall set aside funds for public housing authorities to provide educational programs for disadvantaged adults living in public housing. Grants funded under this section shall be called Gateway Grants.~~

(v) ~~The SEA will evaluate grant recipients based on the federal requirements for program evaluation.~~

(m) The SEA will provide direct and equitable access to and will review grant proposal applications during an open grant competition. The adult education program will demonstrate that the twelve considerations outlined in Section 231 of the Act are being met in order to be considered for a grant award. The adult education program must assure that the services are coordinated with and are not duplicative services under other Federal, State and local programs. The comments of the adult education program and responses thereto shall be attached to the application when it is forwarded to the state.

(n) Federal funds for new grantees shall be allocated on the basis of an application, budget, and proposed number of students to be served. State funds will be matched on the ratio specified by the Adult Education Act regulations in existence for the current fiscal program year.

(o) The SEA will evaluate grant recipients based on the federal requirements for program evaluation.

(p) Adult education programs will follow all requirements set forth in the SEA Adult Education State Plan and State Plan Amendments.

(q) Adult education programs will meet the state performance measures of pre-/post-assessing 60% of their students and increasing the average number of student contact hours each fiscal year.

(r) Adult education programs will use an SEA-approved management information system to document student enrollment, goals, attendance, educational gains, and other information as required by the National Reporting System (NRS). Programs will update data monthly.

[OAR Docket #09-874; filed 5-8-09]

**TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES**

[OAR Docket #09-873]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 13. Student Assessment
- 210:10-13-4. Test security and validity [AMENDED]
- 210:10-13-10. Requests to view or take possession of documents [AMENDED]
- 210:10-13-11. Testing students with disabilities [AMENDED]
- 210:10-13-18. Oklahoma School Accountability System [AMENDED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

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Superseded rules:

- Subchapter 13. Student Assessment
- 210:10-13-4. Test security and validity [AMENDED]
- 210:10-13-10. Requests to view or take possession of documents [AMENDED]
- 210:10-13-11. Testing students with disabilities [AMENDED]
- 210:10-13-18. Oklahoma School Accountability System [AMENDED]

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N/A

ANALYSIS:

The proposed rule amendments bring the present Oklahoma School Testing Program (OSTP) into line with changes in state and federal statute regarding student assessment.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 13. STUDENT ASSESSMENT

210:10-13-4. Test security and validity

(a) School administrators or their designees shall maintain security on tests administered under the auspices of the Oklahoma School Testing Program through following the procedures listed below:

(1) School superintendents shall designate both district and building test coordinators before October 1 of each school year. Names and telephone numbers of district test coordinators shall be recorded on the OSTP Questionnaire conducted in the fall semester of each school year. This questionnaire is the order form provided by the testing vendors for all tests in the OSTP including large print and Braille test forms.

(2) The State Department of Education shall provide student/parent pretest information materials to schools for designated grade levels before testing.

(3) The State Department of Education shall require the contracting test publisher to place an embargo on the sale, sampling, and/or distribution of test materials utilized in the OSTP to any person or organization in Oklahoma (other than the official distribution of such materials purchased for the OSTP by the State Department of Education). This embargo is to be enforced from the first day of contract with the State Department of Education throughout use of this test for the OSTP and until the Department has given notice that the test series is no longer going to be used in the OSTP. The State Department of Education may enter into a Memorandum of Understanding with publicly funded schools to meet the requirements of federal programs. Violation of this agreement by a contracting test publisher can result in automatic and immediate forfeiture of the contract and reimbursement to the State Department of Education (by the contracting company) of any funds expended in the conduct of the OSTP.

(4) No person nor organization--either private or public--shall obtain copies of any test materials utilized in the OSTP other than through the official distribution of test materials to public schools immediately prior to administration of the annual OSTP. Any person or organization attempting to order such materials from the contracting test publisher (or from other scoring companies handling OSTP or "off-grade" scoring and reporting) shall be reported by the contractor to the State Superintendent of Public Instruction.

(5) All student test materials (i.e., test booklets, prompts for writing assessment, and answer documents) shall be bound by the test publisher in packages of designated lot sizes. Test booklets shall be individually sealed, as practicable, to prohibit them from being opened. When seals are used, the following procedures shall be followed: they shall remain intact until tests are distributed to students at the beginning of the test administration session; each test booklet seal shall be broken only by the student who is administered the test, except where special education or Section 504 accommodations allow the opening of

the test; and unused tests shall remain sealed. When seals are not used, the following procedures shall be followed: tests booklets shall remain closed until distributed to students at the beginning of these test administration session; each test booklet shall be opened only by the student who is administered the test, except where special education or Section 404504 accommodations allow the opening of the book and turning of pages by someone other than the students. No test booklets shall be viewed by any person other than the student taking the test at the time of testing, except in the case of special education, Section 504, or ELL accommodations which allow a test administrator to assist a student being tested.

(6) All test materials shall be inventoried upon receipt from the test publisher/contractor. Any discrepancies representing shortages in the quantity of materials supplied and the quantity needed for tests administered shall be reported immediately to the contracting company by the district test coordinator. Immediately upon receipt and inventory of materials, all tests, and other materials shall be locked in a secure place by the district test coordinator or school administrator. The site level distribution of test documents and materials may occur beginning one ~~school~~ week prior to testing. Exceptions to the test materials distribution time limit needed by the largest districts in the state shall be registered with and approved by the Student Assessment Section of the State Department of Education at least four weeks prior to the first designated testing window of each year. During the days in which tests are being administered in each school district, all test administrators are responsible for locking all test materials in a secure place when the tests are not being utilized in the official test administration with students. This includes the time period between completion of the test administration and delivery of the answer documents and other test materials to the district test coordinator. Further, the building test coordinator is responsible for ensuring that materials are properly locked in a secure place at the times specified above. Test booklets are not to leave school buildings at any time (i.e., students' test booklets are not to be taken home by an employee or the community member/test monitor before, during, or after test administration has been completed). Exceptions to test booklets leaving a school site shall be made at the discretion of the State Department of Education Student Assessment Section for the purpose of secure transport to a site of instruction for the purpose of test administration, upon a written request from a District Test Coordinator. These requests must be registered with and approved by the Student Assessment Section at least four weeks prior to the first designated testing window of each year.

(7) An accounting is to be conducted on all test booklets. Unused test booklets are to remain in "shrink-wrap" (or otherwise packaged) when possible. All unused tests are to be returned to the test publisher. Failure to return test booklets to the appropriate companies (1) will result

in a school or district being reported to the State Superintendent and (2) may result in invalidation of the school's and/or district's scores.

(8) The contracting test publisher shall print electronically read identification codes on all documents containing secured test items prior to distribution of these materials to the public schools. Within all test program components of the OSTP, the contracting test publisher shall record the specific series of numbers (represented by the "bar codes") assigned to each school district and building site within a district. Inventory lists of test document bar codes by school site shall be provided for each district test coordinator.

(9) ~~On the first available school day following the test administration in each school district, the~~ The district test coordinator shall ship all answer documents and specified identification forms to the designated scoring/reporting company and all other test materials to the contracting test publisher in accordance with the schedule for return of materials provided in the Test Preparation Manual. If a district fails to return materials and answer documents in a timely fashion, the district may be penalized with additional costs- and the test scores for the individual school(s) and/or district in question may be declared invalid. If a district fails to complete or incorrectly complete answer documents and/or demographic pages or other required testing-related materials, the district may be penalized with additional costs- and may also receive a deficiency on the district accreditation report.

(10) The contracting test publisher shall submit an inventory of test materials to the State Department of Education each year. This inventory shall document the quantity of materials distributed to each school district and received from each school district-- recorded by school site as indicated by the numbers represented by the "bar codes" printed on test materials. Quantities of writing assessment materials distributed to and retrieved from schools will be reported to the State Department of Education by the contracting test publisher.

(11) School superintendents from whom incomplete quantities of materials have been received shall be notified of this discrepancy and shall be provided a date by which the remaining materials must be returned to the test publisher. The test publisher shall notify the Department of Education of all school districts from which test materials have not been received after this date. Names of these school districts shall be reported to the State Superintendent- and may also receive a deficiency on the district accreditation report.

(12) Reproduction in any form of any copyrighted test materials--including test documents, teachers' test administration manuals, and student pretest materials--is strictly prohibited. Photocopying of these materials constitutes a violation of federal copyright laws. To ensure that all school employees and community members are aware of this regulation and the laws in support of same, the district or building test coordinator shall post a sign to this effect over each copy machine. The Federal Copyright

Law--as it applies to the multiple-choice and/or Writing Assessment Component of the OSTP--prohibits the photocopying of any part of the student Test Booklet. This includes the lined writing pages, the writing prompt, and the student's written response. This portion of the set of test documents is considered protected under the copyright guidelines [as is the writing prompt]. These items shall remain protected, and thus may not be copied, printed, or disseminated in any manner, until they are officially released by the OSDE.

(13) Every test administered within the OSTP shall be administered by an education-certified professional person employed by the school district.

(14) No person shall teach test items to students (except in the case of an alternate special education assessment in which authentic performance tasks may be utilized), change students' answers, or in any manner provide answers to test questions for students before, during, or after test administration has been completed. Violation of this regulation may result in revocation of the person's teaching, counseling, administrative, and/or other certificate(s).

(15) All of the following actions are prohibited in that such actions represent violations of test security:

(A) Using secured test items as instructional tools or for student "practice"--either verbatim as written or in reworded form. Note: Secured test items are those provided to measure student knowledge and/or skills on OSTP tests. Said items are to be differentiated from sample test items that are provided at the beginning of each subtest and used, according to official test administration procedures, solely for the purpose of understanding directions and marking answers.

(B) Reading secured test items orally to students at any time before, after, or during test administration unless it is an IEP, Section 504, or ELL accommodation, in which case an affidavit shall be signed, prior to reading items, by the test administrator/reader stating they shall not reveal any test items, writing prompts, or other secured information to any person.

(C) Deviating from any instruction provided in the official test administration manual.

(D) Allowing students to view and/or read the writing assessment prompts before test administration or discussing or exposing the theme or topic of the prompt.

(E) Providing answers to secured test items. This includes provision of cues, clues, hints, and/or actual answers in any form--written, printed, verbal (oral), or nonverbal. In regard to the writing assessment component of the OSTP, prohibited actions include the provision of "hints" or any form of clues in regard to the manner in which students respond to the prompt (e.g., "brainstorming" about the topic of the prompt; offering suggestions regarding how to respond; assisting the student or class in organizing the response; and all other such deviations from the printed instructions for administering the test).

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- (F) Changing students' responses to secured test items and/or influencing or encouraging students to change their answers to test items at any time.
- (16) Test Security Forms provided by the State Department of Education's test contractor(s) shall be distributed by the district test coordinator with test materials to the persons designated on each form.
- (A) OSTP Test Security Forms shall be provided for the following:
- Form 1: Superintendent and District Test Coordinator
 - Form 2: Building Principal and Building Test Coordinator
 - Form 3: Test Administrators and Test Monitors.
- (B) After completing the test administration, these forms shall be signed by the designated persons and returned to the district test coordinator. The district test coordinator shall return all signed forms to the respective scoring company. Failure to sign and return the appropriate forms may result in:
- a school or district being reported to the State Superintendent; and
 - invalidation of a school's and/or district's test scores.
- (17) The contracting test companies shall provide the State Department of Education the signed OSTP Test Security Forms or a report of names of educators who signed SDE/OSTP Test Security Forms and an accounting of the number of tests and manuals:
- distributed to, and
 - returned from each school district.
- (18) All test administration sessions shall be conducted according to the standardized procedures described in the test administrators' manuals. This includes reading the directions to students verbatim; ~~timing each subtest according to the time delineated in the official administration manual~~; refraining from allowing students to read test items before test timing begins and/or beyond the completion of time specified for each section of each test; and assuring that only the materials designated for student test use are on the student's desk during test sessions. Any violation of security provisions in Section 210:10-13-4 constitutes invalidation of the test and test results. Such violations shall be reported to the State Superintendent and may result in a school's and/or school district's test scores being declared as invalid.
- (19) All test administration sessions shall be monitored by an adult other than the test administrator. All test monitors shall be approved by the superintendent or school principal. Superintendents and principals may designate school employees or noncertified members of the community to serve as test monitors. All test administration procedures including time specifications, State Board of Education Rules 210:10-13, and the Instructions for Test Monitors shall be distributed to test monitor(s) before test administration.

- (b) School administrators or their designee(s) shall assure that all test administration procedures replicate standardized testing conditions to preserve test validity. Such procedures are stated in the manuals for administering the test.

210:10-13-10. Requests to view or take possession of documents

Responses to requests to view or take possession of test documents shall be executed as specified herein. Documents shall include student test books containing secured test items; student answer sheets; and test administrator manuals. In order to maintain the security and validity of the testing materials, individuals making requests to view test documents must comply with the following procedural requirements:

- ~~Test viewing will NOT be the month before or during testing. Test viewing will NOT be allowed beginning one month before and extending throughout the testing window.~~
- The person will submit a request to the State Department of Education's ~~Student Assessment Section~~ Office of Accountability and Assessment.
- Viewing shall take place at the State Department of Education.
- The viewing of test documents will be limited to no more than two viewers during a single time period.
- ~~The Student Assessment Team Leader~~ The Assistant Superintendent of the Office of Accountability and Assessment or his/her designee will remain in the room during the viewing.
- Students will not be allowed to view tests.
- The viewing of assessment materials will not be allowed for professional development purposes.
- ~~Viewers of tests shall be prohibited from duplicating, paraphrasing, or summarizing test items in any form--by hand-written means or through use of any mechanical tool (i.e., audio or video tape recorder; copy machine; still picture camera; or other). cell phones camera; or any other electronic or mechanical means.)~~
- ~~(8) Tests and test materials shall be considered secured documents. No viewer shall be allowed to remove secured documents from the viewing room.~~
- ~~(9) No unauthorized person shall be allowed to view an OSTP writing assessment prompt until after that prompt has been administered in Oklahoma as a test item. Viewing of writing test prompts shall be subject to the same procedures and conditions as viewing of other test materials.~~
- ~~(10) Prior to the viewing of any test materials, all viewers shall sign an affidavit stating that~~
 - they shall not reveal any test items, writing prompts, or other secured information to any person; and
 - they shall ~~neither~~ not serve as a test administrator nor test monitor.
- ~~(11) A student's answer sheet or writing assessment essay may be viewed only by the student's parent, legal guardian or by a student of legal age. Any person requesting to view student test documents shall provide proof~~

of his or her status as the parent or legal guardian of the student whose documents are required for viewing. Proof of identification shall be provided in one of the following forms:

- (A) the student's birth certificate; and
 - (B) a driver's license containing a picture of the requesting person; or
 - (C) other recognized official form of identification.
- In addition, the person shall provide proof of his or her status as parent or legal guardian of the student whose documents are requested for viewing.

(13) When sufficient writing prompts are available, once writing assessments have been scored and reported, the SDE will provide the student essay responses to the individual student's home school district by electronic means. The information will be provided as a service to Oklahoma public schools for purposes related to instructional improvement only. Schools and districts receiving such data will make every reasonable effort to insure that these individual student testing results are secure and remain confidential. The SDE reserves the right to use these data for research and assessment improvement purposes.

210:10-13-11. Testing students with disabilities

(a) Acceptable accommodations of the general assessments of the OSTP for students with disabilities shall be:

- (1) specified in the student's IEP under the Individuals with Disabilities Education Act (IDEA); or
- (2) specified for student served under Americans With Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

(b) The use of test accommodations which deviate from established standardized test procedures for the general assessments of the OSTP shall be reported to the State Department of Education's Student Assessment Section.

(c) Large print and Braille versions of the tests may be utilized with students whose visual disabilities necessitate such accommodations. The student must be utilizing large print or Braille in daily classwork as indicated on the student's IEP on file at the school district. To order large print or Braille tests, the district test coordinator shall indicate the quantities required at each grade level tested on the annual questionnaire.

(d) Students with disabilities who cannot be assessed in a valid and reliable manner with the general state assessment even with accommodations, as specified in the student's IEP, shall be assessed with an appropriate alternate assessment provided by the State Department of Education. Eligibility for an alternate assessment shall be determined annually by the student's IEP team. Alternate assessments may include, but not be limited to, portfolio assessments—or modified assessments. The scores from alternate assessments shall be included in accountability calculations for the school, district, and state according to the standard AYP calculation procedures, as specified in federal law.

(e) Students with the most significant cognitive disabilities shall participate in an alternate assessment named the Oklahoma Alternate Assessment Program (OAAP) and should not exceed a small percentage of the special education population.

The OAAP shall be designed for students who are participating in ~~adapted Priority Academic Student Skills (PASS)~~an alternative curriculum based on the Curriculum Access Resource Guide (CARG).

(f) The OAAP shall consist of a portfolio assessment, which may include authentic performance tasks. A portfolio assessment is a collection of student-generated or student-focused products that exhibit ~~the student's interests, range of skills, and development over time.~~the alternative approach to teaching the Priority Academic Student Skills (PASS). Teams of teachers shall score the OAAP portfolio. If authentic performance tasks are used, teachers completing the portfolio shall be provided with information regarding these tasks during a specified time prior to the completion of the portfolio.

(g) Students with cognitive disabilities that inhibit their ability to attain, even after receiving appropriate instructional interventions, grade-level achievement standards within the same time frame as other students may demonstrate academic proficiency through participation in a statewide system of modified assessments. These assessments, the Oklahoma Modified Alternate Assessment Program (OMAAP), shall be based in the content drawn from the Priority Academic Students Skills (PASS), and shall be designed to be rigorous, reliable and valid measures of the academic content required of all students.

210:10-13-18. Oklahoma School Accountability System

(a) **Adequate Yearly Progress (AYP).** The Oklahoma School Accountability System shall be based on AYP. All public elementary and secondary schools and local educational agencies (LEAs) shall be accountable for student achievement and for making Adequate Yearly Progress (AYP) according to federal law. AYP will be determined by meeting or exceeding statewide performance targets for required student groups in Reading/Language Arts and Mathematics on state tests; administering tests to 95 percent of students in each required student group; and meeting statewide targets for attendance rates and graduation rates where applicable. Alternatively, schools shall make AYP by showing growth in Reading/Language Arts and Mathematics on state tests as required by Safe Harbor regulations as defined in the No Child Left Behind Act of 2001, Public Law 107-110.

(b) **Consequences of Testing Irregularities or Misconduct on Test Scores and AYP.**

(1) If the State Department of Education (SDE) Student Assessment Office receives documentation of a student cheating on a test, the student's score shall be "invalidated." The student's score report for that content area shall read "Invalidated." The "invalidated" score shall have the effect of nonparticipation when aggregated with scores of other students at the school, district, and state levels.

(2) If a student does not attempt the test (such as refusal to read items or mark answers, finishing in 5 minutes, or randomly marking answers), no special action shall be taken. The student's test shall be scored and the score aggregated with the rest of the scores at the school, district, and state levels according to standard procedure.

(3) If a student becomes ill during testing and is not able to complete the test, the test shall not be scored and

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not counted in the summary scores. The student shall be counted as absent. If an alternate equivalent form of the test is available through the OSTP, the student may be given an opportunity to take the alternate equivalent form within the same testing window. In this case, the first test shall not be scored and the alternate equivalent test shall be scored in its place. (Note: Alternate Equivalent test forms of the OSTP shall only be made available through the SDE only if determined practicable by the State Department of Education.)

(4) If any violation of security provisions (Section 210:10-13-4) occurs, such violations shall be reported in writing to the Student Assessment Section of the State Department of Education and may result in a student's, a school site's, and/or a school district's test scores being declared as invalid (Section 210:10-13-4 (18)). In the case of invalidation, each invalidated score shall have the effect of a zero score and each zero score shall be aggregated with the remaining student scores at the school, district, and state levels. If the violation is not the fault of the students involved, and if an alternate equivalent form of the test is available through the OSTP, students may be given the alternate equivalent form within the same testing window at the district's expense if this is the first year for a security violation within the school and/or district in question. In the case that an alternate equivalent form is administered, the individual student score report shall reflect the scores from the alternate equivalent test (in place of the previous invalidated scores) and shall be aggregated at the school, district, and state levels. (Note: Alternate Equivalent test forms of the OSTP shall only be made available through the SDE only if determined practicable by the State Department of Education.)

(5) If extreme changes in test scores or in Academic Performance Index (API) scores occur for a school or district from year to year, an investigation shall be conducted, which may include, but not be limited to, a hand erasure analysis, and results of any apparent testing irregularity or misconduct reported to the State Board of Education for possible further action, which may include but not be limited to, score invalidation.

(6) Erasures shall be identified statewide by electronic scanning of all student answer documents, and the following action shall be taken: Scores for classes whose wrong-to-right erasures exceed the state average by more than four standard deviations shall be identified for further investigation. For each class with excessive erasures, the proportion of wrong-to-right erasures to the total number of erasures will be taken into account. A report shall be made to the State Board of Education of schools where classes have been identified with excessive erasures as defined by the criteria above for possible further action, which may result in score invalidation.

(7) Steps for Dealing with Reported Testing Irregularities or Misconduct

(A) **Step One.** When report of a testing irregularity or misconduct is made to the State Department of Education Student Assessment Section, the school site

and/or school district involved shall be required to respond by conducting an investigation and providing in writing to the State Department of Education Student Assessment Section an explanation of how the testing misconduct/irregularity occurred and a description of the measures taken to prevent the misconduct from occurring again.

(B) **Step Two.** The testing irregularity or misconduct shall be categorized into one of three violation categories (minor, major, and critical) according to the severity of the violation and its possible consequences. Possible consequences may include, but not be limited to, invalidation of scores, accreditation with deficiency, accreditation with warning, accreditation with probation.

(C) **Step Three.** At the end of each testing period, a testing violations report shall be prepared by the Student Assessment office for review by the State Superintendent and possible further action.

(c) **Procedures for Schools to Review AYP Data and Appeal Accountability Decisions.**

(1) To assure the validity of AYP determinations prior to the release of the AYP data reports, as required by No Child Left Behind, the State Department of Education will forward to schools the preliminary AYP Data Reports containing component pieces from the school district, testing vendor, and the State Department of Education. Each school district must review these component pieces for accuracy and report any inaccuracies to the entity supplying the information within the applicable timelines. If the school district does not report inaccuracies within the timeline the State Department of Education will rely on the data in the preliminary AYP Data Report.

(2) Upon receiving their preliminary AYP Data Reports from the State Department of Education for use in creating School and District Report Cards, districts shall review the data in the preliminary AYP Data Reports and report any discrepancies with the data components previously reviewed by the district to the Student Assessment Section of the State Department of Education within the specified timeline.

(3) Subsequent to the review of the preliminary AYP Data Report, if a principal of a school, or a majority of the parents of the students enrolled in a school, believe that any accountability decision contained in the AYP Data Report is in error the principal shall provide supporting evidence to the district. The district must consider the evidence and if warranted, request an appeal in writing to the State Department of Education. The State Department of Education must receive the appeal request within ten working days of the release of the AYP Data Reports.

(4) If a school and/or district has had test scores invalidated because of a testing irregularity or misconduct with the effect of nonparticipation for aggregation purposes, and such action results in a API score that prevents the school and/or district from making AYP, the district may appeal this accountability decision on a first time occurrence and request placement on Probationary Status

instead of receiving an API score. At the end of the next consecutive year, if the school and/or district do not make AYP, they shall not be allowed to invoke Safe Harbor and shall automatically be identified as being in School Improvement status.

(5) When a school district or charter school appeals an accountability decision, the appeal request will be sent to the Office of Accountability and Assessment on the appeal form provided by the State Department of Education. The school district or charter school must specify on the form, if a hearing pursuant to Title 75 O.S. § 309 is requested. If such a hearing is requested, the district must provide a written waiver of the right of the district to receive a final determination from the State Department of Education within the 30 day period required by the NCLB Act. In that event, all parties will cooperate to expedite the hearing process. If a hearing pursuant to Title 75 O.S. § 309 is not requested, the school district must submit with the appeal request written evidence supporting its appeal. The district may also request to address the AYP Appeals Committee in person or by telephone. All appeal requests will initially be reviewed by the Office of Accountability and Assessments to determine whether the appeal request remains with the AYP Appeals Committee or is forwarded to the State Superintendent for a hearing pursuant to Title 75 O.S. § 309. The AYP Appeal Committee will consist of members of the State Department of Education's School Improvement Leadership Team and may also include additional members appointed by the State Superintendent. The AYP Appeals Committee will review the district's evidence submitted with the appeal and if requested, hear comments from the school district, before providing a final determination in writing within thirty working days from release of the AYP Data Reports.

(6) At the end of the State Department of Education Appeals process, the State Department of Education shall report to the State Board of Education the statewide list of School Improvement schools.

(d) Sanctions for public elementary and secondary schools that do not make Adequate Yearly Progress (AYP)

(1) Title I schools that do not make Adequate Yearly Progress (AYP) for two consecutive years shall be identified as being in School Improvement status. Title I schools in the state of Oklahoma shall be subject to the sanctions defined in the No Child Left Behind Act of 2001, Public Law 107-110.

(2) Non-Title I schools that do not make AYP for two consecutive years or more shall be subject to sanctions as determined by the State Board of Education. The State Board of Education may utilize sanction options identified in the No Child Left Behind Act of 2001, Public Law 107-110, as deemed appropriate based upon relevant circumstances of the school's performance. The sanctions shall include but not be limited to the following:

- (A) provide school improvement plan,
- (B) provide technical assistance,
- (C) offer school choice,
- (D) provide supplemental services,

- (E) take corrective action, or
- (F) implement a restructuring plan.

(e) Rewards for public elementary and secondary schools that make Adequate Yearly Progress (AYP)

(1) **Academic Achievement Awards - Title I, Part A.** Title I Schools that meet AYP shall be eligible for Academic Achievement Awards. Academic Achievement Awards, under section 1117 (b) of the No Child Left Behind Act of 2001, states that each state receiving a grant under federal funds shall establish a program for making academic achievement awards to recognize schools that significantly close the achievement gap between subgroups of students or exceed their adequate yearly progress. Schools that receive Title I, Part A funds are eligible for Academic Achievement Awards.

(2) **State Academic Performance Award Program.**

(A) All public elementary and secondary schools that make Adequate Yearly Progress, shall be recognized by the state as Distinguished Schools and eligible for state funds, if available, as established by the State Academic Performance Index (API) Program (O.S. § 70-30-152).

(B) Nonmonetary recognition may include, but not be limited to, citations of congratulations from the State Superintendent of Public Instruction as the designee of the State Board of Education, the Governor or designee, the Representative and Senator representing the school district, and a flag for each school achieving Distinguished status.

[OAR Docket #09-873; filed 5-8-09]

**TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 15. CURRICULUM AND INSTRUCTION**

[OAR Docket #09-872]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Priority Academic Student Skills
Part 11. Social Studies
210:15-3-102. United States History 1850 to the present for high school
[AMENDED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

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Permanent Final Adoptions

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Part 11. Social Studies

210:15-3-102. United States History 1850 to the present for high school [AMENDED]

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N/A

ANALYSIS:

The proposed rule amendments revise the core curriculum *Priority Academic Student Skills (PASS)*, United States History: 1850 to Present, to comply with the requirements set forth in 70 O. S. § 11-103.6(a).

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 3. PRIORITY ACADEMIC STUDENT SKILLS

PART 11. SOCIAL STUDIES

210:15-3-102. United States History 1850 to the present for high school

(a) ~~The focus of the course in United States History for Grades 9-12 is the immediate pre-Civil War era to the present (1850-present). However, for the high school end of instruction examination over "United States History," the time frame is 1850-1975, or from approximately the Compromise of 1850 through the withdrawal of United States military and diplomatic personnel from Vietnam. NOTE: Standard 1 social studies process skills should be integrated throughout the content standards and used in teaching and assessing the course content at the classroom and district level. At the state level, Standard 1 social studies process skills will be measured and reported within each of the content standards (2, 3, 4, 5, 6, and 7). Process skill assessment items will be content based and reported under each of the content standards. For assessment purposes, each standard will have items using primary and secondary source documents, timelines, maps, charts, graphs, pictures, photographs, and/or political cartoons. There will be a balance of graphic and textual stimulus materials within the various U.S. History test forms. At least 50 percent of the~~

~~assessment items will have appropriate pictorial and graphical representations.~~

~~(b) In United States History, the student will describe and analyze the causes, events, and effects of the Civil War and Reconstruction era; examine the impact of immigration and the Westward Movement on American society; and evaluate the economic effects of the Industrial Revolution and the changing role of the United States in world affairs at the turn of the twentieth century. He or she will also describe the social, cultural, and economic events between the World Wars; investigate and analyze the Great Depression, and the causes, events and effects of World War II; and assess the foreign and domestic policies of the United States since World War II. The student will continue to strengthen, expand, and put to use the full range of process and research skills in social studies.~~

~~(1) **Standard.** The student will demonstrate process skills in social studies.~~

~~(A) Identify, analyze, and interpret primary and secondary sources (e.g., artifacts, diaries, letters, photographs, documents, newspapers, media, and computer-based technologies).~~

~~(B) Recognize and explain how different points of view have been influenced by nationalism, racism, religion, culture and ethnicity.~~

~~(C) Distinguish between fact and opinion in examining documentary sources.~~

~~(D) Construct timelines of United States history (e.g., landmark dates of economic changes, social movements, military conflicts, constitutional amendments, and presidential elections).~~

~~(E) Explain the relationships between geography and the historical development of the United States by using maps, graphs, charts, visual images, and computer-based technologies.~~

~~(F) Develop discussion, debate, and persuasive writing and speaking skills, focusing on enduring issues (e.g., individual rights vs. the common good, and problems of intolerance toward cultural, ethnic, and religious groups), and demonstrating how divergent viewpoints have been and continue to be addressed and reconciled.~~

~~(2) **Standard.** The student will analyze causes, key events, and effects of the Civil War era.~~

~~(A) Examine the economic and philosophical differences between the North and South, as exemplified by such persons as Daniel Webster and John C. Calhoun.~~

~~(B) Trace the events leading to secession and war (e.g., the Compromise of 1850, the Kansas-Nebraska Act, and the Dred Scott case).~~

~~(C) Identify leaders on both sides of the war (e.g., Abraham Lincoln, Ulysses S. Grant, Jefferson Davis, Robert E. Lee, Frederick Douglass, and William Lloyd Garrison).~~

~~(D) Interpret the importance of critical developments in the war, such as major battles (e.g., Fort~~

- Sumter, Gettysburg, and Vicksburg), the Emancipation Proclamation, and Lee's surrender at Appomattox.
- (E) Relate the basic provisions and postwar impact of the 13th, 14th, and 15th Amendments to the Constitution.
- (F) Evaluate the continuing impact of Reconstruction policies on the South, including southern reaction (e.g., sharecropping, Black Codes, Ku Klux Klan, *Plessy v. Ferguson*, and Jim Crow laws).
- (3) **Standard.** The student will analyze the impact of immigration and the Westward Movement on American society.
- (A) Detail the contributions of various immigrant, cultural, and ethnic groups (e.g. Irish, Chinese, Italians, and Germans).
- (B) Examine ethnic conflict and discrimination.
- (C) Investigate changes in the domestic policies of the United States relating to immigration.
- (D) Compare and contrast the attitudes toward Native American groups as exhibited by federal Indian policy (e.g., establishment of reservations, assimilation, and the Dawes Act) and actions of the United States Army, missionaries, and settlers.
- (4) **Standard.** The student will examine the effects of the Industrial Revolution on the economy of the United States.
- (A) Identify the impact of new inventions and industrial production methods, including new technologies in transportation and communication.
- (B) Evaluate the significance of immigration on the labor supply and the movement to organize workers.
- (C) Describe the effects of the "muckrakers" and reform movements (e.g., women's suffrage and temperance) that resulted in government policies affecting child labor, wages, working conditions, trade, monopolies, taxation and the money supply.
- (D) Assess the impact of industrialization, the expansion of international markets, urbanization, and immigration on the economy.
- (E) Evaluate the rise of the Progressive Movement in relation to political changes at the national and state levels (e.g., workers' compensation, the direct primary, initiative petition, referendum, and recall).
- (F) Examine the causes of the money panics of 1873, 1893, and 1907, explaining how the establishment of the Federal Reserve System addressed the problems.
- (5) **Standard.** The student will analyze the changing role of the United States in world affairs at the turn of the twentieth century.
- (A) Identify the goals of imperialism, explaining its impact on developed and developing nations.
- (B) Identify the role of the Spanish American War in the development of the United States as a world power.
- (C) Evaluate the role of United States foreign policy and presidential leadership in the construction of a canal in Panama.
- (D) Describe the strengths and weaknesses of Theodore Roosevelt's "Big Stick Diplomacy."
- (E) Analyze the causes and effects of United States involvement in World War I.
- (F) Examine the rationale for the failure of the United States to join the League of Nations and the nation's return to isolationism.
- (6) **Standard.** The student will describe the social, cultural, economic, and technological ideas and events in the United States in the era between the World Wars.
- (A) Evaluate literature, music, dance, and forms of entertainment, including the Harlem Renaissance, the Jazz Age, and "talkies."
- (B) Investigate the longterm effects of reform movements, such as women's suffrage and prohibition (e.g., the 18th, 19th, and 21st Amendments to the Constitution).
- (C) Analyze the impact of the automobile, and urban and rural electrification on society.
- (D) Describe rising racial tensions and labor unrest common in the era (e.g., the Tulsa Race Riots and the sit down strikes).
- (E) Examine the growing disparity between the wealth of corporate leaders and the incomes of small business owners, industrial workers, and farmers.
- (F) Identify causes contributing to an unstable economy, (e.g., the increased reliance on installment buying, a greater willingness to speculate and buy on margin in the stock market, and government reluctance to interfere in the economy).
- (7) **Standard.** The student will investigate and analyze the causes and legacy of the Great Depression.
- (A) Examine changes in business cycles, weaknesses in key sectors of the economy, and government economic policies in the late 1920s.
- (B) Analyze the effects of the Stock Market Crash.
- (C) Evaluate the impact of the Great Depression, the Dust Bowl, and the New Deal economic policies on business and agriculture, and on the American people, their culture and political behavior.
- (D) Identify the contributions of key individuals of the period (e.g., Will Rogers, Eleanor and Franklin Roosevelt, Charles Lindbergh, and Woody Guthrie).
- (E) Assess the impact of the expanded role of government in the economy since the 1930s.
- (8) **Standard.** The student will analyze the major causes, events, and effects of United States involvement in World War II.
- (A) Relate the rise of totalitarian regimes in the Soviet Union, Germany, Italy, and Japan to the rise of communism, Nazism, and fascism in the 1930s and 1940s, and the response of the United States.
- (B) Investigate appeasement, isolationism, and the war debates in the United States prior to the outbreak of war.

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- (C) Evaluate the impact of preparation and mobilization for war, including the internment policies and their effects (e.g., *Korematsu v. United States*).
- (D) Detail major battles, military turning points, and key strategic decisions in both European and Pacific theaters.
- (E) Analyze public and political reactions in the United States to the events of the Holocaust.
- (9) **Standard.** The student will assess the successes and shortcomings of United States foreign policy since World War II.
- (A) Identify the origins of the Cold War, and its foreign and domestic consequences, including confrontations with the Soviet Union in Berlin and Cuba.
- (B) Examine the proliferation of nuclear weapons and the arms race.
- (C) Describe the role of the United States in the formation of the United Nations, NATO, and other alliances.
- (D) Evaluate the role of the United States in attempts at the containment of communism in Europe, Asia, and Latin America, including the Truman Doctrine and the involvement of the United Nations in Korea.
- (E) Describe the fear of communist influence within the United States, including the McCarthy hearings.
- (F) Evaluate the causes and longterm foreign and domestic consequences of United States military commitments in southeast Asia, especially Vietnam.
- (G) Examine the strategic and economic factors in the development of Middle East policy, and relations with African nations, such as South Africa.
- (H) Assess the reasons for the collapse of communism in eastern Europe and the Soviet Union, and relate the end of the Cold War to new challenges to the United States leadership role in the world.
- (10) **Standard.** The student will analyze the economic, social, and political transformation of the United States since World War II.
- (A) Describe de jure and de facto segregation policies, attempts at desegregation and integration, and the impact of the Civil Rights Movement on society (e.g., *Brown v. Board of Education of Topeka, Kansas*).
- (B) Evaluate the success of the women's liberation movement and the changing roles of women in society.
- (C) Examine the technology revolution and its impact on communication, transportation, and industry.
- (D) Assess the impact of violent crime, and illegal drug use and trafficking.
- (E) Explain the effects of increased immigration, the influx of political refugees, and the increasing number of undocumented aliens on society and the economy.
- (F) Identify the contributions of political leaders, political activists, and civil rights leaders, and the major issues and trends in national elections (e.g., differences between the two major political parties, and the rise of third party candidates).
- (G) Examine the post war rise in the standard of living, the oil embargo and the inflation of the 1970s, and the federal budget deficit problems of the 1980s and early 1990s.
- (H) Evaluate the impact of political scandals (e.g., Watergate, Iran Contra, and the Clinton impeachment) on federal law, national policies, and political behavior.
- (I) Analyze how the principles and structures of the United States Constitution have changed through amendment and judicial interpretation (e.g., the 22nd and 25th Amendments, and *Gideon v. Wainwright* and *Miranda v. Arizona*).
- (J) Compare and contrast conservative and liberal economic strategies, including the positions of political parties and interest groups on major issues in the post World War II era.
- (a) The focus of the course in United States History for Grades 9-12 is the immediate pre-Civil War era to the present (1850-present). However, for the high school ACE U.S. HISTORY examination, the time frame is approximately 1850-1975, or approximately from the Compromise of 1850 through the withdrawal of United States military and diplomatic personnel from Vietnam. NOTE: Standard 1 social studies process skills should be integrated throughout the content standards and used in teaching and assessing the course content at the classroom and district level. At the state level, Standard 1 social studies process skills will be measured and reported within each of the content standards (1, 2, 3, 4, 5, and 6). Process skill assessment items will be content-based and reported under each of the content standards. For assessment purposes, each standard will have items using primary and secondary source documents, timelines, maps, charts, graphs, pictures, photographs, and/or political cartoons. There will be a balance of graphic and textual stimulus materials within the various U.S. History test forms. At least 50 percent of the assessment items will have appropriate pictorial and graphical representations.
- (b) In United States History, the student will describe and analyze the causes, events, and effects of the Civil War and Reconstruction era; examine the impact of immigration and the settlement of the American West on American society; and evaluate the economic effects of the industrialization and the changing role of the United States in world affairs at the turn of the twentieth century. He or she will also describe the social, cultural, and economic events between the World Wars; investigate and analyze the Great Depression, and the causes, events and effects of World War II; and assess the foreign and domestic policies of the United States since World War II. The student will continue to strengthen, expand, and put to use the full range of process and research skills in social studies.
- (1) **Standard.** The student will demonstrate process skills in social studies.

- (A) Identify, analyze, and interpret primary and secondary sources (e.g., artifacts, diaries, letters, photographs, documents, newspapers, media, and computer-based technologies).
- (B) Recognize and explain how different points of view have been influenced by nationalism, racism, religion, culture and ethnicity.
- (C) Distinguish between fact and opinion in examining documentary sources.
- (D) Construct timelines of United States history (e.g., landmark dates of economic changes, social movements, military conflicts, constitutional amendments, and presidential elections).
- (E) Explain the relationships between geography and the historical development of the United States by using maps, graphs, charts, visual images, and computer-based technologies.
- (F) Develop discussion, debate, and persuasive writing and speaking skills, focusing on enduring issues (e.g., individual rights vs. the common good, and problems of intolerance toward cultural, ethnic, and religious groups), and demonstrating how divergent viewpoints have been and continue to be addressed and reconciled.
- (2) **Standard.** The student will analyze causes, key events, and effects of the Civil War/Reconstruction era.
- (A) Examine the economic and philosophical differences (e.g., sectionalism, popular sovereignty, states' rights debate, nullification, abolition, and tariffs) between the North and South, as articulated by Daniel Webster and John C. Calhoun.
- (B) Trace the events leading to secession and war (e.g., the Compromise of 1850, the Fugitive Slave Act, the Kansas-Nebraska Act, "Bleeding Kansas," the Dred Scott case, John Brown's Raid on Harpers Ferry, 1860 presidential election, secession of South Carolina, and the attack on Fort Sumter).
- (C) Identify political and military leaders of the war (e.g., Abraham Lincoln, Ulysses S. Grant, Jefferson Davis, Robert E. Lee, Frederick Douglass, and William Lloyd Garrison).
- (D) Interpret the importance of critical developments in the war, including major battles (e.g., Fort Sumter, "Anaconda Plan," Bull Run, Gettysburg, Vicksburg, Antietam, battle of the Monitor and Merrimack, and the North's "total war strategy"), the Emancipation Proclamation, and Lee's surrender at Appomattox.
- (E) Relate the basic provisions and postwar impact of the 13th, 14th, and 15th Amendments to the Constitution.
- (F) Evaluate the continuing impact of Reconstruction policies on the South, including southern reaction (e.g., tenant farming, Freedmen's Bureau, sharecropping, Black Codes, Ku Klux Klan, Carpetbaggers, scalawags, Plessy v. Ferguson, and Jim Crow laws).
- (3) **Standard.** The student will analyze the impact of immigration, the settlement of the American West, and industrialization on American society.?
- (A) Analyze the impact of immigration, migration and settlement patterns.
- (i) Analyze immigration, including the reasons for immigration, employment, settlement patterns, and contributions of various immigrant, cultural, and ethnic groups (e.g., Irish, Chinese, Italians, Germans, Japanese, and Southeast/Central Europeans) from 1850-1930.
- (ii) Examine ethnic conflict and discrimination.
- (iii) Analyze changes in the domestic policies of the United States relating to immigration (e.g., the CHINESE EXCLUSION ACT, the rise of nativism, Ellis Island, and the "Gentlemen's Agreement") from 1850-1930.
- (iv) Evaluate the significance of immigration on the labor supply and the movement to organize workers (e.g., growth of labor pool, rise of the labor movement, Pullman strikes, Haymarket Riot, Eugene V. Debs, Samuel Gompers, John L. Lewis, and the use of court injunctions to halt labor strikes).
- (v) Compare and contrast social attitudes and federal policies toward Native American peoples (e.g., the Indian Wars of 1850-1890, establishment of reservations, attempts at assimilation, and the DAWES ACT, and the destruction of the bison herds) and actions of the United States Army, missionaries, and settlers during the settlement of the American West, 1850-1890.
- (B) Evaluate the impact of industrialization on American society.
- (i) Identify the impact of new inventions and industrial production methods, including new technologies in transportation and communication between 1850-1920 (e.g., Thomas Edison, Alexander G. Bell, Henry Ford, the Bessemer process, the Westinghouse Company, barbed wire, the western cattle drives).
- (ii) Describe the effects of the "muckrakers" (e.g., Carey Nation, Susan B. Anthony, Elizabeth Cady Stanton, Alice Paul, Ida Tarbell, Upton Sinclair, and William Jennings Bryan) and reform movements (e.g., Women's Suffrage, Temperance, Populism, and the Grange Movement) that resulted in government policies affecting child labor, wages, working conditions, trade, monopolies, taxation and the money supply (e.g., Sherman Anti-trust Act and Triangle Shirtwaist Factory Fire).
- (iii) Assess the impact of industrialization, the expansion of international markets, urbanization, and immigration on the economy.
- (iv) Evaluate the rise of the Progressive Movement in relation to political changes at the national

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and state levels (e.g., workplace protections, conservation of natural resources, increased political strength of third parties, the direct primary, initiative petition, referendum, and recall).?

(v) Examine the causes of the money panics of 1873, 1893, and 1907, explaining how the establishment of the Federal Reserve System addressed the problems.

(4) **Standard.** The student will analyze the changing role of the United States in world affairs at the turn of the twentieth century.

(A) Evaluate the motivations and impact of American Imperialism on international relations.

(i) Identify the goals of and reasons for imperialism (e.g., Open Door Policy, annexation of Hawaii, influence of Admiral Alfred T. Mahan, and the concept of "white man's burden") explaining its impact on developed and developing nations (e.g., "banana republic").?

(ii) Analyze the role of the Spanish-American War in the development of the United States as a world power (e.g., yellow journalism, Rough Riders, PLATT AMENDMENT, TELLER AMENDMENT, territorial acquisitions, and contributions of Admiral George Dewey).

(iii) Evaluate the reasons for United States involvement in locating a canal in Central America and the actions of President Theodore Roosevelt regarding the Panama Canal.

(iv) Compare and contrast the strengths and weaknesses of Theodore Roosevelt's foreign policy and other presidential foreign policies from 1890-1910, including "Big Stick Diplomacy," "Dollar Diplomacy," "Missionary Diplomacy," the Great White Fleet, ROOSEVELT COROLLARY, and interventionism.

(B) Evaluate the causes and effects of World War I on American politics, economy, and society.

(i) Analyze the factors leading to the involvement of the United States in World War I (e.g., the alliance systems, submarine warfare, and the Zimmerman Note) and the effects of the war on the United States (e.g., mobilization, propaganda, women in the workplace, and the First Red Scare).

(ii) Examine the reasons why the United States did not join the League of Nations and for the nation's return to isolationism (e.g., Wilson's Fourteen Points and the Treaty of Versailles).

(5) **Standard.** The student will describe the social; cultural; economic; and technological ideas and events in the United States in the era between the World Wars.

(A) Compare and contrast cultural, economic, and social events and trends between the World Wars.

(i) Evaluate literature, music, dance, and forms of entertainment of the 1920s and 1930s (e.g., the Harlem Renaissance, the Jazz Age, flappers, the "Lost Generation," and "talkies").?

(ii) Investigate the long term effects of reform movements, such as the Women's Suffrage Movement, Temperance/Prohibition Movements (e.g., the 18th, 19th, and 21st Amendments to the Constitution), and the Early Civil Rights Movement and leaders (e.g., Booker T. Washington and W. E. B. Du Bois).

(iii) Analyze the impact of the automobile, aviation (e.g., Charles Lindbergh), electrification, and urbanization (e.g., the Great Migration) on American society.

(iv) Describe rising racial tensions and labor unrest common in the era (e.g., the Tulsa Race Riot, the resurgence of the Ku Klux Klan, the "Back to Africa" Movement and Marcus Garvey, the rise of industrial unions, and the labor sit-down strikes).

(B) Analyze the effects of the destabilization of the American economy.

(i) Examine the growing disparity between the wealth of corporate leaders and the incomes of small business owners, industrial workers, and farmers.

(ii) Identify causes contributing to an unstable economy (e.g., the increased reliance on installment buying, a greater willingness to speculate and buy on margin in the stock market, and government reluctance to interfere in the economy or laissez-faire policy).

(iii) Examine changes in the business cycle (e.g., the "Black Tuesday" Stock Market Crash and bank failures), weaknesses in key sectors of the economy (e.g., agriculture and manufacturing), and government economic policies in the late 1920s.

(iv) Analyze the effects of the Stock Market Crash between October 1929 and March 1933 (e.g., unemployment, the shrinking economy, Herbert Hoover's economic policies, the "Bonus Army," Securities and Exchange Commission, "Hoovervilles," and the presidential election of 1932).

(C) Analyze the Great Depression, the Dust Bowl, and the New Deal economic policies.

(i) Evaluate the impact of the Great Depression, the Dust Bowl (e.g., migration of the Okies and exodusters), and the New Deal economic policies on business and agriculture, as well as on the American people, their culture and political behavior. (e.g., FDR's court packing plan and the "fire-side chats").

(ii) Assess the impact of the expanded role of government in the economy since the 1930s. (e.g., FDR's "New Deal," deficit spending and new federal agencies - Social Security Administration, FDIC, TVA, WPA, and CCC).

(iii) Identify the contributions of key individuals of the period between the wars (e.g.,

- Will Rogers, Eleanor Roosevelt, Franklin Roosevelt, Huey Long, "The Brain Trust," and Woody Guthrie).
- (6) **Standard.** The student will analyze the major causes, events, and effects of United States' involvement in World War II.
- (A) Examine changes in American society and government policy as the nation prepared for and entered World War II.
- (i) Relate the rise of totalitarian regimes in the Soviet Union, Germany, Italy, and Japan to the rise of communism, Nazism, and fascism in the 1930s and 1940s, and the response of the United States.
- (ii) Describe the roles of appeasement and isolationism in the United States' reluctance to involve itself in world conflicts during 1937-1941 (e.g., the Lend-Lease Act, and the Neutrality Acts).
- (iii) Evaluate the impact of preparation and mobilization for war, including the internment policies and their effects (e.g., internment of minority Americans, such as, Japanese, Germans, and Italians; *Korematsu v. United States*; rationing; role of women in the workforce and armed services; and discrimination and segregation at home and in the armed forces).
- (B) Describe events affecting the outcome of World War II.
- (i) Identify major battles, military turning points, and key strategic decisions in both the European and Pacific Theaters of operation (e.g., Pearl Harbor; Battle of Midway; the D-Day Invasion; Battle of the Bulge; the development and use of the atomic bomb; island-hopping strategy, such as Iwo Jima; and the Allied conferences, such as Yalta).
- (ii) Analyze public and political reactions in the United States to the events of the Holocaust (e.g., Nuremberg War Trials).
- (7) **Standard.** The student will analyze the foreign and domestic policies of the United States since World War II.
- (A) Analyze the origins, international alliances, and efforts at containment of Communism.
- (i) Identify the origins of the Cold War and its foreign and domestic consequences, including confrontations with the Soviet Union in Berlin and Cuba (e.g., the postwar division of Europe, the Warsaw Pact, the "Iron Curtain," the Marshall Plan, the Berlin Airlift, the Berlin Wall, the Bay of Pigs Invasion, and the Cuban Missile Crisis).
- (ii) Evaluate the United States' attempts at the containment of Communism including the Truman Doctrine and the involvement of the United Nations in the Korean War.
- (iii) Describe the fear of communist influence within the United States including the McCarthy hearings (e.g., the Second Red Scare and various congressional hearings).
- (B) Describe events which changed domestic and foreign policies during the Cold War and its aftermath.
- (i) Examine the proliferation of nuclear weapons and the arms race (e.g., Sputnik and the space race; development and effects of nuclear weapons; the Rosenbergs' spy trial; and the SALT treaties).
- (ii) Describe the role of the United States in the formation of the United Nations, NATO, and SEATO.
- (iii) Evaluate the causes and long term foreign and domestic consequences of United States' military commitments in Southeast Asia, including the Vietnam War (e.g., "Domino Theory;" the Tonkin Gulf Resolution; the Tet Offensive; the presidential elections of 1968 and 1972; student protests; expanded television coverage of the war; and the War Powers Act).
- (iv) Examine the strategic and economic factors in the development of Middle East policy and relations with African nations, including South Africa.
- (v) Analyze the reasons for the collapse of Communism in Eastern Europe and the Soviet Union, and relate the end of the Cold War to new challenges to the United States' leadership role in the world.
- (C) Analyze the economic, social, and political transformation within the United States since World War II.
- (i) Describe de jure and de facto segregation policies, attempts at desegregation and integration, and the impact of the Civil Rights Movement on society (e.g., *Brown v. Board of Education of Topeka, Kansas*, the Montgomery Bus Boycott, the lunch counter sit-down strikes in Oklahoma City and elsewhere, the Freedom Rides, integration of Little Rock Central High School, the Civil Rights Act of 1964, and the Voting Rights Act of 1965).
- (ii) Evaluate the success of the Women's Liberation Movement (e.g., Equal Rights Amendment, *Roe v. Wade*, Betty Friedan, and NOW) and the changing roles of women during the 1950s through the mid-1970s.
- (iii) Examine the technology revolution and its impact on communication, transportation, and industry.
- (iv) Assess the impact of violent crime, and illegal drug use and trafficking.
- (v) Explain the effects of increased immigration, the influx of political refugees, and the increasing number of undocumented aliens on society and the economy.
- (vi) Identify the contributions of political leaders, political activists, civil rights leaders (e.g., Dr. Martin Luther King, Jr., Malcolm X, Thurgood Marshall, and César Chavez), major issues, and

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scandals, including the Watergate Scandal, and major trends in national elections (e.g., differences between the two major political parties, and the rise of third party candidates).

(vii) Examine the postwar rise in the standard of living, the OPEC Oil Embargo, the inflation of the 1970s, and the federal budget deficit problems of the 1980s and early 1990s.

(viii) Evaluate the impact of political scandals (e.g., Iran-Contra, and the Clinton impeachment) on federal law, national policies, and political behavior.

(ix) Analyze how the principles and structures of the United States Constitution have changed through amendment and judicial interpretation (e.g., the 22nd and 25th Amendments, the Warren Court, Gideon v. Wainwright, and Miranda v. Arizona).

(x) Compare and contrast conservative and liberal economic strategies, including the positions of political parties and interest groups on major issues to the present.

[OAR Docket #09-872; filed 5-8-09]

TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 15. CURRICULUM AND INSTRUCTION

[OAR Docket #09-871]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Priority Academic Student Skills
Part 13. The Arts
210:15-3-114.2. Definitions for music [AMENDED]
210:15-3-115. The arts for grade 1 [AMENDED]
210:15-3-116. The arts for grade 2 [AMENDED]
210:15-3-117. The arts for grade 3 [AMENDED]
210:15-3-118. The arts for grade 4 [AMENDED]
210:15-3-119. The arts for grade 5 [AMENDED]
210:15-3-120. The arts for grade 6 [AMENDED]
210:15-3-121. The arts for grade 7 [AMENDED]
210:15-3-122. The arts for grade 8 [AMENDED]

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ANALYSIS:

The proposed rule amendments provide additional clarity and detail to the Priority Academic Student Skills, Oklahoma's core curriculum. The changes reflect terminology in common usage within the music teaching profession and align from grade-to-grade certain objectives within the elementary music standard.

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN O. S. 75,
SECTION 308.1(A), WITH AN EFFECTIVE DATE
OF JUNE 11, 2009:**

SUBCHAPTER 3. PRIORITY ACADEMIC STUDENT SKILLS

PART 13. THE ARTS

210:15-3-114.2. Definitions for music

The following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**AB form**" means a musical plan that has two different parts, or sections.

"**ABA form**" means a musical plan that has three sections. The first and last sections are the same. The middle section is different.

"**Accelerando**" means perform gradually faster.

"**Acoustic instruments**" means traditional musical instruments that produce sound and amplify it by natural means (piano, guitar, trumpet, etc.), as opposed to instruments that produce and amplify sound electronically (synthesizers, sound modules, etc.).

"Acoustics" means the science of sound generation.

"Alto" means the lowest female voice.

"Allegro" means a quick and lively tempo.

"Andante (ahn-DAHN-tay)" means a walking pace, flowing (tempo).

"Articulation" means the degree to which notes are separated or connected such as staccato or legato.

"A tempo" means return to the previous tempo.

"Augmentation" means a compositional device in which a melodic line is repeated in longer note values.

"Aural" means relating to the sense of hearing, listening.

"Ballad" means a narrative song.

"Ballet" means a dance performance, often involving a narrative or plot sequence, usually accompanied by music. A ballet is characterized by conventional steps, poses, and graceful movements including leaps and spins. Women ballet dancers often wear pointe shoes to perform steps balancing on the tips of their toes.

"Bar" means a vertical line dividing measures on the staff.

"Baroque" means 1600-1750. Secular music predominated over sacred music and there was a certain "theatrical" spirit of elaborate design in the music, painting, and architecture. Polyphony and counterpoint from the Renaissance still predominate but homophonic texture (melody with chordal accompaniment) gains importance. New instrumental forms (solo sonata, concerto grosso, overture, etc.) and vocal forms (aria, recitative, opera, oratorio, and cantata, etc.) were developed. Noted composers of the time include Bach, Vivaldi, Handel.

"Bass" means the lowest male singing voice.

"Bass clef" means symbol placed on the five-line staff in traditional notation that tells you that the fourth line of the staff is the note F.

"Beat" means the consistent pulse that occurs throughout a rhyme, song or recorded musical selection.

"Body percussion" means sounds produced by the use of the body (e.g., clap, ~~snare~~, pat, slap, tap, stamp, ~~stomp~~, whistle, etc.).

"Bluegrass" means a type of American country music using acoustic instruments.

"Blues" means a genre of African-American music often expressing suffering, hardship and longing.

"Brass family" means wind instruments made out of metal with either a cup or funnel-shaped mouthpiece, such as trumpet, cornet, bugle, trombone, tuba, euphonium, saxophone, and French horn.

"Cadence" means a chordal or melodic progression which occurs at the close of a phrase, section or composition which gives the feeling of a temporary or permanent ending.

"Call and response" means a song style that follows a simple question and answer pattern in which a soloist leads and a group responds.

"Chord" means a combination of three or more tones sounded simultaneously.

"Chorus" means the repetitive part of a song that occurs between the verses; also a large group of singers.

"Classical" means 1750-1820, referred to as the "Age of Enlightenment"; the meaning of "classicism" in music

relates to the ancient Greek ideals of objectivity, emotional restraint, and a balanced clear musical form of short, regular phrases. Instrumental music surpassed vocal music in popularity. More attention was given to dynamic shading (getting gradually louder or softer). Dissonant sounds were resolved into consonant sounds. Noted composers of the time include Wolfgang Amadeus Mozart, Ludwig van Beethoven, Franz Joseph Haydn.

"Classroom instruments" means instruments typically used in the general music classroom, including, for example: recorder-type instruments, autoharp, mallet instruments, simple percussion, keyboard, and electronic instruments.

"Clef" means symbol placed at the beginning of the staff to indicate the pitch of the notes on the staff (treble clef and bass clef).

"Coda" means closing section of a composition.

"Collage" means twentieth-century technique of making art in which various materials, such as paper, photographs, fabric, string, etc., are pasted on a flat surface.

"Common time" means 4/4 meter.

"Compose" means a person who writes music.

"Composition" means the completed arrangement of music.

"Concert" means a musical performance for an audience, requiring the cooperation of several musicians.

"Concerto" means a piece musical work for a soloist and orchestra.

"Conductor" means director of an orchestra or chorus.

"Contemporary" means 1900 to present. There are many different musical trends occurring simultaneously, including music for film and television. Some of the broader tendencies of modernism are Neoromanticism, Expressionism, Neoclassicism, American jazz/blues, popular music for Broadway and film. Noted composers of the time include Igor Stravinsky, Aaron Copeland, Duke Ellington

"Contour" means the direction of a musical melodic line.

"Counter melody" means a vocal part which contrasts with the main melody; an independent melody which complements the main melody.

"Crescendo" means gradually louder.

"Cue" means a signal given by the director of a performing group to begin either at the beginning of the music or after they have concluded a section at rest.

"Cut time" means meter in which there are two beats in each measure and a half note receives one beat.

"Dal segno, D.S. al fine" means repeat from the sign to fine (the end).

"D.C. al fine" means to the end.

"Decrescendo" means gradually softer. Synonymous with diminuendo.

"~~Diminution~~ Diminution" means the shortening of note values.

"Duet" means a composition performed by two performers.

"Duration" means how long a sound lasts.

"Dynamics" means varying degrees of loud and soft (pianissimo, piano, mezzo piano, mezzo forte, forte, fortissimo, sforzando).

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"Elements of music" means pitch - the highness or lowness of a particular note; rhythm - beats per measure; harmony - two or more tones sounding together; dynamics - varying degrees of loud and soft; number of sounds occurring simultaneously; form - the organization of a musical composition; tempo - the speed or pace of music; melody - a succession or pattern of musical tones or pitches; tone color - the quality of sound of an instrument or voice.

"Flat" means b - a symbol that lowers the pitch of a note one-half step.

"Folk music" means music of a particular people, nation or region, originally transmitted orally, sometimes as a rhythmic accompaniment to manual work or to mark a specific ritual.

"Form" means the organization of a musical composition according to its sections of repetition, contrast, variation or development.

"Forte-*f*" means loud (dynamic).

"Fortissimo-*ff*" means very loud (dynamic).

"Four sections of an orchestra" means woodwind instruments - include the flute, oboe, piccolo, English horn, clarinet, bassoon, contrabassoon, and saxophone. Many of these instruments are pipes perforated by holes in their sides, which produce musical sound when the columns of air within them vibrate by blowing on a mouthpiece. String instruments - include the violin, viola, cellos (or cello), and double bass. All of these have strings that produce sound when stroked with a bow or plucked. Brass instruments - include the French horn, trumpet, trombone, and tuba, all of which have metal instrument bodies and mouthpieces. Percussion instruments - musical instruments that are struck or shaken to produce a sound, includes tympany, bass drum, snare drum, cymbals, triangle, gongs, glockenspiel, and xylophone and marimba.

"Genre" means a category of musical composition, such as symphony, opera, string quartet, cantata, concerto, etc.

"Harpichord" means a keyboard instrument of European origin, resembling a piano and having horizontal strings plucked by leather or quill points connected to the keys.

"Harmony" means two or more tones sounding together.

"Impressionism" means 1880-1918. This style was centered mostly in France. The composers developed a new musical "language" that has affected music even to the present day. Composers experimented with: new coloristic effects in instruments and the voice and in harmonies, new combinations of scales and rhythms. There were parallels to the artwork of the time in the "feeling" of lightness and exoticism in the music. Noted composers of the time include Claude Debussy, Maurice Ravel.

"Instrument groupings or instrument families" means classification of instruments by the way or material by which sound is made (i.e. strings, brass, percussion, wind).

"Interval" means the difference in pitch distance between two tones.

"Intonation" means the degree to which pitch is accurately produced in performance, by the musicians in an ensemble.

"Jazz" means a popular style of music characterized by strong, prominent meter, improvisation, and dotted or syncopated patterns.

"Key signature" means the sharps and flats placed at the beginning of a composition or line of music denoting the scale on which the music is based.

"Major scale" means a scale built on the pattern of two whole steps, one half step, three whole steps, and one half step.

"Measure" means a group of beats in written music, set off by vertical lines; the notes and rests comprised between two vertical bar lines.

"Melody" means a succession or pattern of musical tones or pitches. Arranging these pitches creates a specific tonal and rhythmic succession of sounds that makes each piece recognizable and expresses a musical idea or tune.

"Meter" means the grouping of accented and unaccented beats in a pattern of two (ONE, two, ONE, two) or three (ONE, two, three, ONE, two, three) or combinations of two and three, which gives internal organization, consistency and flow to the music.

"Meter signature" ~~means an indication at the beginning of a musical work, usually presented in the form of a fraction, the lower of which indicates the unit of measurement and the upper number of which indicates the number of units that make up a measure (see also "time signature").~~ means an indication at the beginning of a musical work, the lower number indicates the kind of note to receive one beat, and the upper number indicates the number of beats that make up a measure (see also "time signature").

"Mezzo forte - *mf*" means medium loud.

"Mezzo piano - *mp*" means medium soft.

"MIDI" means an acronym for Musical Instrument Digital Interface. The standard specifications that enable electronic instruments to communicate with one another and with computers.

"Minor scale" means a scale built on the pattern of one whole step, one half step, two whole steps, one half step, and two whole steps.

"Motive" means a short melodic or rhythmic pattern.

"Movement" means the principal division or section of a musical composition.

"Notation" means method in which music is written down, usually on a staff, indicating specific pitches and the duration of each pitch. ~~In Western culture, this system works just like fractions (i.e., whole notes, half notes, quarter notes, eighth notes, sixteenth notes).~~

"Note" means a musical symbol that denotes both pitch and duration.

"Opera" means a theatrical performance involving a drama, the text of which is sung to the accompaniment of an orchestra.

"Opera glasses" means small decorative low-powered binoculars for use by people in the audience at theatrical, operatic, or ballet performances.

"Orchestra" means group of musicians playing together on instruments. In Western music, the orchestra typically includes string, wind, brass and percussion instrument groupings.

"Overture" means an extended orchestral introduction to an opera, ballet, or similar type of musical presentation.

"Percussion family" means instruments that produce sounds of definite or indefinite pitch when shaken or struck including tympani, bass drum, snare drum, xylophone, marimba, cymbal, triangle, chimes, and piano.

"Percussive sounds" means sounds made by striking, shaking and/or scraping.

"Phrase" means a relatively short portion of a melodic line which expresses a musical idea, comparable to a line or sentence in poetry.

"Phrasing" means dividing musical sentences into melodic and/or rhythmic sections, similar to the effect of punctuation in language.

"Pianissimo" means very soft.

"Piano" means a large musical instrument consisting of a wooden case with wires stretched inside it and a row of white and black keys.

"Piano - p" means soft; pianissimo *-pp* - very soft (dynamic). Italian for "soft."

"Pitch" means the highness or lowness of a particular note.

"Polyphony" means the simultaneous combination for different melodies and rhythms.

"Prelude" means an introductory movement of a piece.

"Presto" means very fast- tempo.

"Prima donna" means the principal female singer in an opera.

"Quartet" means a composition for four instruments or voices.

"Range" means pitches from low to high which a singer or instrumentalist may perform.

"Refrain" means a short section of repeated music which occurs at the end of each stanza.

"Reggae" means Jamaican dance music, mixing African and Caribbean rhythms.

"Renaissance" means 1400-1600. This period is referred to as the "Golden Age of Polyphony" (poly - many, and phony - sounds), where there are two or more melodic lines sounding simultaneously. Vocal music predominated but instrumental music had increased interest as an independent style. Music was heard in church as well as the households of the aristocracy and upper classes. There was more of a tendency to use major/minor tonality rather than modality, as in the Medieval times. Noted composers of the time include Gabrielli, Monteverdi, Palestrina.

"Repertoire" means a variety of musical pieces.

"Repetition" means music that is the same, or almost the same, as music that was heard earlier.

"Rests" means symbols used to represent silence between notes.

"Rhythm" means the term which denotes the organization of sound in time or the proportion or duration of notes. Beats per measure.

"Rhythm pattern" means a group of long and short sounds/silences.

"Ritardando" means perform gradually slower.

"Romantic" means 1820-1900. During the nineteenth and early twentieth century Romantic music was expressive and exciting, and stressed the expression of feeling using of a wide dynamic range, expanded harmonies of new chords and progressions. Noted composers of the time include Johannes Brahms, Richard Wagner, Franz Schubert, Robert Schumann.

"Rondo" means a composition consisting of a recurring theme alternating with contrasting sections.

"Round" means a song imitated at the same pitch by a second (or third) group of singers who begin at a designated time during the song (e.g., "Row, row, row your boat").

"Scale" means an organization of pitches in ascending or descending sequence.

"Score" means the written depiction of all the parts of a musical ensemble with the parts layered vertically and rhythmically aligned.

"Sequence" means the repetition of a melodic ensemble with the parts layered vertically and rhythmically aligned.

"Sharp - #" means a symbol which raises the pitch of a note one-half step.

"Solo" means playing or singing alone. A solo performer is called a soloist.

"Sonata" means an instrumental piece in several movements.

"Sonata - allegro form" means a return form consisting of three sections: exposition, development, and recapitulation.

"Soprano" means the highest female voice.

"Soul music" means a form of rhythm and blues.

"Staff" means the musical ~~ladder graph~~ made up of a set of five parallel lines and four spaces on which music is written ~~and makes it easy for you to tell how high or low a sound is.~~ The lines and spaces are counted from the bottom up to the top.

"Staves" means the plural of staff. The five parallel lines on which music is written.

"String instrument family" means instruments with strings that produce sound when plucked, bowed, or struck including violin, viola, cello, and bass.

"String quartet" means an ensemble of four stringed instruments including two violins, a viola, and a cello, also music performed by the ensemble.

"Style" means the distinctive or characteristic manner in which the elements of music are treated.

"Swing era" means a period of music from 1935 to 1945.

"Symphony" means a piece musical work for a large orchestra usually in four movements.

"Syncopation" means deliberate shifting of the pattern of strong and weak beats.

"Synthesizer" means a machine that produces sound electronically.

"Tempo" means the speed or pace of music. Musical tempos are expressed in Italian and include *lento*, very slow; *adagi*, slow; *moderato*; *allegro*, lively; *presto*, fast; *vivace*, very fast.

"Tenor" means the highest male voice.

"Texture" means the way individual parts of music are layered or the number of sounds occurring simultaneously.

"Theme" means a melody that assumes importance in a composition because of its central and continued use.

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"**Time signature**" means the meter (number of beats per measure and kind of note getting one beat, e.g., 2/4 or 3/4 or 4/4 meter).

"**Tonality**" means the key or ~~tone~~tonal center of a piece of music.

"**Tone Color**" means the quality of sound of an instrument or voice.

"**Tone poem**" means programmatic work for a symphony.

"**Transposition**" means the process of changing the key of a composition.

"**Treble**" means high in pitch.

"**Treble clef**" means symbol placed on the five-line staff in traditional notation indicating the pitch of the notes and locating G on the second line from the bottom.

"**Two-part songs**" means songs written for performance by two distinct voices.

"**Vibrato**" means a slight wavering or pulsating of tone.

"**Virtuoso**" means a performer with brilliant, flawless technique.

"**Unison**" means two or more parts performing the same pitches or melody simultaneously.

"**Waltz**" means a dance in triple meter, made famous in Vienna in the late 1800s.

"**Wind instrument family**" means instruments originally made of wood, in which sound is produced by the vibration of air including piccolo, flute, clarinet, oboe, English horn, bassoon, and contrabassoon.

210:15-3-115. The arts for grade 1

(a) Visual art.

(1) **Standard - language of Visual art.** The student will identify visual art terms (e.g., collage, design, original, portrait, paint, subject, etc.).

(A) Use appropriate art vocabulary.

(B) Name elements of art; line, color, form, shape, texture, value and space.

(C) Name the principles of design; rhythm, balance, contrast, movement, center of interest (emphasis) and repetition.

(D) Use the elements of art and principals of design.

(2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.

(A) Understand art reflects a culture.

(B) Identify connections between visual arts and other arts disciplines.

(C) Identify specific works of art produced by artists in different cultures, times and places.

(3) **Standard - Visual art expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of visual art.

(A) Experiment in color mixing with various media.

(B) Use a variety of subjects, basic media and techniques in making original art including drawing, painting, and sculpture.

(C) Demonstrate beginning skills of composition using the elements of art and principles of design.

(D) Use art media and tools in a safe and responsible manner.

(4) **Standard - Visual art appreciation.** The student will appreciate visual art as a vehicle of human expression.

(A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.

(B) Demonstrate respect for their work and the work of others.

(C) Demonstrate thoughtfulness and care in completion of artworks.

(b) General music.

(1) **Standard - language of music.** The student will read, notate and interpret music.

(A) Identify the elements of music:

(i) Melody (high and low, upward and downward, leaps and repeats)

(ii) Rhythm (strong and weak beats, meter in 2/4, long and short sounds)

(iii) Harmony (~~sing with instruments, without instruments, play ostinato pattern on rhythm or melody instruments as an accompaniment~~)(sing accompanied, sing unaccompanied, perform ostinato pattern as accompaniment)

(iv) Form (introduction, repetition/contrast, solo/chorus, verse/refrain)

(v) Color (classroom percussion instruments, sounds from nature, machines, or the environment, orchestra instruments from each family of instruments - trumpet, clarinet, violin, tympani)

(vi) Pitch (high and low)

(vii) Tempo (fast and slow, getting faster or slower)

(viii) Dynamics (loud and soft, getting louder or softer)

~~(B) Recognize basic rhythm patterns by using rhythm syllables (quarter note, eighth note, half note patterns).~~

(B) Use a system of syllables, numbers or letters to demonstrate basic notation:

(i) Rhythmic (quarter note, quarter rest, paired eighth notes)

(ii) Melodic (sol, mi, la or 5, 3, 6)

(C) Recognize basic features of familiar and unfamiliar songs:

(i) Dynamics - loud and soft

(ii) Tempo - fast and slow

~~(iii) Styles — action songs, chants, rhymes, singing games~~

(iii) Form - same and different

(2) **Standard - music history and culture.** The student will recognize the development of music from an historical and cultural perspective.

~~(A) Recognize music from our country, work songs, holiday songs and music from different countries.~~

~~(B) Sing and perform music from a variety of folk, ethnic, classical and contemporary songs.~~

~~(A) Sing and perform action songs, chants, rhymes, singing games and dances from a variety of cultures.~~

~~(B) Recognize music from our country, work songs, holiday songs and music from different countries.~~

(C) Identify music and instruments from different cultures.

(3) **Standard - music expression.** The student will perform, imitate, and compose a variety of music within specific guidelines.

(A) Participate in music through singing and/or playing instruments.

(B) Match pitches, sing in tune and use appropriate tone and expression.

(C) Respond to the beat or rhythm in music by clapping, walking, running, skipping, galloping, hopping, playing classroom instruments, or chanting.

(D) Play simple rhythmic patterns using sounds and silences on classroom percussion instruments to accompany songs and rhythm activities.

(E) Play simple pitch patterns (tones) on instruments, such as bells or xylophones.

(F) While listening to a musical piece, use directional hand movements to follow the melodic contour (sound or progression of single tones).

(G) Respond to unfinished short melodic patterns using voice or classroom instruments.

(4) **Standard - music appreciation.** The student will learn to appreciate music and expand their listening beyond music currently familiar to the student.

(A) and practice appropriate audience or performer behavior appropriate for the context and style of music performed.

(B) Demonstrate respect for music performed by the student and by other students and professional performers.

(C) Discuss likes and dislikes of music of different styles.

210:15-3-116. The arts for grade 2

(a) **Visual art.**

(1) **Standard - language of Visual art.** The student will identify visual art terms (e.g., collage, design, original, portrait, paint, subject, etc.).

(A) Use appropriate art vocabulary.

(B) Name and describe elements of art; line, color, form, shape, texture, value and space.

(C) Name and describe the principles of design; rhythm, balance, contrast, movement, center of interest (emphasis) and repetition.

(D) Use the elements of art and principals of design to communicate ideas.

(2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.

(A) Understand art reflects the culture of its origin.

(B) Identify connections between characteristics of the visual arts and other arts disciplines.

(C) Identify specific works of art produced by artists in different cultures, times and places.

(3) **Standard - Visual art expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of visual art.

(A) Experiment in color mixing with various media.

(B) Use a variety of subjects, basic media and techniques in making original art including drawing, painting, weaving, sculpture, and ceramics.

(C) Demonstrate beginning skills of composition using the elements of art and principles of design.

(D) Use art media and tools in a safe and responsible manner.

(4) **Standard - Visual art appreciation.** The student will appreciate visual art as a vehicle of human expression.

(A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.

(B) Demonstrate respect for their work and the work of others.

(C) Demonstrate thoughtfulness and care in completion of artworks.

(b) **General music.**

(1) **Standard.- language of music.** The student will read, notate and interpret music.

(A) Identify the elements of music:

(i) Melody (steps, leaps, and repeated tones, melody patterns, high and low, upward and downward motives, repeated phrases)

(ii) Harmony (~~accompaniment and no accompaniment, chord changes, ostinato patterns~~)(sing accompanied, sing unaccompanied, perform ostinato patterns as accompaniment, sing to chordal accompaniment)

(iii) Tone Color (classroom percussion instruments, identify trumpet, clarinet, violin, tympani, different tone quality of an individual or group)

(iv) Rhythm (strong and weak beats, meter in 2/4 and 3/4, long and short sounds, rhythm patterns in songs and ostinatos).

(v) Form (introduction, coda, repetition/contrast, solo/chorus, AB)

(vi) Pitch (higher and lower)

(vii) Tempo (fast and slow, gradually faster and slower, suddenly faster and slower)

(viii)Dynamics (loud and soft, gradually louder and softer, suddenly louder and softer)

~~(B) Recognize basic rhythm patterns by using rhythm syllables (quarter note, eighth note, half note, whole note patterns and the corresponding rests).~~

(B) Use a system of syllable, numbers or letters to demonstrate basic notation:

(i) Rhythmic (quarter note, quarter rest, paired eighth notes, half note, half rest, whole note, whole rest)

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- (ii) Melodic (sol, mi, la, do or 5, 3, 6, 1)
- (C) Recognize basic features of familiar and unfamiliar songs:
 - (i) Dynamics - loud and soft, gradual change of louder and softer
 - (ii) Tempo - fast and slow, gradual change of faster and slower
 - ~~(iii) Styles — action songs, chants, rhymes, singing games of different cultures~~
 - (iii) Form - same and different
- (2) **Standard - music history and culture.** The student will recognize the development of music from an historical and cultural perspective.
 - ~~(A) Recognize music from our country, work songs, holiday songs and music from different countries.~~
 - ~~(B) Sing and perform action songs, singing games and dances from a variety of cultures.~~
 - (A) Sing and perform action songs, chants, rhymes, singing games and dances from a variety of cultures.
 - (B) Recognize music from our country, work songs, holiday songs and music from different countries.
 - (C) Identify music and instruments from different cultures. (i.e. koto, maracas, Native American flute, African talking drum).
- (3) **Standard. music expression.** The student will perform, imitate, and compose a variety of music within specific guidelines.
 - (A) In music through singing (echo singing) and/or playing instruments (body percussion and melodic ostinatos).
 - (B) Match pitches, sing in tune (C-scale range) and use appropriate tone and expression.
 - (C) Respond to the beat or rhythm in music by clapping, walking, running, skipping, galloping, hopping, sliding, playing classroom instruments, or chanting.
 - (D) Play simple rhythmic patterns using sounds and silences on classroom percussion instruments to accompany songs and rhythm activities.
 - (E) Play simple melodies by rote on instruments, such as bells or xylophones.
 - (F) While listening to a musical piece, use directional hand movements to follow the melodic contour (sound or progression of single tones).
 - (G) Respond to unfinished short melodic patterns using voice or classroom instruments.
 - (H) Perform solos and in groups.
- (4) **Standard - music appreciation.** The student will learn to appreciate music and expand their listening beyond music currently familiar to the student.
 - (A) Recognize and practice appropriate audience or performer behavior appropriate for the context and style of music performed.
 - (B) Demonstrate respect for music performed by the student and by other students and professional performers.

- (C) Discuss likes and dislikes of music of different styles.

210:15-3-117. The arts for grade 3

- (a) **Visual art.**
 - (1) **Standard - language of Visual art.** The student will identify visual art terms (e.g., collage, design, original, portrait, paint, subject, etc.).
 - (A) Use appropriate art vocabulary.
 - (B) Name, describe, and understand the elements of art: line, color, form, shape, texture, value and space.
 - (C) Name, describe, and understand the principles of design: rhythm, balance, contrast, movement, center of interest (emphasis) and repetition.
 - (D) Use the elements of art and principals of design to express original ideas.
 - (2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.
 - (A) Understand that art reflects and describes the culture of its origin.
 - (B) Identify connections between different styles of the visual arts and other art disciplines.
 - (C) Identify specific works of art produced by artists including European, American, Native American, African American, Hispanic, and Asian art produced at different times and places.
 - (3) **Standard - Visual art expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of visual art.
 - (A) Experiment in color mixing with various media.
 - (B) Use a variety of subjects, basic media and techniques in making original art including drawing, painting, weaving, sculpture, printmaking, and ceramics.
 - (C) Demonstrate understanding and knowledge of composition using the elements of art and principles of design.
 - (D) Use art media and tools in a safe and responsible manner.
 - (4) **Standard - Visual art appreciation.** The student will appreciate visual art as a vehicle of human expression.
 - (A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.
 - (B) Demonstrate respect for their work and the work of others.
 - (C) Demonstrate thoughtfulness and care in completion of artworks.
- (b) **General music.**
 - (1) **Standard - language of music.** The student will read, notate and interpret music.
 - (A) Identify the elements of music:
 - (i) Melody (steps, wide and narrow leaps, and repeated tones, melody patterns, high and low

- pitches, melodic contour, same, different and similar phrases)
- (ii) Harmony (chordal harmony, chord changes, ostinato patterns, countermelody, rounds)
 - (iii) Tone Color (classroom percussion instruments: trumpet, clarinet, violin, tympani, and different tone quality of an individual or group)
 - (iv) Rhythm (strong and weak beats, steady beat, silent beat, meter in 2/4, 3/4 and 4/4, dotted rhythms).
 - (v) Form (introduction, coda, repetition/contrast, solo/chorus, AB, ABA, rondo, D.C. al fine)
 - (vi) Pitch (higher and lower)
 - (vii) Tempo (fast and slow, faster and slower, gradual and sudden changes in tempo)
 - (viii) Dynamics (loud and soft, gradually louder and softer, suddenly louder and softer)
- ~~(B) Recognize basic rhythm patterns by using rhythm syllables (quarter note, eighth note, half note, whole note, dotted half note patterns).~~
- (B) Use a system of syllables, numbers or letters to demonstrate basic notation:
- (i) Rhythmic (quarter note, quarter rest, paired eighth notes, half note, half rest, whole note, whole rest, dotted half note)
 - (ii) Melodic (sol, mi, la, do re or 5, 3, 6, 1, 2)
- (C) Recognize basic features of familiar and unfamiliar songs:
- (i) Dynamics - loud and soft, gradual change of louder and softer
 - (ii) Tempo - fast and slow, gradual change of faster and slower
 - ~~(iii) Styles—songs, chants, rhymes, different cultures~~
 - (iii) Form - same and different, similar
- (D) Identify instrument ensembles (brass, strings, woodwinds, percussion)
- (2) **Standard - music history and culture.** The student will recognize the development of music from an historical and cultural perspective.
- ~~(A) Recognize music from our country, work songs, holiday songs and music from different countries.~~
- ~~(B) Sing and perform action songs, singing games and dances from a variety of cultures.~~
- (A) Sing and perform action songs, chants, rhymes, singing games and dances from a variety of cultures.
- (B) Recognize music from our country, work songs, holiday songs and music from different countries.
- (C) Identify music and instruments from different cultures. (i.e., bagpipe, wooden flute, koto, panpipes).
- (3) **Standard - music expression.** The student will perform, imitate, and compose a variety of music within specific guidelines.
- (A) Participate in music through singing (echo singing, rounds and partner songs) and/or playing instruments (body percussion and melodic ostinatos).

- (B) Match pitches, sing in tune (C-scale range) and use appropriate tone and expression.
 - (C) Respond to the beat or rhythm in music by clapping, walking, running, skipping, galloping, sliding, playing classroom instruments, or chanting.
 - (D) Play simple rhythmic patterns using sounds and silences on classroom percussion instruments to accompany songs and rhythm activities.
 - (E) Play simple melodies by rote on instruments, such as bells or xylophones.
 - (F) While listening to a musical piece, use directional hand movements to follow the melodic contour (sound or progression of single tones).
 - (G) Respond to unfinished short melodic patterns using voice or classroom instruments.
 - (H) Perform solos and in groups.
 - (I) Sing two-part rounds, partner songs and ostinatos.
- (4) **Standard - music appreciation.** The student will learn to appreciate music and expand their listening beyond music currently familiar to the student.
- (A) Recognize and practice appropriate audience or performer behavior appropriate for the context and style of music performed.
 - (B) Demonstrate respect for music performed by the student and by other students and professional performers.
 - (C) Use appropriate terms to explain preferences for musical works and styles.

210:15-3-118. The arts for grade 4

- (a) **Visual arts.**
- (1) **Standard - language of Visual art.** The student will identify visual art terms (e.g., architecture, contour, medium, mixed media, perspective, symbol, etc.).
- (A) Know how works of art are made with respect to the materials, media, techniques, and sources of ideas.
 - (B) Describe and use the principles of design: rhythm, balance, contrast, movement, variety, center of interest (emphasis), and repetition in works of art.
 - (C) Describe and use the elements of art: line, color, form, shape, texture, value (light and dark), and space in works of art.
 - (D) Discuss observations of visual and expressive features seen in the environment (such as colors, textures, shapes, etc.).
- (2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.
- (A) Describe and place a variety of specific significant art objects by artist, style and historical and cultural context.
 - (B) Identify themes and purposes of works of art and artifacts in history and culture.
 - (C) Demonstrate a basic knowledge of several fields of art such as painting, sculpture, drawing,

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computer graphics, printmaking, architecture, and fiber arts.

(D) Identify how the visual arts are used in today's world including the popular media of advertising, television, and film.

(3) **Standard - Visual arts expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of art.

(A) Make original works of art using a variety of materials (media), and techniques (skills), and sources for ideas.

(B) Use observation, memory and imagination in making original works of art.

(C) Apply knowledge of a basic art vocabulary through experiences in making original works of art.

(4) **Standard - Visual arts appreciation.** The student will learn to appreciate visual art as a vehicle of human expression.

(A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.

(B) Demonstrate respect for their work and the work of others.

(C) Demonstrate thoughtfulness and care in completion of artworks.

(b) **General music.**

(1) **Standard - language of music.** The student will read, notate and interpret music.

~~(A) Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).~~

~~(B) Recognize basic notational symbols (written representation of music) including: treble clef, time signatures (2/4, 3/4, 4/4, and 6/8), note values, whole note, half note, quarter note, eighth note, dotted half note, dotted quarter note, dotted whole note and the corresponding rests.~~

~~(C) Experiment with variations in and demonstrate understanding of tempo (speed), timbre or tone color (sound quality), dynamics (degree of loudness), and phrasing for expressive purposes.~~

~~(D) Use correct terminology to discuss the elements of music.~~

~~(i) Melody (steps, wide and narrow leaps, octave leap, and repeated tones, melody patterns, melodic contour, same, different, similar phrases)~~

~~(ii) Rhythm (strong and weak beats, steady beat, offbeat, silent beat, meter in 2/4, 3/4, 4/4 and 6/8)~~

~~(iii) Harmony (chordal harmony, chord changes, ostinato patterns, counter melody, rounds, thick and thin texture)~~

~~(iv) Form (introduction, coda, repetition/contrast, solo/chorus, AB, ABA, rondo, D.C. al fine)~~

~~(v) Tone Color (duets, trios, chorus, voice ranges [soprano, alto, tenor, bass] and instrument ranges [flute, tuba, violin, tympani])~~

~~(vi) Pitch - high and low~~

~~(vii) Tempo — allegro (fast), lento (slow), andante (walking), moderato (moderate).~~

~~(viii) Dynamics — forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft).~~

~~(E) Visually and aurally identify instrumental ensembles (e.g. orchestra, jazz band), orchestral instruments and classification of voice (e.g., soprano, alto, tenor, bass).~~

(A) Use correct terminology to discuss the elements of music.

(i) Melody (steps, wide and narrow leaps, octave leap, and repeated tones, melody patterns, melodic contour, same, different, similar phrases)

(ii) Rhythm (strong and weak beats, steady beat, offbeat, silent beat, meter in 2/4, 3/4, 4/4 and 6/8)

(iii) Harmony (chordal harmony, chord changes, ostinato patterns, counter melody, rounds, thick and thin texture)

(iv) Form (introduction, coda, repetition/contrast, solo/chorus, AB, ABA, rondo, D.C. al fine)

(v) Tone Color - sound quality of individual and group performances by voice or instrument to include duets, trios, quartets, chorus, etc., and ranges (soprano, alto, tenor, bass).

(vi) Pitch - high and low

(vii) Tempo - allegro (fast), lento (slow), andante (walking), moderato (moderate).

(viii) Dynamics - forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft).

(B) Use a system of syllables, numbers or letters to demonstrate basic notation:

(i) Rhythmic (quarter note, quarter rest, paired eighth notes, half note, half rest, whole note, whole rest, dotted half note, sixteenth notes, single eighth note, single eighth rest, syncopation, 2/4, 3/4, 4/4, 6/8).

(ii) Melodic (sol, mi, la, do, re, high do, low la, low sol or 5, 3, 6, 1, 2, 8, low 6, low 5, treble clef)

(C) Experiment with variations in and demonstrate understanding of tempo (speed), timbre or tone color (sound quality), dynamics (degree of loudness), and phrasing for expressive purposes.

(D) Identify visually and aurally:

(i) Instrumental ensembles (symphony orchestra, jazz band)

(ii) Families of orchestral instruments (strings, woodwinds, brass and percussion)

(iii) Classification of voice ranges (soprano, alto, tenor, bass)

(E) Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).

(2) **Standard - music history and culture.** The student will recognize the development of music from an historical and cultural perspective.

- (A) Sing or play a variety of folk, ethnic, classical, and contemporary musical pieces.
 - (B) Listen and describe music from a variety of styles, periods and cultures including European, Native American, African American, Hispanic, and Asian.
 - (C) Identify music and instruments from different cultures. (i.e. bagpipe, wooden flute, koto, pan-pipes).
 - (D) Identify and describe roles of musicians in various music settings and cultures.
- (3) **Standard - music expression.** The student will perform, imitate, and compose a variety of music within specific guidelines.
- (A) Participate in music through singing (echo singing, rounds and partner songs) and/or playing instruments (body percussion and melodic ostinatos).
 - (B) Match pitches, sing in tune (C-scale range) and use appropriate tone and expression.
 - (C) Respond to the beat or rhythm in music by clapping, playing classroom instruments.
 - (D) Play simple and syncopated rhythm patterns using sounds and silences on classroom percussion instruments to accompany songs and rhythm activities.
 - (E) Play simple melodies on instruments, such as bells or xylophones.
 - (F) While listening to a musical piece, use directional hand movements to follow the melodic contour (sound or progression of single tones).
 - (G) Respond to unfinished short melodic patterns using voice or classroom instruments.
 - (H) Perform solos and with groups.
 - (I) Sing two-part rounds, partner songs/ostinatos.
- (4) **Standard - music appreciation.** The student will learn to appreciate music and expand their listening beyond music currently familiar to the student.
- (A) Recognize and practice appropriate audience or performer behavior appropriate for the context and style of music performed.
 - (B) Demonstrate respect for music performed by the student and by other students and professional performers.
 - (C) Use appropriate terms to explain preferences for musical works and styles.

210:15-3-119. The arts for grade 5

(a) **Visual arts.**

- (1) **Standard - language of Visual art.** The student will identify visual art terms (e.g., architecture, contour, medium, mixed media, perspective, symbol, etc.).
- (A) Describe and apply knowledge of the principles of design: rhythm, balance (symmetrical, asymmetrical, radial) contrast, movement, variety, center of interest (emphasis), and repetition in their own art work, and the art works of others.
 - (B) Describe and use the elements of art: line, color, form, shape, texture, value (light and dark),

and space in works of art. Identify and discriminate between types of shape (geometric and organic), colors (primary, secondary, complementary, intermediates, neutrals, tints, tones, shades, and values), lines (characteristics, quality), textures (tactile and visual), and space (background, middleground, foreground, placement, perspective, overlap, negative, positive, size, color) in their own art work, and the art works of others.

(C) Know how works of art are made with respect to the materials, media, techniques, and sources of ideas.

(D) Discuss observations of visual and expressive features seen in the environment (such as colors, textures, shapes, etc.).

(2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.

(A) Describe and place a variety of specific significant art objects by artist, style and historical and cultural context.

(B) Identify themes and purposes of works of art and artifacts in history and culture.

(C) Identify how the visual arts are used by artists in today's world, including the popular media of advertising, television, and film (e.g., illustrator, fashion designer, sculptor, display designer, painter, graphic designer, animator, photographer).

(D) Communicate in-depth knowledge gained through integrated study of a visual art theme, historical period, or event.

(3) **Standard - Visual art expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of art.

(A) Make original works of art using a variety materials (media), and techniques (skills), and sources for ideas.

(B) Use observation, memory and imagination in making original works of art.

(C) Demonstrate safe and proper use, care, and storage of media, materials, and equipment.

(D) Apply knowledge of a basic art vocabulary through experiences in making original works of art.

(E) Demonstrate a basic knowledge of media, techniques and processes in:

(i) Painting

(I) media: tempera, watercolor, oil, and acrylic.

(II) processes: wet-on-wet, wet-on-dry, wash, resist, sponge.

(ii) Sculpture or Architecture

(I) media: paper, papier-mache, clay, plaster, cardboard, wood, found objects, beads, sand, wire.

(II) processes: carving, constructing, and assembling

(iii) Drawing

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- (I) media: pencils, colored pencils, markers, chalks, crayons, oil-pastels,
- (II) processes: sketching, contour line, hatching, crosshatching,
- (iv) Printmaking
- (I) media: printing ink, styrofoam, stencil, found object.
- (II) processes: relief, silkscreen, and monoprint.
- (v) Fiber Arts
- (I) media: cloth, yarn, ribbon, found objects, paper, and rope
- (II) processes: weaving, stitchery, braiding, and basketry.
- (4) **Standard - Visual art appreciation.** The student will learn to appreciate visual art as a vehicle of human expression.
- (A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.
- (B) Demonstrate respect for their work and the work of others.
- (C) Demonstrate thoughtfulness and care in completion of artworks.
- (b) **General music.**
- (1) **Standard - language of music.** The student will read, notate and interpret music.
- ~~(A) Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).~~
- ~~(B) Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and phrasing for expressive purpose in performing music.~~
- ~~(C) Identify basic notational symbols (written representation of music), including: treble and bass clef, time signatures; (2/4, 3/4, 4/4, and 6/8); note values (whole note, half note, quarter note, eighth note, dotted half note, and the corresponding rests).~~
- ~~(D) Define and use correct terminology to identify and discuss the elements of music including:~~
- ~~(i) Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale (five tone scale)).~~
- ~~(ii) Rhythm (even and uneven rhythm patterns, syncopation, triplets, dotted rhythms).~~
- ~~(iii) Harmony (partner songs, counter melody, descant, major and minor chords).~~
- ~~(iv) Form (AB, ABA, round, rondo, introduction, coda, interlude, verse and refrain, prelude).~~
- ~~(v) Tone color (duet, trio, quartet, chorus, voice ranges and instrument ranges)~~
- ~~(vi) Pitch (high and low)~~
- ~~(vii) Tempo (allegro (fast), lento (slow), andante (walking), moderato (moderate))~~
- ~~(viii) Dynamics (forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft)).~~
- ~~(E) Identify visually and aurally:~~
- ~~(i) instrumental ensembles (marching band, symphony orchestra, jazz band).~~
- ~~(ii) families of orchestral instruments (strings, wood winds, brass, and percussion).~~
- ~~(iii) classification of voice ranges (soprano, alto, tenor, bass).~~
- ~~(A) Define and use correct terminology to identify and discuss the elements of music including:~~
- ~~(i) Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale (five-tone scale)).~~
- ~~(ii) Rhythm (even and uneven rhythm patterns, syncopation, triplets, dotted rhythms).~~
- ~~(iii) Harmony (partner songs, counter melody, descant, major and minor chords).~~
- ~~(iv) Form (AB, ABA, round, rondo, introduction, coda, interlude, verse and refrain, prelude).~~
- ~~(v) Tone color - sound quality of individual and group performances by voice or instrument to include duets, trios, quartets, chorus, etc. and ranges (soprano, alto, tenor, bass).~~
- ~~(vi) Pitch (high and low)~~
- ~~(vii) Tempo - allegro (fast), lento (slow), andante (walking), moderato (moderate)~~
- ~~(viii) Dynamics - forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft).~~
- ~~(B) Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and phrasing for expressive purpose in performing music.~~
- ~~(C) Use a system of syllables, numbers or letters to demonstrate basic notation:~~
- ~~(i) Rhythmic (quarter note, quarter rest, paired eighth notes, half note, half rest, whole note, whole rest, dotted half note, sixteenth notes, single eighth note, single eighth rest, dotted quarter note, syncopation, 2/4, 3/4, 4/4, 6/8)~~
- ~~(ii) Melodic (diatonic scale, treble clef, bass clef)~~
- ~~(D) Identify visually and aurally:~~
- ~~(i) instrumental ensembles (marching band, symphony orchestra, jazz band).~~
- ~~(ii) families of orchestral instruments (strings, wood winds, brass, and percussion).~~
- ~~(iii) classification of voice ranges (soprano, alto, tenor, bass).~~
- ~~(E) Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).~~
- (2) **Standard - music history and culture.** The student will recognize the development of music from an historical and cultural perspective.

- (A) Sing or play a variety of folk, ethnic, classical, and contemporary musical compositions.
- (B) Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).
- (C) Recognize, describe and listen to music from a variety of:

- (i) Styles (jazz, mariachi band, opera, musical, call response);
- (ii) Periods (Baroque, Classical, Romantic, Impressionism and Contemporary);
- (iii) Cultures including European, Native American, African American, Hispanic, and Asian.

(A) Sing or play a variety of folk, ethnic, classical, and contemporary musical compositions.

(B) Recognize, describe and listen to music from a variety of:

- (i) Styles (jazz, mariachi band, opera, musical, call-response);
- (ii) Periods (Baroque, Classical, Romantic, Impressionism and Contemporary);
- (iii) Cultures including European, Native American, African American, Hispanic, and Asian.

(C) Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).

(D) Identify and describe roles of musicians in various music settings and cultures.

(3) **Standard - music expression.** The student will perform, compose, improvise and arrange a variety of music within specified guidelines.

(A) Perform basic tonal patterns and rhythm patterns on classroom instruments (autoharp, recorder, percussion instruments, and guitar).

(B) Demonstrate the ability to read music from basic notation (written representation of music).

(C) Compose music using a variety of electronic and computer sources.

(D) Respond physically or using classroom instruments to basic rhythm patterns (including triplets, dotted rhythms, syncopation).

(E) Perform and create melodies and accompaniments in solo or group ensembles through singing and playing instruments (e.g., four chord songs on autoharp).

(F) Sing or play musical compositions demonstrating knowledge of tonal and rhythmic elements (including syncopated patterns, beats and offbeats).

(G) Use a system for counting beat and rhythm patterns (rhythm syllables and body movement) to demonstrate knowledge of rhythms found in musical compositions.

(H) Identify uses of music in everyday life (film, television, background music, and commercials).

(I) Recognize and identify the appropriate ways to use the following elements of musical style:

- (i) Dynamics (piano, forte)
- (ii) Tempo (allegro, lento, andante, moderato)
- (iii) Conducting patterns of simple meters (2/4, 3/4, 4/4, 6/8)
- (iv) Articulation (staccato, legato, accent)

(A) Participate in music through singing (echo singing, rounds and partner songs) and/or playing instruments (body percussion and melodic ostinatos).

(B) Match pitches, sing in tune (C-scale range) and use appropriate tone and expression.

(C) Respond to the beat or rhythm in music by clapping, playing classroom instruments.

(D) Play simple and syncopated rhythm patterns using sounds and silences on classroom percussion instruments to accompany songs and rhythm activities.

(E) Play simple melodies on instruments, such as bells or xylophones.

(F) While listening to a musical piece, use directional hand movements to follow the melodic contour (sound or progression of single tones).

(G) Respond to unfinished short melodic patterns using voice or classroom instruments.

(H) Perform solos and with groups.

(I) Sing two-part rounds, partner songs/ostinatos

(J) Identify uses of music in everyday life (film, television, background music, and commercials).

(4) **Standard - music appreciation.** The student will learn to appreciate music and extend their listening beyond music currently familiar to the student.

(A) Recognize and practice appropriate audience or performer behavior appropriate for the context and style of music performed.

(B) Demonstrate respect for music performed by the student and by other student and professional performers.

(C) Use appropriate terms to explain preferences for musical works and styles.

(D) Identify criteria for evaluating a musical composition or a musical performance.

210:15-3-120. The arts for grade 6

(a) **Visual arts.**

(1) **Standard - language of Visual art.** The student will identify Visual Art terms (i.e., still life, contour, composition, foreshortening foreground, perspective, etc.).

(A) Describe and apply knowledge of the principles of design: rhythm, balance (symmetrical, asymmetrical, radial) contrast, movement, variety, center of interest (emphasis), and repetition in his/her own art work, and the art works of others.

(B) Describe and use the elements of art: line, color, form, shape, texture, value (light and dark), and space in works of art. Identify and discriminate between types of shape (geometric and organic),

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- colors (primary, secondary, complementary, intermediates, neutrals, tints, tones, shades, and values), lines (characteristics, quality), textures (tactile and visual), and space (background, middleground, foreground, placement, perspective, overlap, negative, positive, size, color) in his/her own art work, and the art works of others.
- (C) Compare works which are similar or different in expressive quality, composition, and style.
- (D) Discuss works of art of different media and styles beyond statements of mere preference.
- (2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.
- (A) Recognize and describe the cultural and ethnic traditions which have influenced the visual arts including European, American, Native American, African American, Hispanic, and Asian traditions.
- (B) Describe and place a variety of specific significant art objects by artist, style, and historical and cultural context.
- (C) Identify the variety of art forms used in business and industry, including advertising, television, and film.
- (D) Discuss the relationship that exists between visual art and other art forms such as music, dance, and drama.
- (E) Communicate in-depth knowledge gained through integrated study of a visual art theme, historical period, or event.
- (3) **Standard - Visual arts expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of art.
- (A) Make original works of art using a variety of materials (media), and techniques (skills), and sources for ideas.
- (B) Use observation, memory and imagination in making original works of art.
- (C) Demonstrate safe and proper use, care, and storage of media, materials, and equipment.
- (D) Apply knowledge of a basic art vocabulary through experiences in making original works of art.
- (E) Demonstrate a basic knowledge of media, techniques and processes in:
- (i) Painting
 - (I) media: tempera, watercolor, oil, and acrylic.
 - (II) processes: wet-on-wet, wet-on-dry, wash, resist, sponge.
 - (ii) Sculpture or Architecture
 - (I) media: paper, papier-mâché, clay, plaster, cardboard, wood, found objects, beads, sand, wire.
 - (II) processes: carving, constructing, and assembling.
 - (iii) Drawing
 - (I) media: pencils, colored pencils, markers, chalks, crayons, oil-pastels,
 - (II) processes: sketching, contour line, hatching, crosshatching.
 - (iv) Printmaking
 - (I) media: printing ink, styrofoam, stencil, found object.
 - (II) processes: relief, silkscreen, and monoprint.
 - (v) Fiber Arts
 - (I) media: cloth, yarn, ribbon, found objects, paper, and rope.
 - (II) processes: weaving, stitchery, braiding, and basketry.
- (4) **Standard - Visual art appreciation.** The student will appreciate visual art as a vehicle of human expression.
- (A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.
- (B) Demonstrate respect for their work and the work of others.
- (C) Demonstrate thoughtfulness and care in completion of artworks.
- (b) **General music.**
- (1) **Standard - language of music.** The student will read, notate and interpret music.
- (A) ~~Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).~~
- (B) ~~Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and phrasing for expressive purpose in performing music.~~
- (C) ~~Identify basic notational symbols (written representation of music), including: treble and bass clef, time signatures (2/4, 3/4, 4/4, and 6/8); note values (whole note, half note, quarter note, eighth note, dotted half note, dotted quarter note, and the corresponding rests).~~
- (D) ~~Define and use correct terminology to identify and discuss the elements of music including:~~
- (i) ~~Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale [five tone scale]).~~
 - (ii) ~~Rhythm (steady beat, back beat, syncopation, triplets, dotted rhythms, 2/2 meter).~~
 - (iii) ~~Harmony (partner songs, rounds, descants, countermelody, descant, major and minor chords).~~
 - (iv) ~~Form (AB, ABA, round, rondo, theme and variations, introduction, coda, interlude, verse and refrain, prelude).~~
 - (v) ~~Tone color (opera, musical theater, duet, trio, quartet, chorus, voice ranges and instrument ranges).~~
 - (vi) ~~Pitch (range and register).~~
 - (vii) ~~Tempo — allegro (fast), lento (slow), andante (walking), moderato (moderate).~~
 - (viii) ~~Dynamics — forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft).~~

- (E) Identify visually and aurally:
- (i) instrumental ensembles (marching band, symphony orchestra, jazz band).
 - (ii) families of orchestral instruments (strings, woodwinds, brass, and percussion).
 - (iii) classification of voice ranges (soprano, alto, tenor, bass).

(A) Define and use correct terminology to identify and discuss the elements of music including:

- (i) Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale [five-tone scale]).
- (ii) Rhythm (steady beat, back beat, syncopation, triplets, dotted rhythms, 2/2 meter).
- (iii) Harmony (partner songs, rounds, descants, countermelody, descant, major and minor chords).
- (iv) Form (AB, ABA, round, rondo, theme and variations, introduction, coda, interlude, verse and refrain, prelude).
- (v) Tone color (opera, musical theater, duet, trio, quartet, chorus, voice ranges and instrument ranges).
- (vi) Pitch (range and register).
- (vii) Tempo - allegro (fast), lento (slow), andante (walking), moderato (moderate).
- (viii) Dynamics - forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft).

(B) Identify basic notational symbols (written representation of music), including: treble and bass clef, time signatures (2/4, 3/4, 4/4, and 6/8); note values (whole note, half note, quarter note, eighth note, dotted half note, dotted quarter note, and the corresponding rests).

(C) Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and phrasing for expressive purpose in performing music.

(D) Identify visually and aurally:

- (i) instrumental ensembles (marching band, symphony orchestra, jazz band).
- (ii) families of orchestral instruments (strings, woodwinds, brass, and percussion).
- (iii) classification of voice ranges (soprano, alto, tenor, bass).

(E) Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).

(2) **Standard - music history and culture.** The student will recognize the development of music from an historical and cultural perspective.

(A) Sing or play a variety of folk, ethnic, classical, and contemporary musical compositions.

~~(B) Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).~~

~~(C) Recognize, describe and listen to music from a variety of:~~

- ~~(i) Styles (jazz, mariachi band, opera, musical, call response).~~
- ~~(ii) Periods (Baroque, Classical, Romantic, Impressionism and Contemporary).~~
- ~~(iii) Cultures including European, Native American, African American, Hispanic, and Asian.~~

~~(B) Recognize, describe and listen to music from a variety of:~~

- ~~(i) Styles (jazz, mariachi band, opera, musical, call-response).~~
- ~~(ii) Periods (Baroque, Classical, Romantic, Impressionism and Contemporary).~~
- ~~(iii) Cultures including European, Native American, African American, Hispanic, and Asian.~~

~~(C) Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).~~

~~(D) Identify and describe the roles of musicians in various music settings and cultures.~~

(3) **Standard - music expression.** The student will perform, compose, improvise and arrange a variety of music within specified guidelines.

(A) Perform basic tonal patterns and rhythm patterns on classroom instruments (autoharp, recorder, percussion instruments, and guitar).

(B) Demonstrate the ability to read music from basic notation in treble or bass clef (e.g. folk songs, patriotic songs, etc.).

(C) Sing with an acceptable tone quality throughout his/her singing ranges or play an instrument with an acceptable tone quality throughout an appropriate range.

(D) Compose music using a variety of sound sources, including electronic and computer to compose music.

(E) Respond physically or using classroom instruments to basic rhythm patterns (including triplets, dotted rhythms, syncopation).

(F) Perform and create melodies and accompaniments in solo or group ensembles through singing and playing instruments (e.g. four-chord songs on autoharp).

(G) Sing or play musical compositions demonstrating knowledge of tonal and rhythmic elements (including syncopated patterns, beats and offbeats).

(H) Use a system for counting beat and rhythm patterns (rhythm syllables and body movement) to demonstrate knowledge of rhythms found in musical compositions.

(I) Identify uses of music in everyday life (film, television, background music, and commercials).

(J) Recognize and identify the appropriate ways to use the following elements of musical style:

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- (i) Dynamics - (piano, forte)
 - (ii) Tempo - (allegro, lento, andante, moderato)
 - (iii) Conducting patterns of simple meters (2/4, 3/4, 4/4, 6/8)
 - (iv) Articulation (staccato, legato, accent)
- (4) **Standard - music appreciation.** The student will learn to appreciate music and extend their listening beyond music currently familiar to the student.
- (A) Recognize and practice appropriate audience or performer behavior appropriate for the context and style of music performed.
 - (B) Demonstrate respect for music performed by the student and by other students and professional performers.
 - (C) Use appropriate terms to explain preferences for musical works and styles.
 - (D) Identify criteria for evaluating a musical composition or a musical performance.

210:15-3-121. The arts for grade 7

(a) Visual art.

- (1) **Standard - language of Visual art.** The student will identify Visual Art terms (i.e., architecture, collage, medium, perspective, symbol, etc.).
- (A) Describe and apply knowledge of the principles of design: rhythm, balance (symmetrical, asymmetrical, radial) contrast, movement, variety, center of interest (emphasis), and repetition in his/her own art work, and the art works of others.
 - (B) Describe and use the elements of art: line, color, form, shape, texture, value (light and dark), and space in works of art. Identify and discriminate between types of shape (geometric and organic), colors (primary, secondary, complementary, intermediates, neutrals, tints, tones, shades, and values), lines (characteristics, quality), textures (tactile and visual), and space (background, middleground, foreground, placement, perspective, overlap, negative, positive, size, color) in his/her own art work, and the art works of others.
 - (C) Compare works which are similar or different in expressive quality, composition, and style.
 - (D) Discuss works of art of different media and styles beyond statements of mere preference.
- (2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.
- (A) Recognize and describe the cultural and ethnic traditions which have influenced the visual arts including European, American, Native American, African American, Hispanic, and Asian traditions.
 - (B) Identify and be familiar with a range of art works, identifying artist, culture and style from a historical context.
 - (C) Identify how the visual arts are used by artists in today's world, including the popular media of advertising, television, and film. (Illustrator, fashion

designer, sculptor, display designer, painter, graphic designer, animator, photographer).

- (D) Identify the relationship that exists between visual art and other art forms such as music, dance, and drama.
- (3) **Standard - Visual art expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of art.
- (A) Use observation, memory and imagination in making original works of art.
 - (B) Assess and modify art work in progress based on an understanding of art materials and techniques.
 - (C) Demonstrate safe and proper use, care, and storage of media, materials, and equipment.
 - (D) Depict three-dimensional qualities by overlapping planes, vertical position, size and color intensity, in original art work.
 - (E) Develop and apply skills and techniques using a variety of art media, and processes in making two- and three-dimensional works of art:
 - (i) Ceramics
 - (I) media: clay, modeling clay, clay substitutes, glazes, paint, stains.
 - (II) processes: pinch and pulled forms, slab, coil, incising, etc.
 - (ii) Drawing
 - (I) media: pencils, colored pencils, markers, chinks, crayons, oil-pastels,
 - (II) processes: sketching, contour line, hatching, crosshatching, stippling, rendering shading
 - (iii) Fiber Arts
 - (I) media: cloth, yarn, ribbon, found objects, paper, and rope.
 - (II) processes: weaving, stitchery, braiding, and basketry.
 - (iv) Mixed Media
 - (I) media: tissue paper, photos, found objects, foil, fiber, paint, paper, and magazines.
 - (II) processes: collage, bas-relief.
 - (v) Painting
 - (I) media: tempera, watercolor, oil, and acrylic.
 - (II) processes: wet-on-wet, wet-on-dry, wash, resist, sponge.
 - (vi) Printmaking
 - (I) media: printing ink, styrofoam, stencil, found object.
 - (II) processes: relief, silkscreen.
 - (vii) Sculpture or Architecture
 - (I) media: paper, papier-mâché, clay, plaster, cardboard, wood, found objects, beads, sand, wire.
 - (II) processes: carving, constructing, and assembling.
- (4) **Standard - Visual art appreciation.** The student will appreciate visual art as a vehicle of human expression.

(A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.

(B) Demonstrate respect for their work and the work of others.

(C) Demonstrate thoughtfulness and care in completion of artworks.

(b) **General music.**

(1) **Standard - language of music.** The student will read, notate and interpret music.

(A) ~~Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).~~

(B) ~~Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and phrasing for expressive purpose in performing music.~~

(C) ~~Identify basic notational symbols (written representation of music), including: treble and bass clef, time signatures; (2/4, 3/4, 4/4, and 6/8); note values (whole note, half note, quarter note, eighth note, dotted half note, dotted quarter note, and the corresponding rests).~~

(D) ~~Define and use correct terminology to identify and discuss the elements of music including:~~

(i) ~~Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale [five tone scale], intervals, major and minor scale).~~

(ii) ~~Rhythm (steady beat, back beat, syncopation, triplets, dotted rhythms, 2/2 meter).~~

(iii) ~~Harmony (partner songs, rounds, descants, countermelody, major and minor chords).~~

(iv) ~~Form (Unity and Variety, AB, ABA, round, rondo, theme and variations, march, introduction, coda, interlude, verse and refrain, prelude).~~

(v) ~~Tone color (opera, musical theater, duet, trio, quartet, chorus, voice ranges and instrument ranges, a capella)~~

(vi) ~~Pitch (range and register, change pitch with compositional devices such as imitation, inversion and transposition).~~

(vii) ~~Tempo—allegro (fast), lento (slow), andante (walking), moderato (moderate).~~

(viii) ~~Dynamics—forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft, crescendo and decrescendo).~~

(E) ~~Identify visually and aurally:~~

(i) ~~instrumental ensembles (marching band, symphony orchestra, jazz band);~~

(ii) ~~families of orchestral instruments (strings, woodwinds, brass, and percussion);~~

(iii) ~~Classification of voice ranges (soprano, alto, tenor, bass).~~

(A) Define and use correct terminology to identify and discuss the elements of music including:

(i) Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale [five-tone scale], intervals, major and minor scale).

(ii) Rhythm (steady beat, back beat, syncopation, triplets, dotted rhythms, 2/2 meter).

(iii) Harmony (partner songs, rounds, descants, countermelody, major and minor chords).

(iv) Form (Unity and Variety, AB, ABA, round, rondo, theme and variations, march, introduction, coda, interlude, verse and refrain, prelude).

(v) Tone color (opera, musical theater, duet, trio, quartet, chorus, voice ranges and instrument ranges, a capella)

(vi) Pitch (range and register, change pitch with compositional devices such as imitation, inversion and transposition).

(vii) Tempo - allegro (fast), lento (slow), andante (walking), moderato (moderate).

(viii) Dynamics - forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft, crescendo and decrescendo).

(B) Identify basic notational symbols (written representation of music), including: treble and bass clef, time signatures; (2/4, 3/4, 4/4, and 6/8); note values (whole note, half note, quarter note, eighth note, dotted half note, dotted quarter note, and the corresponding rests).

(C) Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and phrasing for expressive purpose in performing music.

(D) Identify visually and aurally:

(i) instrumental ensembles (marching band, symphony orchestra, jazz band);

(ii) families of orchestral instruments (strings, woodwinds, brass, and percussion);

(iii) Classification of voice ranges (soprano, alto, tenor, bass).

(E) Notate (written representation of music) simple pitch and rhythm patterns presented aurally (listening).

(2) **Standard - music history and culture.** The student will recognize the development of music from a historical and cultural perspective.

(A) Sing or play a variety of folk, ethnic, classical, and contemporary musical compositions.

~~(B) Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).~~

~~(C) Recognize, describe and listen to music from a variety of:~~

~~(i) Styles (jazz, mariachi band, opera, musical, call response)~~

~~(ii) Periods (Baroque, Classical, Romantic, Impressionism and Contemporary)~~

~~(iii) Cultures including European, Native American, African American, Hispanic, and Asian.~~

(B) Recognize, describe and listen to music from a variety of:

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(i) Styles (jazz, mariachi band, opera, musical, call-response)

(ii) Periods (Baroque, Classical, Romantic, Impressionism and Contemporary)

(iii) Cultures including European, Native American, African American, Hispanic, and Asian

(C) Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).

(D) Identify and describe the roles of musicians in various music settings and cultures.

(3) **Standard - music expression.** The student will perform, compose, improvise and arrange a variety of music within specified guidelines.

(A) Perform basic tonal patterns and rhythm patterns on classroom instruments (autoharp, recorder, percussion instruments, and guitar).

(B) Demonstrate the ability to read music from basic notation in treble or bass clef (e.g., folk songs, patriotic songs).

(C) Sing with an acceptable tone quality throughout his/her singing ranges or play an instrument with an acceptable tone quality throughout an appropriate range.

(D) Compose music using a variety of electronic and computer sound sources.

(E) Respond physically or using classroom instruments to basic rhythm patterns (including triplets, dotted rhythms, syncopation).

(F) Perform and create melodies and accompaniments in solo or group ensembles through singing and playing instruments (e.g. four-chord songs on autoharp).

(G) Sing or play musical compositions demonstrating knowledge of tonal and rhythmic elements (including syncopated patterns, beats and offbeats).

(H) Use a system for counting beat and rhythm patterns (rhythm syllables and body movement) to demonstrate knowledge of rhythms found in musical compositions.

(I) Identify uses of music in everyday life (film, television, background music, and commercials).

(J) Recognize and identify the appropriate ways to use the following elements of musical style:

(i) Dynamics - (piano, forte)

(ii) Tempo - (allegro, lento, andante, moderato)

(iii) Conducting patterns of simple meters (2/4, 3/4, 4/4, 6/8)

(iv) Articulation (staccato, legato, accent)

(4) **Standard - music appreciation.** The student will learn to appreciate music and extend their listening beyond music currently familiar to the student.

(A) Recognize and practice appropriate audience or performer behavior appropriate for the context and style of music performed.

(B) Demonstrate respect for music performed by the student and by other student and professional performers.

(C) Use appropriate terms to explain preferences for musical works and styles.

(D) Identify criteria for evaluating a musical composition or a musical performance.

210:15-3-122. The arts for grade 8

(a) **Visual art.**

(1) **Standard - language of Visual art.** The student will identify visual art terms (e.g., architecture, collage, medium, perspective, symbol, etc.).

(A) Identify and apply knowledge of the principles of design: rhythm, balance (symmetrical, asymmetrical, radial), contrast, movement, variety, center of interest (emphasis), and repetition in their own artwork, and the art works of others.

(B) Identify and apply the elements of art: line, color, form, shape, texture, value (light and dark), and space in works of art. Discriminate between types of shape (geometric and organic), colors (primary, secondary, complementary, intermediates, neutrals, tints, tones, shades, and values), lines (characteristics, quality), textures (tactile and visual), and space (background, middleground, foreground, placement, one-, two-, and three-point perspective, overlap, negative, positive, size, color) in their own artwork, and the art works of others.

(C) Compare works which are similar or different in expressive quality, composition, and style.

(D) Discuss works of art of different media and styles beyond statements of mere preference.

(2) **Standard - Visual art history and culture.** The student will recognize the development of visual art from a historical and cultural perspective.

(A) Recognize and describe the cultural and ethnic traditions which have influenced the visual arts including European, American, Native American, African American, Hispanic, and Asian traditions.

(B) Explain the purpose of visual art and artists in history and culture.

(C) Identify how the visual arts are used by artists in today's world, including the popular media of advertising, television, and film (e.g., illustrator, fashion designer, sculptor, display designer, painter, graphic designer, animator, photographer).

(D) Identify the relationship that exists between visual art and other art forms such as music, dance, and drama.

(3) **Standard - Visual art expression.** The students will observe, select, and utilize a variety of ideas and subject matter in creating original works of art.

(A) Use observation, memory and imagination in making original works of art.

(B) Assess and modify art work in progress based on an understanding of art materials and techniques.

(C) Demonstrate safe and proper use, care, and storage of media, materials, and equipment.

(D) Depict three-dimensional qualities by overlapping planes, vertical position, size and color intensity, in original art work.

(E) Develop and apply skills and techniques using a variety of art media, and processes in making two- and three-dimensional works of art.

(i) Ceramics:

(I) media: clay, modeling clay, clay substitutes, glazes, paint, stains.

(II) processes: pinch and pulled forms, slab, coil, incising, etc.

(ii) Drawing

(I) media: pencils, colored pencils, markers, chalks, crayons, oil-pastels,

(II) processes: sketching, contour line, hatching, crosshatching, stippling, rendering shading

(iii) Fiber Arts

(I) media: cloth, yarn, ribbon, found objects, paper, and rope

(II) processes: weaving, stitchery, braiding, and basketry.

(iv) Mixed Media

(I) media: tissue paper, photos, found objects, foil, fiber, paint, paper, magazines.

(II) processes: collage, bas-relief.

(v) Painting:

(I) media: tempera, watercolor, oil, and acrylic.

(II) processes: wet-on-wet, wet-on-dry, wash, resist, sponge.

(vi) Printmaking

(I) media: printing ink, styrofoam, stencil, found object.

(II) processes: relief, silkscreen.

(vii) Sculpture or Architecture

(I) media: paper, papier-mâché, clay, plaster, cardboard, wood, found objects, beads, sand, wire.

(II) processes: carving, constructing, and assembling.

(4) **Standard - Visual art appreciation.** The student will appreciate visual art as a vehicle of human expression.

(A) Demonstrate appropriate behavior while attending a visual arts exhibition in a museum or art gallery.

(B) Demonstrate respect for their work and the work of others.

(C) Demonstrate thoughtfulness and care in completion of artworks.

(b) **General music.**

(1) **Standard - language of music.** The student will read, notate and interpret music.

~~(A) Notate (written representation of music) short melodies presented aurally (listening).~~

~~(B) Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and melodic and rhythmic phrasing for expressive purpose in performing music.~~

~~(C) Identify basic notational symbols (written representation of music), including: treble and bass clef, time signatures; (2/4, 3/4, 4/4, and 6/8); note values (whole note, half note, quarter note, eighth note, dotted half note, dotted quarter note, and the corresponding rests).~~

~~(D) Define and use correct terminology to identify and discuss the elements of music including:~~

~~(i) Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale [five-tone scale], intervals, major and minor scale).~~

~~(ii) Rhythm (steady beat, back beat, syncopation, triplets, dotted rhythms, 2/2 meter).~~

~~(iii) Harmony (partner songs, rounds, descants, countermelody, major and minor chords, polyphony, harmony in thirds and sixths).~~

~~(iv) Form (Unity and Variety, AB, ABA, round, rondo, theme and variations, march, introduction, coda, interlude, verse and refrain, prelude).~~

~~(v) Tone color (opera, musical theater, duet, trio, quartet, chorus, voice ranges and instrument ranges, a capella and electronic tone color).~~

~~(vi) Pitch (range and register, change pitch with compositional devices such as imitation, inversion and transposition).~~

~~(vii) Tempo—allegro (fast), lento (slow), andante (walking), moderato (moderate).~~

~~(viii) Dynamics—forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft, crescendo and decrescendo).~~

~~(E) Identify visually and aurally:~~

~~(i) Instrumental ensembles (marching band, orchestra, jazz band).~~

~~(ii) Families of orchestral instruments (strings, woodwinds, brass, and percussion).~~

~~(iii) Classification of voice ranges (soprano, alto, tenor, bass).~~

(A) Define and use correct terminology to identify and discuss the elements of music including:

(i) Melody (steps, wide and narrow leaps, repeated tones, phrases, pentatonic scale [five-tone scale], intervals, major and minor scale).

(ii) Rhythm (steady beat, back beat, syncopation, triplets, dotted rhythms, 2/2 meter).

(iii) Harmony (partner songs, rounds, descants, countermelody, major and minor chords, polyphony, harmony in thirds and sixths).

(iv) Form (Unity and Variety, AB, ABA, round, rondo, theme and variations, march, introduction, coda, interlude, verse and refrain, prelude).

(v) Tone color (opera, musical theater, duet, trio, quartet, chorus, voice ranges and instrument ranges, a capella and electronic tone color).

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- (vi) Pitch (range and register, change pitch with compositional devices such as imitation, inversion and transposition).
- (vii) Tempo - allegro (fast), lento (slow), andante (walking), moderato (moderate).
- (viii) Dynamics - forte (loud), piano (soft), mezzo forte (medium loud), mezzo piano (medium soft, crescendo and decrescendo).
- (B) Identify basic notational symbols (written representation of music), including: treble and bass clef, time signatures; (2/4, 3/4, 4/4, and 6/8); note values (whole note, half note, quarter note, eighth note, dotted half note, dotted quarter note, and the corresponding rests).
- (C) Experiment with variations in and demonstrate understanding of tempo (speed), tone quality (sound quality), dynamics (degree of loudness) and melodic and rhythmic phrasing for expressive purpose in performing music.
- (D) Identify visually and aurally:
- Instrumental ensembles (marching band, orchestra, jazz band).
 - Families of orchestral instruments (strings, woodwinds, brass, and percussion).
 - Classification of voice ranges (soprano, alto, tenor, bass).
- (E) Notate (written representation of music) short melodies presented aurally (listening).
- (2) **Standard - music history and culture.** The student will recognize the development of music from an historical and cultural perspective.
- (A) ~~Sing or play a variety of folk, ethnic, classical, and contemporary musical compositions.~~
- (B) ~~Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).~~
- (C) ~~Recognize, describe and listen to music from a variety of:~~
- ~~Styles (jazz, mariachi band, opera, musical, call response);~~
 - ~~Periods (Baroque, Classical, Romantic, Impressionism and Contemporary);~~
 - ~~Cultures including European, Native American, African American, Hispanic, and Asian.~~
- (A) Sing or play a variety of folk, ethnic, classical, and contemporary musical compositions.
- (B) Recognize, describe and listen to music from a variety of:
- Styles (jazz, mariachi band, opera, musical, call-response);
 - Periods (Baroque, Classical, Romantic, Impressionism and Contemporary);
 - Cultures including European, Native American, African American, Hispanic, and Asian.
- (C) Identify and differentiate the use of musical elements and instruments from other parts of the world and compare them to the use of musical elements in American music (patriotic, orchestral, band and folk).
- (D) Identify and describe the roles of musicians in various music settings and cultures.
- (3) **Standard - music expression.** The student will perform, compose, improvise and arrange a variety of music within specified guidelines.
- Perform basic tonal patterns and rhythm patterns on classroom instruments (autoharp, recorder, percussion instruments, and guitar).
 - Demonstrate the ability to read music from basic notation (written representation of music).
 - Use a variety of sound sources, including electronic and computer to compose music.
 - Respond physically or using classroom instruments to basic rhythm patterns.
 - Perform in solo or group ensembles through singing and playing instruments.
 - Sing or play musical compositions demonstrating knowledge of tonal and rhythmic elements.
 - Use a system for counting beat and rhythm patterns (rhythm syllables and body movement) to demonstrate knowledge of rhythms found in musical compositions.
 - Identify uses of music in everyday life (film, television, background music, and commercials).
 - Recognize and identify the appropriate ways to use the following elements of musical style:
 - Dynamics - (piano, forte)
 - Tempo - (allegro, lento, andante, moderato)
 - Conducting patterns of simple meters (2/4, 3/4, 4/4, 6/8)
 - Articulation (staccato, legato, accent)
- (4) **Standard - music appreciation.** The student will learn to appreciate music and extend their listening beyond music currently familiar to the student.
- Recognize and practice appropriate audience or performer behavior appropriate for the context and style of music performed.
 - Demonstrate respect for music performed by the student and by other student and professional performers.
 - Use appropriate terms to explain preferences for musical works and styles.
 - Identify criteria for evaluating a musical composition or a musical performance.

[OAR Docket #09-871; filed 5-8-09]

**TITLE 210. STATE DEPARTMENT OF
EDUCATION
CHAPTER 15. CURRICULUM AND
INSTRUCTION**

[OAR Docket #09-870]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 31. Middle School Mathematics Laboratories for Public Schools with Low Student Achievement in Mathematics Program

210:15-31-2. Middle school mathematics laboratories for public schools with low student achievement in mathematics program [AMENDED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

DATES:

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Superseded rules:

Subchapter 31. Middle School Mathematics Laboratories for Public Schools with Low Student Achievement in Mathematics Program

210:15-31-2. Middle school mathematics laboratories for public schools with low student achievement in mathematics program [AMENDED]

Gubernatorial approval:

October 7, 2008

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26 Ok Reg 97

Docket Number:

08-1296

INCORPORATION BY REFERENCE:

N/A

ANALYSIS:

The proposed rule amendments will eliminate the need for school sites to provide a permanent location for the mathematics laboratory.

CONTACT PERSON:

Connie Holland, 405-521-3308

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN O. S. 75,
SECTION 308.1(A), WITH AN EFFECTIVE DATE
OF JUNE 11, 2009:**

**SUBCHAPTER 31. MIDDLE SCHOOL
MATHEMATICS LABORATORIES FOR
PUBLIC SCHOOLS WITH LOW STUDENT
ACHIEVEMENT IN MATHEMATICS PROGRAM**

**210:15-31-2. Middle school mathematics laboratories
for public schools with low student
achievement in mathematics program**

(a) The State Department of Education shall identify public schools with low student achievement in mathematics at the middle school level that meet the following criteria:

(1) Each school shall have at least fifty percent of its students performing below satisfactory on the eighth grade mathematics criterion referenced test of the Oklahoma School Testing Program in at least one of the two preceding years.

(2) There shall be a limit of one school per school district each year.

(3) There shall be representation from urban, suburban, and rural districts provided that such schools meet all other criteria.

(4) There shall be representation from each quadrant of the state provided that such schools meet all other criteria.

(b) Each selected school shall:

~~(1) provide a classroom facility for permanent occupation of the mathematics laboratory.~~

~~(2) implement the computer education teaching system as recommended by the vendor and the State Department of Education.~~

~~(3) develop a Mathematics Laboratory Team which may include up to ten administrators, teachers, and technicians selected by school personnel to operate and utilize the computer education teaching system.~~

~~(4) attend all professional development provided by the vendor and the State Department of Education for appropriate implementation of the program.~~

~~(5) establish benchmark goals based upon preassessment data and state performance standards for the Oklahoma School Testing Program which will be submitted to the State Department of Education.~~

(c) Each participating school shall provide disaggregated data to the State Department of Education through quarterly reports.

[OAR Docket #09-870; filed 5-8-09]

**TITLE 210. STATE DEPARTMENT OF
EDUCATION
CHAPTER 15. CURRICULUM AND
INSTRUCTION**

[OAR Docket #09-869]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 33. Celebrate Freedom Week

210:15-33-2. Celebrate Freedom Week requirements [AMENDED]

Permanent Final Adoptions

AUTHORITY:

70 O. S. § 3-104, State Board of Education

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SUPERSEDED EMERGENCY ACTIONS:**Superseded rules:**

Subchapter 33. Celebrate Freedom Week
210:15-33-2. Celebrate Freedom Week requirements [AMENDED]

Gubernatorial approval:

August 21, 2008

Register Publication:

26 Ok Reg 53

Docket Number:

08-1254

INCORPORATION BY REFERENCE:

N/A

ANALYSIS:

The proposed rule amendments relate to grade appropriate instruction during Celebrate Freedom Week.

CONTACT PERSON:

Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 33. CELEBRATE FREEDOM WEEK

210:15-33-2. Celebrate Freedom Week requirements

- (a) By December 31, 2007, each public school district in the state will include as a part of a social studies class, during Celebrate Freedom Week, appropriate instruction concerning the intent, meaning, and importance of the Declaration of Independence and the United States Constitution, including the Bill of Rights, in their historical contexts.
- (b) The religious references in the writings of the founding fathers shall not be censored.
- (c) The study of the Declaration of Independence will include the study of the relationship of the ideas expressed in that document to subsequent American history, including the relationship of its ideas to the rich diversity of our people as

a nation of immigrants, the American Revolution, the formulation of the United States Constitution, and the abolitionist movement, which led to the Emancipation Proclamation and the women's suffrage movement.

(d) During Celebrate Freedom Week students in grades three through twelve will study and recite the text quoted below:

(1) "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. That to secure these rights, Governments are instituted among Men, deriving their just powers from the consent of the governed."

(2) Students may be excused from the recitation of the text, if:

(A) The parent or guardian of the student submits to the school district a written request that the student be excused;

(B) As determined by the school district, the student has a conscientious objection to the recitation; or

(C) The student is a child of a representative of a foreign government to whom the United States government extends diplomatic immunity.

(e) The Oklahoma State Department of Education will provide a curriculum guide for public schools that identifies different levels of content and rigor for the grade-appropriate subject matter to be covered during Celebrate Freedom Week.

[OAR Docket #09-869; filed 5-8-09]

TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 20. STAFF

[OAR Docket #09-867]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 9. Professional Standards: Teacher Education and Certification

Part 9. Teacher Certification

210:20-9-102. Career development program for paraprofessionals [AMENDED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

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Superseded rules:
Subchapter 9. Professional Standards: Teacher Education and Certification
Part 9. Teacher Certification
210:20-9-102. Career development program for paraprofessionals [AMENDED]

Gubernatorial approval:
November 6, 2008

Register Publication:
26 Ok Reg 247

Docket Number:
08-1423

INCORPORATION BY REFERENCE:
N/A

ANALYSIS:
The proposed rule amendments, in accordance with statutory requirements at 70 O. S. § 6-127A, amend the career development program for paraprofessionals and adds additional requirements for certification of paraprofessionals.

CONTACT PERSON:
Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 9. PROFESSIONAL STANDARDS: TEACHER EDUCATION AND CERTIFICATION

PART 9. TEACHER CERTIFICATION

210:20-9-102. Career development program for paraprofessionals

(a) The State Department of Education shall issue a paraprofessional credential to an applicant who meets the following requirements:

- (1) has a high school diploma or a General Educational Development (GED) Diploma,
- (2) has met a career development paraprofessional program approved by the State Board of Education, and
- (3) has on file with the Board a current Oklahoma criminal history record from the Oklahoma State Bureau of Investigation as well as a national fingerprint-based criminal history record provided by the Federal Bureau of Investigation. Upon receipt of the Oklahoma criminal history record, the Board may issue a temporary credential which shall be effective until receipt of the national fingerprint-based criminal history record. The person applying for a credential shall be responsible for the cost of the criminal history records.

(b) The State Department of Education shall issue a one-year, renewable for up to three years, early childhood, elementary education, or special education teaching license to a paraprofessional who meets the following requirements:

- (1) Has been employed for one full year with a public school as a paraprofessional in the area for which a license is being pursued.
- (2) Has a bachelor's degree from an accredited college.
- (3) Has passed the Oklahoma General Education Test, the Early Childhood or Elementary Education or Special Education Oklahoma Subject Area Test and the Oklahoma Professional Teaching Exam (PK-8).
- (4) Has on file with the State Board of Education a current Oklahoma criminal history record from the Oklahoma State Bureau of Investigation as well as a national fingerprint-based criminal history record provided by the Federal Bureau of Investigation. Upon receipt of the Oklahoma criminal history record, the Board may issue a temporary credential which shall be effective until receipt of the national fingerprint-based criminal history record. The person applying for a credential shall be responsible for the cost of the criminal history records.
- (5) Has made application to the Oklahoma State Department of Education.
- (6) The individual shall be reported on the certified personnel report and be considered as any other certified employee.
- (7) The State Department of Education shall issue a standard teaching certificate upon successful completion of a residency year program and twelve (12) semester hours of professional education coursework from an accredited institution of higher education which has an accredited program related to the license sought, including a minimum of three (3) semester hours in reading instruction, from a higher education program accredited by the Oklahoma Commission for Teacher Preparation.

[OAR Docket #09-867; filed 5-8-09]

**TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 20. STAFF**

[OAR Docket #09-868]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 9. Professional Standards: Teacher Education and Certification
Part 9. Teacher Certification
210:20-9-99.1. National certification bonus for school psychologists, speech-language pathologists, and audiologists [AMENDED]

AUTHORITY:
70 O. S. § 3-104, State Board of Education

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Subchapter 9. Professional Standards: Teacher Education and Certification

Part 9. Teacher Certification

210:20-9-99.1. National certification bonus for school psychologists, speech-language pathologists, and audiologists [AMENDED]

Gubernatorial approval:

October 7, 2008

Register Publication:

26 Ok Reg 98

Docket Number:

08-1297

INCORPORATION BY REFERENCE:

N/A

ANALYSIS:

The proposed rule amendments delete the full-time requirement for nationally certified psychologists who are nationally certified by the National School Psychology Certification Board, or a speech-language pathologist or audiologist who holds a Certificate of Clinical Competence awarded by the American Speech-Language Hearing Association and are eligible for the bonus prescribed in 70 O. S. § 6-204.2 and 70 O. S. § 6-206.

CONTACT PERSON:

Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 9. PROFESSIONAL STANDARDS: TEACHER EDUCATION AND CERTIFICATION

PART 9. TEACHER CERTIFICATION

210:20-9-99.1. National certification bonus for school psychologists, speech-language pathologists, and audiologists

(a) Subject to availability of funds, a bonus in the amount prescribed in 70 O.S. § 6-206, shall be provided to individuals currently providing service to children and who are an Oklahoma school psychologist who has been designated as a nationally certified school psychologist by the National School Psychology Certification Board, or a speech-language pathologist or audiologist who holds a Certificate of Clinical Competence awarded by the American Speech-Language Hearing Association.

(b) If adequate funding is not available for a full bonus to be provided, the bonus amount may be prorated.

(c) Psychologists, speech-language pathologists, or audiologists eligible for the bonus are those individuals currently

~~employed full time~~ in the public schools of Oklahoma and are carried on the school personnel report submitted to the State Department of Education. ~~Full time equates to a minimum of 175 contracted days and a minimum of 6 hours per day, Monday through Friday, and must be correctly reported to the State Department of Education through school personnel records as a full time equivalency of 1.0, and the~~The individual must be coded as a speech-language pathologist, psychologist, or audiologist only. Individuals may be employed in multiple districts, ~~as long as full time equivalency equals 1.0.~~

(d) To document having a current national certificate, being employed ~~full time~~ by a public school district, and are currently providing services to children as a psychologist, speech-language pathologist, or audiologist, as of January 1 of the year the bonus is to be awarded, a verification form will be sent to each nationally certified person to be signed by the psychologist, speech-language pathologist, or audiologist and the superintendent of the local school district and returned to the State Department of Education before the bonus is awarded.

(e) Verification of national certification shall be provided to the State Department of Education prior to the bonus being awarded.

[OAR Docket #09-868; filed 5-8-09]

**TITLE 210. STATE DEPARTMENT OF EDUCATION
CHAPTER 30. SCHOOL FACILITIES AND TRANSPORTATION**

[OAR Docket #09-866]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Transportation

210:30-5-1. District operation and management [AMENDED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

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Superseded rules:

Subchapter 5. Transportation

210:30-5-1. District operation and management [AMENDED]

Gubernatorial approval:

August 21, 2008

Register Publication:

26 Ok Reg 54

Docket Number:

08-1253

INCORPORATION BY REFERENCE:

N/A

ANALYSIS:

New school bus dealers submit certification to the Oklahoma State Department of Education that all new buses sold meet or exceed all national and state specifications and safety standards for the date of manufacture. These proposed rule amendments will prohibit school districts from purchasing used or previously owned buses unless they are certified to meet or exceed the specifications and safety standards for the date of manufacture. State Transportation Aid shall be withheld from any school district that purchases buses without the required certification.

CONTACT PERSON:

Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 5. TRANSPORTATION

210:30-5-1. District operation and management

(a) **Administration.** The local superintendent and board of education shall be held responsible for applying these regulations to all pupil transportation under their administration and supervision. In keeping with this responsibility, each local board of education shall examine and periodically review the school district's bus fleet liability insurance coverage and its tort liability insurance coverage to assure such coverages are coordinated to protect the interest of the students, general public, and school district. Any school district maintaining a school may provide transportation with the approval of the State Board of Education.

(b) **Students.**

- (1) A student must live in a school district authorized by law to furnish transportation.
- (2) A student must live one and one-half (1 1/2) miles or more by commonly traveled road from the school attended. Students living less than one and one-half (1 1/2) miles from school may be transported, but shall not be counted in determining state aid.
- (3) A normal school day consists of not less than six (6) hours, exclusive of lunch period, with the exception of the first and kindergarten grades. Transportation may be provided for kindergarten age students to and from school during the normally scheduled morning and evening bus operation. Districts desiring to provide additional transportation for kindergarten students at midday may do so at local district expense but it is not required.
- (4) The local school district is responsible for providing transportation for an eligible special education student when transportation has been identified as "related service" necessary to enable the student to receive the

educational services outlined in his/her Individualized Education Program (IEP).

(5) Students living in a school district not offering the grade which they are entitled to pursue are entitled to transportation to a school authorized by law to provide transportation to and from school provided they have been legally transferred and reside in the transportation area.

(c) **Activities.** All Oklahoma school districts shall develop policies and procedures authorizing transportation for extracurricular activities and community involvement purposes as authorized by 70 O.S. § 5-130.

(d) **Routes and boundaries.** All school bus routes shall be evaluated annually for safety and efficiency by the local school district supervisor of transportation or designee.

(1) **Boundaries.**

(A) A change in transportation area made after July 1, will not become effective until the next July 1, unless all boards of education affected agree to the proposed change.

(B) An elementary area that has been assigned to a high school transportation area may be changed to another high school transportation area by mutual agreement, in writing, by the three (3) boards of education affected and the approval of the State Board of Education.

(C) A part or all of an elementary school district that is isolated from the remainder of the school district's transportation area because of topography or previous annexations to another high school district, may be changed from one high school district's transportation area to another high school district's transportation area if the State Board of Education determines the change should be made on the basis of good administration.

(D) When a dependent school district is surrounded by an independent school district, that district must be designated as the transportation area for the high school students.

(E) An independent school district's transportation route may extend into a dependent school district's territory to pick up students whose grade is not offered in the dependent district, ~~if the area is within its transportation area.~~

(F) Upon mutual agreement of two (2) school districts, a school district may cross a portion of another district provided the doors of the school bus are kept closed.

(2) **Petition for changing boundary lines.**

(A) Seventy percent (70%) of the legal voters residing in a district who have children eligible to attend a public school (grades K through 12) or who have children under the age of five (5) may petition the State Board of Education for an election to change any part or all of a district from one transportation area to another.

(B) The State Board of Education will approve a convenient date for an election, supply ballots, and send a representative to assist with the election.

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(C) If fifty-one percent (51%) of all such legal voters in the district vote for the change, the election makes a good recommendation to the State Board of Education.

(3) **Changing areas, high school districts discontinued.** High school districts and/or elementary school districts that must be placed in one or more high school transportation area or areas because a high school has been discontinued may be placed in a transportation area or areas on the following basis:

(A) All or part of District "A" may be placed in the transportation area of high school District "B", whose transportation area is not adjacent to District "A", provided high school District "C", which has transportation area that separates District "A" from District "B" transportation area, appears to be in jeopardy of being discontinued itself, and provided the number of people in District "A", who want to be placed in the transportation area of District "B", justifies such an arrangement. People in District "A" requesting these arrangements to enable them to annex to District "B" will be given much more consideration than those desiring to transfer only.

(B) No portion of a school district that is adjacent to a high school district's transportation area, but is separated from the high school area by a natural barrier, will be placed in the high school district's transportation area unless or until there is a road connecting the two (2) areas that is maintained in a manner that will justify the operation of a school bus over the road across the barrier.

(e) **School bus.**

(1) **Equipment.**

(A) Transportation equipment used to transport ten (10) or more public school children at one time shall meet all the minimum standards required for Types A, B, C, and D buses.

(B) Vehicles having a seating capacity of fewer than (10) passengers, excluding the operator, are not required to meet the State minimum standards for school buses.

(2) **School bus inspections.**

(A) A driver shall perform a daily pre-trip safety inspection of the vehicle. The inspection shall include brakes, lights, tires, exhaust system, gauges, windshield wipers, steering and fuel. The driver shall make a daily written report describing the condition of the bus and listing any deficiencies. This report is to remain on file with the local Chief Administrative Officer or designee for a period of ninety (90) days.

(B) A school district shall have each school bus mechanically inspected annually by an inspector approved by the Oklahoma State Department of Education.

(C) At least twice during each school year, each pupil who is transported in a school vehicle shall be instructed in safe riding practices, and participate in emergency evacuation drills. This instruction should

be conducted during the first two weeks of each semester.

(3) **School bus inspector qualifications.**

(A) Any person licensed to inspect school buses by the Department of Public Safety under the Motor Vehicle Laws of Oklahoma prior to July 1, 2001, may be qualified to perform annual school bus inspections.

(B) Any person not meeting the qualifications as prescribed in (A) may be qualified to perform the annual school bus inspection by submitting proof to the Oklahoma State Department of Education that they meet the following qualifications:

(i) Two years experience as an automotive technician and certification by the Association for Automotive Service Excellence (ASE), or

(ii) Any person qualified to perform inspections under the Federal Motor Carrier Safety Act, appendix G.

(iii) Any person successfully completing an Inspector's Training Course approved by the Oklahoma State Department of Education.

(4) **Standards and school bus specifications.**

(A) The NATIONAL MINIMUM STANDARDS FOR SCHOOL BUSES applies to school bus construction and equipment. The Oklahoma State Board of Education has accepted the various methods bus manufacturers use to meet the requirements of these standards and all requirements under the Federal Motor Vehicle Safety Standards. (P.L. 89-563) The responsibility for compliance with Federal and State bus specifications rests with dealers and manufacturers.

(B) State Standards in addition to Federal Requirements also apply as follows:

(i) No school district may purchase any used or previously owned school bus unless the seller certifies prior to the sale, that the bus meets all safety standards and specifications for the date of manufacture of the used bus. Any school district that purchases a used or previously owned bus without the certification regarding compliance with standards shall forfeit their state transportation aid. The seller of any used or previously owned school bus shall certify to the local board of education that any such transportation equipment meets all Oklahoma and National Standards required for the date of its manufacture.

~~(ii) School buses converted for purposes other than transporting pupils to or from school shall be painted a color other than national school bus yellow with loading lights disconnected.~~

~~(iii) A church bus transports persons including school age children to and from religious services. The words "church bus" in letters not less than eight (8) inches in height shall be contained on the front and rear of the bus. Visual signals shall be used when the vehicle is stopped on the highway receiving or discharging passengers. Church buses~~

used for the purpose of transporting children to and from ~~schools~~ schools accredited by the State Department of Education shall be painted national school bus yellow.

~~(iv) A copy of the invoice on all purchases of new chassis and/or bodies shall be submitted to the Transportation Officer of the State Department of Education.~~

(C) School districts that convert or have converted school buses to Liquefied Petroleum Gas (LPG) shall comply with safety standards prescribed by the National Fire Protection Association, Standard No. 58 (NFPA-58) and the Oklahoma Liquefied Petroleum Gas Administration. In order to insure safe installation and proper maintenance of equipment, all personnel must also meet the following existing requirements of the Oklahoma Liquefied Petroleum Gas Administration: "No person, firm, corporation, association, or other entity shall engage in the manufacturing, assembling, fabrication, installing, or selling of any system, container, or apparatus to be used in this State in or for the transportation, storing, dispensing, or utilization of LPG, nor shall any transporter, distributor, or retailer of LPG store, dispense and/or transport over the highways of this State any LPG for use in this State in any system, container, apparatus, or appliance without having first obtained a permit to do so as provided..."

(f) **Special education.**

(1) **Loading responsibility.** The local school district is responsible for the special education child from the time the student is loaded at the "home curb" until returned and unloaded at the "home curb". The parent or their designee is responsible for "door-to-curb", "curb-to-door", and "street crossing" of the child to the designated loading and unloading point.

(2) **Extended boundaries.** Based upon mutual agreement between two participating school districts, a school district offering special education classes may extend its transportation program to include the transportation of students qualifying for special education in an adjacent school district which does not offer special education classes.

(g) **School bus driver certification.**

(1) **General criteria.**

(A) No board of education shall have authority to enter into any written contract with a school bus driver who does not hold a valid certificate issued by the State Board of Education authorizing said bus driver to operate a school bus.

(B) The State Board of Education requires all public school bus drivers to complete a school bus drivers training course approved by the State Department of Education to obtain a standard certificate.

(C) All school bus drivers must have not less than 20-40 vision (Snellen) in each eye and not less than 20-40 vision (Snellen) with both eyes and a minimum

field of vision of 70 degrees horizontal median vision in each eye.

(D) Any person with diabetes requiring insulin by injection shall not be eligible for a school bus certificate.

(E) The use of tobacco by a school bus driver is not permitted during the operation of the bus while hauling pupils. The use of any intoxicating or non-intoxicating alcoholic beverage by the driver eight (8) hours prior to or during the operation of a school bus is strictly prohibited. The use of any controlled dangerous substance seventy-two (72) hours prior to or during the operation of a school bus is strictly prohibited. The possession of any controlled dangerous substance on a school bus is strictly prohibited.

(F) All school bus drivers shall have an annual health certificate signed by a physician licensed by this state filed in the office of the local Chief Administrative Officer or designee attesting that such physician has examined the applicant and that the applicant has no sign or symptoms of ill health, and is otherwise, from the observation of such physician, physically and mentally capable of safely operating a school bus. As an alternative to the annual physical examination requirements for school bus drivers, school districts may adopt a policy that utilizes a biannual physical examination, provided the examination is in compliance with the physical qualifications and examination requirements of the Federal Motor Carrier Safety Act, Subpart E 391.41 to 391.50.

(G) Substitute and activity school bus drivers shall meet all the requirements prescribed for regular bus drivers.

(H) At a minimum, the Chief Administrative Officer or designee shall conduct an annual driving record check of all school bus drivers, including substitute and activity drivers. The Oklahoma State Department of Education shall be immediately notified of any violation(s) that make a school bus driver ineligible to hold an Oklahoma School Bus Driver's Certificate.

(2) **Certificate requirements.**

(A) The Chief Administrative Officer or designee shall certify to the State Department of Education that each applicant submitted for Standard Five-Year Certification:

(i) Is at least 18 years of age.

(ii) Has successfully completed a ~~twenty-four hour~~ special school bus drivers' course approved by the State Department of Education.

(iii) Holds a valid Commercial Drivers license (CDL) appropriate for the type of vehicle driven with the proper endorsements required by the Department of Public Safety.

(iv) Has not been convicted, plead guilty, or nolo contendere to a felony during the last ten years.

- (v) Has passed a driving record check, and no certificate shall be issued to any person who, within the preceding three years:
- (I) Has had a license suspended or revoked, canceled or withdrawn pursuant to the Implied Consent Laws at 47 O.S. §751 et seq.
 - (II) Has a conviction for a violation of 47 O.S. §11-902 which includes driving, operating or being in actual physical control of a vehicle while under the influence of alcohol or any intoxicating drug.
 - (III) Has been convicted or plead guilty to a violation of 47 O.S. §761, operating a motor vehicle while impaired by consumption of alcohol.
 - (IV) Has been convicted of any municipal violation of driving under the influence of alcohol or drugs or operating a motor vehicle while impaired or being in actual physical control of a motor vehicle while impaired.
 - (V) Has had four or more traffic violations. (excluding parking violations)
- (B) The Chief Administrative Officer or designee shall certify to the State Department of Education that the applicant for an Emergency One-Year School Bus Driver Certificate (Not Renewable).
- (i) Is at least 18 years of age.
 - (ii) Holds a valid Commercial Drivers License with the proper endorsements required by the Department of Public Safety.
- (C) Requirements for Renewal of the Standard Five-Year Certificate include:
- (i) Every five years, each driver shall have successfully completed 4 hours per year of inservice training approved by the State Department of Education.
 - (ii) The local Chief Administrative Officer or designee shall certify to the State Department of Education that the applicant meets all requirements for standard certification, [47 O.S. § 15-109]
 - (iii) Each applicant has a health certificate on file signed by a licensed physician and meets all vision requirements and is not dependent upon insulin by injection,
 - (iv) Each applicant has not been convicted or plead guilty of a felony in the last ten years, and
 - (v) A driving record has been checked and meets State Board of Education requirements for certification.

[OAR Docket #09-866; filed 5-8-09]

TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 35. STANDARDS FOR ACCREDITATION OF ELEMENTARY, MIDDLE LEVEL, SECONDARY, AND CAREER AND TECHNOLOGY SCHOOLS

[OAR Docket #09-865]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Standards for Elementary, Middle Level, Secondary, and Career and Technology Schools

Part 21. Standard XI: Accreditation Status

210:35-3-201. Statement of the standard [AMENDED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

DATES:

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Superseded rules:

Subchapter 3. Standards for Elementary, Middle Level, Secondary, and Career and Technology Schools

Part 21. Standard XI: Accreditation Status

210:35-3-201. Statement of the standard [AMENDED]

Gubernatorial approval:

October 7, 2008

Register Publication:

26 Ok Reg 99

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08-1298

INCORPORATION BY REFERENCE:

N/A

ANALYSIS:

The proposed rule amendments outline how an accredited school site shall meet all regulatory and statutory requirements. The changes are in keeping with new statutory language concerning school sites on the school improvement list.

CONTACT PERSON:

Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN O. S. 75, SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

**SUBCHAPTER 3. STANDARDS FOR
ELEMENTARY, MIDDLE LEVEL, SECONDARY,
AND CAREER AND TECHNOLOGY SCHOOLS**

**PART 21. STANDARD XI: ACCREDITATION
STATUS**

210:35-3-201. Statement of the standard

(a) Each school site must submit an Application for Accreditation to the Accreditation Standards Section of the State Department of Education by the due date specified on the Application. School sites are accredited for one year. An accredited school site shall meet all regulations and statutory requirements at the beginning of and throughout the school year.

(b) Accreditation status of school sites shall be classified according to the following categories:

(1) Accredited With No Deficiencies--All standards are being met.

(2) Accredited With Deficiencies--A school site fails to meet one or more of the standards but the deficiency does not seriously ~~distract~~detract from the quality of the school's educational program.

(3) Accredited With Warning--A school site:
(A) fails to meet one or more of the standards and the deficiency seriously ~~distracts~~detracts from the quality of the school's educational program; and/or
(B) is declared as a ~~low performing school~~School Improvement School (to be implemented in school year 2008-09).

(4) Accredited With Probation--A school site:
(A) consistently fails to remove or make substantial progress towards removing all deficiencies noted the previous year; and/or,
(B) consistently violates regulations; and/or,
(C) deliberately and unnecessarily violates one or more of the regulations; and/or
(D) is declared as a ~~high challenge school~~School Improvement School year three (3) or beyond (to be implemented in school year 2008-09).

(5) Nonaccredited--The school site is no longer recognized by the State Board of Education.

(c) If a school site is placed on warning or probation, the school board and administration will meet with a committee from the Accreditation Section to review their accreditation status. After the review from the committee, a determination will be made concerning warning, probation or nonaccredited status. The Accreditation Section will then present a recommendation to the State Board of Education.

[OAR Docket #09-865; filed 5-8-09]

**TITLE 304. STATE USE COMMITTEE
CHAPTER 10. OPERATIONAL
PROCEDURES**

[OAR Docket #09-878]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
304:10-1-3. [AMENDED]
304:10-1-4. [AMENDED]
304:10-1-5. [AMENDED]
304:10-1-9. [AMENDED]
304:10-1-10. [AMENDED]
304:10-1-12. [AMENDED]

AUTHORITY:
74 O.S., Section 3009; State Use Committee

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June 11, 2009

SUPERSEDED EMERGENCY ACTIONS:
n/a

INCORPORATIONS BY REFERENCE:
n/a

ANALYSIS:
Proposed rules modify and clarify the process of determination by the State Use Committee of fair market price for products and services; and, of the development and implementation of the procurement schedule, specifically for products and services determined to be suitable for purchase.

CONTACT PERSON:
Gerry Smedley, Administrative Rules Liaison, (405) 522-6597 or Gerry_Smedley@dcs.state.ok.us; Department of Central Services, Administration, 2401 N. Lincoln Boulevard, Suite 206, Oklahoma City, OK 73105.

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,
SECTION 308.1(A), WITH AN EFFECTIVE DATE
OF JUNE 11, 2009:**

304:10-1-3. Qualifications

(a) **Qualification by Committee.** To ensure compliance with the Act, the Committee shall qualify individuals and nonprofit agencies prior to contract award.

(b) **Individual qualification.** An individual shall apply for qualification to the Committee and submit the following documents:

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- (1) To indicate the individual meets the statutory definition of a severely disabled person, the individual shall provide:
- (A) a copy of the application and supporting documentation the individual submitted to the Social Security Administration for determination of disability and a copy of the final disability determination from the Administration;
 - (B) a narrative report, prepared and signed by a person licensed in the state of Oklahoma as a physician describing physical disabilities, or a psychiatrist or psychologist describing mental disabilities. The report shall fully describe the nature of the disability constituting a substantial handicap to employment with supporting medical records; and
 - (C) any additional information the Committee may require related to work history, vocational assessments and work related documents.
- (2) an affidavit that the individual will perform 75% of the work to produce the products or services the individual offers for procurement by the state; and
- (3) a statement which describes the nature and extent as expressed in a percentage of work a subcontractor, other person or entity may perform to produce the products or services.
- (c) **Agency qualification.** A nonprofit agency that has been approved by the Wage and Hour Division of the U.S. Department of Labor as a sheltered workshop shall apply for qualification to the Committee and submit the following documents that indicate the nonprofit agency meets the requirements of a qualified organization:
- (1) a tax-exempt FEI number issued by the IRS, or a certificate from the IRS verifying that the entity meets the requirements for nonprofit status as defined by the IRS; and,
 - (2) a statement describing the nature and extent as expressed in a percentage of the work a subcontractor, other person or entity may perform to produce the products or services ~~the nonprofit agency provides per a contract the Committee awards.~~
 - (3) a copy of certification as a sheltered workshop issued by the U. S. Department of Labor.
 - (4) a current copy of the nonprofit agency's certificate of insurance for worker's compensation insurance.
- (d) **Continuation of qualification.** ~~On~~ By January 31st of each year succeeding initial qualification by the Committee, the qualified organizations shall provide evidence to the Committee of continued ability to qualify as follows:
- (1) A qualified nonprofit agency for the severely handicapped shall submit:
 - (A) a current copy of its certification as a sheltered workshop from the U.S. Department of Labor; and
 - (B) a report for products and services on the Committee's procurement schedule indicating the qualified nonprofit agency for the severely handicapped's total labor hours in direct production by disabled workers and total agency labor hours in direct production by non-disabled workers during the previous calendar year.
 - (C) a current copy of the qualified nonprofit agency for the severely handicapped's certificate of insurance for worker's compensation insurance.
- (2) An individual shall submit:
- (A) a work history for the previous calendar year that indicates the number of hours the individual worked and the number of hours a subcontractor or other individuals worked in direct production of the products and services on the Committee's procurement schedule; and
 - (B) a current physician, psychiatrist or psychologist statement indicating the current status of the condition which constitutes a substantial handicap to employment, which shall include changes in the condition since the previous date of qualification by the Committee.
- (e) **Failure to meet qualifications.** Whenever a qualified organization fails to meet qualifications, the Committee may:
- (1) Remove the qualified organization's products and services from the procurement schedule; or,
 - (2) Revoke the qualification of the qualified organization.
- (f) **Notice of failure to meet qualifications.** The Committee shall direct the contracting officer to send written notice to the qualified organization at least thirty days prior to the effective date of the action taken pursuant to subsection (e) of this section.
- 304:10-1-4. Determination of fair market price**
- The contracting officer shall recommend a fair market price for products and services in accordance with the State Use Committee's approved Fair Market Price Policy and in the manner described in this section.
- (1) The contracting officer shall prepare a current market analysis to determine the fair price for the products or services requisitioned or used by state agencies utilizing internal as well as external sources and established pertinent criteria. When appropriate, the criteria may include, but not be limited to:
 - (A) A survey of comparable private contracts for like products and services;
 - (B) Research of other governmental entities within and outside the State of Oklahoma;
 - (C) Comparison, when appropriate, of wholesale and retail pricing of like commodities.
 - (2) Based on the data described in OAC 304:10-1-4 (1), the contracting officer or designee shall recommend a fair market price with supporting documentation to the Committee for consideration.
 - (3) The Committee shall, by majority vote, approve, modify, amend or disapprove the recommended fair market price.
 - (4) Whenever the Committee establishes a price, the price shall become the fair market price.

(5) If the product or service is one for which the pricing does not vary by state agency or location, the fair market price as approved, modified, or amended, shall remain in effect until the Committee establishes a new fair market price.

(6) If the product or service is one for which the price does vary depending on the state agency, ~~or location, or specifications,~~ the Committee shall approve, ~~by majority vote,~~ each contract for the product or service.

(7) If the product or service is one for which fair market has not been established, either because the fair market for the type of product or service has been determined to vary depending on the state agency, location or specifications, the Contracting Officer, with the approval of the State Purchasing Director, is authorized to award a contract in accordance with the State Use Fair Market Price Policy to a qualified individual or organizations, thereby establishing fair market price, which establishment shall be subject to ratification by the Committee at the next regular Committee meeting.

~~(78)~~ In the event of an emergency, with approval of the State Purchasing Director, the contracting officer may award a contract to an individual or agency for a maximum period of three (3) months without prior Committee approval, but subject to Committee approval at the next regular Committee meeting. If the Committee approves the contract, the contract shall terminate at the end of the contract period.

304:10-1-5. Procurement schedule

(a) Compilation of procurement schedule. The contracting officer shall maintain and publish a current list of all products and services offered by qualified organizations. This schedule shall include:

(1) Products and services that the Committee has established fair market price.

(2) Products and services that are suitable to procure, but for which fair market has not been established. For these products and services, the Committee will establish a fair market price in accordance with 304:10-1-4.

(b) Approval of procurement schedule. The Committee shall approve items on the list or delete items from the list at least annually, consistent with the provisions of the Act, and shall designate the final list of approved items as the Procurement Schedule ~~by majority vote.~~ If additional products or services are offered by individuals or agencies, the Committee may add products and services to the Procurement Schedule ~~by majority vote.~~

304:10-1-9. List of ~~jobs~~ products and services for which fair market has not been determined

The Committee shall publish at least annually, a catalog listing of products and services ~~the jobs that workshops qualified organizations can do for~~ provide to the State of Oklahoma; ~~annually.~~ The list of ~~jobs~~ shall be the Procurement Schedule.

304:10-1-10. Meetings

(a) Number of regular meetings. The Committee shall conduct a minimum of six meetings per year, in compliance with the Open Meeting Act. The schedule for regular meetings will be adopted at the last regular meeting of each calendar year.

(b) Special meetings. Special meetings shall be called by the Committee Chairperson.

(c) Quorum. A majority of all current members of the Committee shall constitute a quorum.

(d) Request for notices of meeting. Upon written request, the Committee Vice-Chairperson shall notify any person, state agency, qualified organization or contractor, at least ten days prior to meeting dates, and shall make available the minutes of all meetings.

(e) Annual Meeting. This meeting shall include training on new rules, bidding guidelines, report requirements but is not limited to these topics. A minimum of one person from each qualified organization must attend to be eligible to participate in State Use contracts.

304:10-1-12. Contract Levy

(a) **Contract levy.** Pursuant to 74 O.S., Section 3004.1, a one percent (1%) fee assessment shall be levied against qualified organizations for every contract awarded under the act for products and services of the severely disabled.

(b) **Monthly reports and contract levy payments.** Qualified organizations shall submit a monthly report by the 15th of each month to the ~~State Use~~ Contracting Officer. The report shall contain the total amount of payments received from state agencies and the one percent (1%) fee assessment based on the total amount of payments stated in the report.

(c) **Failure to submit monthly reports and payments.** Any fee assessment payment that is past due more than sixty (60) days shall be considered delinquent. A written notice of delinquency shall be sent by the ~~State Use~~ Contracting Officer to each qualified organization considered delinquent. The notice shall state the amount due and requirements for compliance.

(d) **Revocation of a qualified organization.** Failure to provide monthly reports and payments will be reported to the ~~State Use~~ Committee and the State Purchasing Director and may result in the revocation of the "qualified organization" procurement schedule and/or termination of their contracts.

[OAR Docket #09-878; filed 5-8-09]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 250. FEE SCHEDULE FOR CONSUMER HEALTH SERVICES

[OAR Docket #09-797]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 3. License Classifications and Associated Fees For Consumer Health Services

Permanent Final Adoptions

310:250-3-1 [AMENDED]
310:250-3-2 [AMENDED]
310:250-3-3 [AMENDED]
310:250-3-6 [AMENDED]

AUTHORITY:

Oklahoma State Board of Health; Title 63 O.S. 63 O.S., §§ 1-106.1 and 1-1118.

DATES:

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SUPERSEDED EMERGENCY ACTIONS:

"n/a"

INCORPORATION BY REFERENCE:

"n/a"

ANALYSIS:

The proposal involves revisions to the rule to increase the fees associated with food service establishments, health facilities, state prisons, schools, non-profit institutions, temporary food services, drug operational permits, and lodging establishments to SubChapter 3 of the present Fee Schedule For Consumer Health Services Regulations. The proposal to Subchapter 3 includes changes to no longer exempt from a license fee, non-profit institutions that use paid employees to operate their establishments, facilities or institutions. Also, the current fee schedule for Public Bathing Place Construction Permits is set forth in Rule in at OAC 310:320-5-5 and is being moved to the License Classifications and Associated Fees for Consumer Health Services. This proposal is necessary to establish all fees assessed by Consumer Protection Division within the Department to be in one location of Rule. This change will help the Consumers of Oklahoma determine the cost of doing business in Oklahoma within in one area and prevent searching documents for fee schedules

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 3. LICENSE CLASSIFICATIONS AND ASSOCIATED FEES FOR CONSUMER HEALTH SERVICES

310:250-3-1. Food service establishments' permits

(a) The following are license classifications and associated fees for food service establishments:

(1) Type 45 Class A- "Frozen Food Locker":

- (A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (2) Type 45 Class B - "Bar":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (3) Class C - "Combination Retail Food":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (4) Class E - "Health Facilities, State Prisons, Schools, (operated by non-profit institutions or government agencies) or Non-Profit Institutions":
(A) Initial - ~~Exempt~~ \$100.00
(B) Renewal - ~~Exempt~~ \$100.00
(C) Late Renewal - ~~Exempt~~ \$150.00
- (5) Class F - "Food Service Establishment":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (6) Class G - "Food Service with Bar":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (7) Class M - "Mobile Food Service and Vendor":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (8) Class R - "Retail Food Store":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (9) Class S - "Seasonal Food Service":
(A) Non-Renewable - ~~\$100.00~~ \$200.00 for one hundred eighty (180) consecutive days only
- (10) Class T - "Temporary Food Service":
(A) ~~\$25.00~~ \$30.00 up to ~~five (5)~~ three (3) days + ~~\$5.00~~ \$15.00 each day in excess of ~~five (5)~~ three (3) days
- (11) Class P - "Food Processors":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (12) Class W - "Food Wholesaler":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (13) Class X - "Privately Owned Prisons":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (14) Class Y - "Salvage Food":
(A) Initial - ~~\$150.00~~ \$350.00
(B) Renewal - ~~\$100.00~~ \$250.00
(C) Late Renewal - ~~\$135.00~~ \$300.00
- (15) Class Z - "Water Bottling Facilities":
(A) Initial - ~~\$150.00~~ \$350.00

- (B) Renewal - ~~\$100.00~~ \$250.00
- (C) Late Renewal - ~~\$135.00~~ \$300.00

(b) An establishment qualifies for a fee exempt license if it is a "food service establishment --fee exempt" as that term is defined in OAC 310:257-1-2.

(c) Late renewal fees apply to any renewal application post-marked and/or received thirty (30) days after the expiration date of the license.

(d) A license not renewed within ninety (90) days of the date shall be ineligible for the renewal. Thereafter, the establishment shall be required to pay an initial fee. The establishment that has not had a valid license for one (1) year is considered a new establishment.

310:250-3-2. Drug operational permits

The following are license classifications and associated fees for over-the-counter wholesalers, brokers, and drug manufacturers:

- (1) Type 48 Class M - "Drug Manufacturers, over-the-counter":
 - (A) Initial - ~~\$100.00~~ \$350.00
 - (B) Renewal - ~~\$50.00~~ \$250.00
 - (C) Late Renewal - ~~\$75.00~~ \$300.00
- (2) Type 48 Class W - "Drug Warehouse":
 - (A) Initial - ~~\$100.00~~ \$350.00
 - (B) Renewal - ~~\$50.00~~ \$250.00
 - (C) Late Renewal - ~~\$75.00~~ \$300.00

310:250-3-3. Lodging establishment operational permits

Fees for lodging establishment operational permits are as follows:

- (1) Type 51 Class A "Hotels and Motels"(Not more than 20 units):
 - (A) Initial - ~~\$100.00~~ \$250.00
 - (B) Renewal - ~~\$50.00~~ \$150.00
 - (C) Late Renewal - ~~\$75.00~~ \$200.00
- (2) Type 51 Class B "Hotels and Motels"(Not more than 100 units):
 - (A) Initial - ~~\$100.00~~ \$300.00
 - (B) Renewal - ~~\$75.00~~ \$200.00
 - (C) Late Renewal - ~~\$112.00~~ \$250.00
- (3) Type 51 Class C "Hotels and Motels"(More than 100 units):
 - (A) Initial - ~~\$100.00~~ \$350.00
 - (B) Renewal - ~~\$100.00~~ \$250.00
 - (C) Late Renewal - ~~\$150.00~~ \$300.00

310:250-3-6. Public Bathing Places Licenses

(a) The following are license classifications and associated fees for Public Bathing Places:

- (1) Type 82 Class I "Indoor Facility"
 - (A) Public Bathing Places License Fee - \$50.00
 - (B) Public Bathing Places Re-inspection Fee - \$250.00
- (2) Type 82 Class O "Outdoor Facility"
 - (A) Public Bathing Places License Fee - \$50.00

- (B) Public Bathing Places Re-inspection Fee - \$250.00

(b) Each filter system for a construction project shall require a separate permit. One project may contain several construction items and require more than one permit. The maximum fee for each public bathing place construction permit will be \$2000.00

(1) New Construction

(A) Pool - Rounded to the nearest 5000 gallons volume - \$100.00 per 5000 gallons (minimum \$500.00 fee)

(B) Spray Pool -Rounded to the nearest 5000 gallons volume - \$100.00 per 5000 gallons (minimum \$500.00 fee)

(C) Spas - Rounded to nearest 100 gallons volume - \$50.00 per 100 gallons (minimum \$250.00 fee)

(2) Modification to Existing Permit

(A) Pool - Rounded to the nearest 5000 gallons volume - \$50.00 per 5000 gallons (minimum \$250.00 fee)

(B) Spray Pool - Rounded to the nearest 5000 gallons volume -50.00 per 5000 gallons (minimum \$250.00 fee)

(C) Spas - Rounded to the Nearest 100 gallons volume - \$25.00 per 100 gallons (minimum \$125.00 fee)

[OAR Docket #09-797; filed 4-29-09]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 257. FOOD SERVICE ESTABLISHMENTS

[OAR Docket #09-798]

RULEMAKING ACTION:
PERMANENT final adoption
RULES:

- Subchapter 1. Purpose and Definitions
 - 310:257-1-2 [AMENDED]
 - 310:257-1-4 [AMENDED]
- Subchapter 3. Management and Personnel
 - 310:257-3-3 [AMENDED]
- Subchapter 5. Food
 - 310:257-5-10 [AMENDED]
 - 310:257-5-50 [AMENDED]
 - 310:257-5-59 [AMENDED]
 - 310:257-5-60 [AMENDED]
 - 310:257-5-61 [AMENDED]
 - 310:257-5-69 [AMENDED]
 - 310:257-5-71 [AMENDED]
- Subchapter 7. Equipment, Utensils and Linens
 - 310:257-7-3 [AMENDED]
 - 310:257-7-37 [AMENDED]
 - 310:257-7-43 [AMENDED]
 - 310:257-7-53 [AMENDED]
 - 310:257-7-75 [AMENDED]
 - 310:257-7-83 [AMENDED]
 - 310:257-7-92 [AMENDED]
- Subchapter 9. Water, Plumbing and Waste
 - 310:257-9-18 [AMENDED]
 - 310:257-9-32 [AMENDED]
 - 310:257-9-69 [AMENDED]
- Subchapter 11. Physical Facilities

Permanent Final Adoptions

310:257-11-2 [AMENDED]
310:257-11-5 [AMENDED]
310:257-11-28 [AMENDED]
Subchapter 15. Compliance and Enforcement
310:257-15-4 [AMENDED]
310:257-15-8 [AMENDED]
310:257-15-32 [AMENDED]

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Oklahoma State Board of Health; 63 O.S. Section 1-104 et seq., Section 1-1114, and Section 1-1118

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Effective:

June 11, 2009

SUPERSEDED EMERGENCY ACTIONS:

"n/a"

INCORPORATION BY REFERENCE:

"n/a"

ANALYSIS:

The current Rule sets forth definitions and parameters to safeguard public health and provide to consumers food that is safe, unadulterated and honestly presented. The proposed rule changes involve the addition of language to clarify existing regulations and correct items of reference. The proposed rule changes also address the definition of Food Service Establishment - fee exempt status and no longer "exempt" them from a license fee if they use paid persons to prepare or serve food on its behalf. The Department presently encumbers the cost of inspecting establishments that are currently defined as "fee exempt". The changes to 310:257 will update food service establishment rule that were printed in error and address the risks of morbidity and mortality caused by foodborne infection.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 1. PURPOSE AND DEFINITIONS

310:257-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Accredited program" means a food protection manager certification program that has been evaluated and listed by an

accrediting agency as conforming to national standards for organizations that certify individuals.

(A) Accredited program refers to the certification process and is a designation based upon an independent evaluation of factors such as the sponsor's mission; organizational structure; staff resources; revenue sources; policies; public information regarding program scope, eligibility requirements, re-certification, discipline and grievance procedures; and test development and administration.

(B) Accredited program does not refer to training functions or educational programs.

"Adulterated" means the definition in 63 O.S. 2001, Section 1-1109.

"Approved" means acceptable to the regulatory authority based on a determination of conformity with principles, practices, and generally recognized standards that protect public health.

"a_w" means water activity which is a measure of the free moisture in a food, is the quotient of the water vapor pressure of the substance divided by the vapor pressure of pure water at the same temperature, and is indicated by the symbol a_w.

"Beverage" means a liquid for drinking, including water.

"Bottled drinking water" means water that is sealed in bottles, packages, or other containers and offered for sale for human consumption, including bottled mineral water.

"Casing" means a tubular container for sausage products made of either natural or artificial (synthetic) material.

"Certified applicator" means any individual who is certified under 7 USC 136(i) or by the Oklahoma State Department of Agriculture as authorized to use or supervise the use of any pesticide that is classified for restricted use. Any applicator who holds or applies registered pesticides or uses dilutions of registered pesticides consistent with the product labeling only to provide a service of controlling pests without delivering any unapplied pesticide to any person so served is not deemed to be a seller or distributor of pesticides.

"Certification number" means a unique combination of letters and numbers assigned by a shellfish control authority to a molluscan shellfish dealer according to the provisions of the National Shellfish Sanitation Program.

"CIP" means cleaned in place by the circulation or flowing by mechanical means through a piping system of a detergent solution, water rinse, and sanitizing solution onto or over equipment surfaces that require cleaning, such as the method used, in part, to clean and sanitize a frozen dessert machine. It does not include the cleaning of equipment such as bandsaws, slicers, or mixers that are subjected to in-place manual cleaning without the use of a CIP system.

"CFR" means Code of Federal Regulations. Citations in this Chapter to the CFR refer sequentially to the Title, Part, and Section numbers, such as 21 CFR 178.1010 refers to Title 21, Part 178, Section 1010.

"Code of Federal Regulations" means the compilation of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government which is published annually by the U.S. Government Printing Office; and contains FDA rules in 21

CFR, USDA rules in 7 CFR and 9 CFR, EPA rules in 40 CFR, and Wildlife and Fisheries rules in 50 CFR.

"Color additive" has the meaning stated in the Federal Food, Drug, and Cosmetic Act, § 201(t) and 21 CFR 70.

"Commingle" means to combine shellstock harvested on different days or from different growing areas as identified on the tag or label, or to combine shucked shellfish from containers with different container codes or different shucking dates.

"Comminuted" means reduced in size by methods including chopping, flaking, grinding, or mincing and includes fish or meat products that are reduced in size and restructured or reformulated such as gefilte fish, gyros, ground beef, sausage; and a mixture of 2 or more types of meat that have been reduced in size and combined, such as sausages made from 2 or more meats.

"Commissary" means a facility used for the servicing of pushcarts and mobile retail units and storage of packaged food and single service articles for use in those units.

"Common dining area" means a central location in a group residence where people gather to eat at mealtime but does not apply to a kitchenette or dining area located within private living quarters.

"Confirmed disease outbreak" means a foodborne disease outbreak in which laboratory analysis of appropriate specimens identifies a causative agent and epidemiological analysis implicates the food as the source of the illness.

"Consumer" means a person who is a member of the public, takes possession of food, is not functioning in the capacity of an operator of a food service establishment or food processing plant, and does not offer the food for resale.

"Corrosion-resistant material" means a material that maintains acceptable surface cleanability characteristics under prolonged influence of the food to be contacted, the normal use of cleaning compounds and sanitizing solutions, and other conditions of the use environment.

"Critical control point" means a point or procedure in a specific food system where loss of control may result in an unacceptable health risk.

"Critical item" means a provision of this Chapter, that, if in noncompliance, is more likely than other violations to contribute to food contamination, illness, or environmental health hazard and is an item that is denoted OAC 310:257-15-41.

"Critical limit" means the maximum or minimum value to which a physical, biological, or chemical parameter must be controlled at a critical control point to minimize the risk that the identified food safety hazard may occur.

"Customer self-service" means customer selection and packaging of a bulk food product from a product module.

"Department" means the Oklahoma State Department of Health.

"Display area" means a location or locations, including physical facilities and equipment, where bulk food is offered for customer self-service.

"Drinking water" means water that meets 40 CFR 141 National Primary Drinking Water Regulations. It is traditionally known as "potable water." The term "water" except where the term used connotes that the water is not potable, such as

"boiler water," "mop water," "rainwater," "wastewater," and "nondrinking" water.

"Dry storage area" means a room or area designated for the storage of packaged or containerized bulk food that is not potentially hazardous and dry goods such as single-service items.

"Easily cleanable" means a characteristic of a surface that:

(A) Allows effective removal of soil by normal cleaning methods; is dependent on the material, design, construction, and installation of the surface; or varies with the likelihood of the surface's role in introducing pathogenic or toxigenic agents or other contaminants into food based on the surface's approved placement, purpose, and use.

(B) Easily cleanable includes a tiered application of the criteria that qualify the surface as easily cleanable as specified in paragraph A of this definition to different situations in which varying degrees of cleanability are required such as the appropriateness of stainless steel for a food preparation surface as opposed to the lack of need for stainless steel to be used for floors or for tables used for consumer dining; or the need for a different degree of cleanability for a utilitarian attachment or accessory in the kitchen as opposed to a decorative attachment or accessory in the consumer dining area.

"Easily movable" means portable; mounted on casters, gliders, or rollers; or provided with a mechanical means to safely tilt a unit of equipment for cleaning; and has no utility connection, a utility connection that disconnects quickly, or a flexible utility connection line of sufficient length to allow the equipment to be moved for cleaning of the equipment and adjacent area.

"Egg" means the shell egg of the domesticated chicken, turkey, duck, goose, or guinea.

"Employee" means the license holder, person in charge, person having supervisory or management duties, person on the payroll, family member, volunteer, person performing work under contractual agreement, or other person working in a food service establishment.

"EPA" means the U.S. Environmental Protection Agency.

"Equipment" means an article that is used in the operation of a food service establishment such as a freezer, grinder, hood, ice maker, meat block, mixer, oven, reach-in refrigerator, scale, sink, slicer, stove, table, temperature measuring device for ambient air, vending machine, or warewashing machine. It does not include items used for handling or storing large quantities of packaged foods that are received from a supplier in a cased or overwrapped lot, such as hand trucks, forklifts, dollies, pallets, racks, and skids. Food equipment that shall be certified by the National Sanitation Foundation (NSF) or an equivalent organization includes but is not limited to, floor mounted refrigerators, grills, warewashing machines, griddles, fryers, ice machines, and steam tables; and counter mounted equipment such as slicers, grinders, food processors, crock-pot/hot holding units, and other similar food processing equipment.

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"Exclude" means to prevent a person from working as a food employee or entering a food service establishment except for those areas open to the general public.

"Farmers Market" means a designated area in which farmers, growers or producers from a defined region gather on a regularly scheduled basis to sell at retail non-potentially hazardous farm food products and whole shell eggs to the public. A portion of the raw food ingredients used by the individual vendor to produce a product must have been grown or raised by the vendor. The individual vendors wishing to process food as defined by Good Manufacturing Practice, OAC 310:260 of the regulations must obtain a state food processor's license. A Farmers' Market must have written operational guidelines and a minimum of six vendors along with a designated market manager or advisory board who will be responsible for distribution of a copy of the guidelines to the vendors. Farmers' Markets must be registered by the Oklahoma Department of Agriculture, Food and Forestry and comply with the Food Service Establishments, OAC 310:257, and/or Good Manufacturing Practice, OAC 310:260. This definition does not include individual farmers who grow and sell unprocessed fruit and/or vegetables from the farm, roadside or truck. Any vendors who prepare or sell any potentially hazardous foods at the Farmers' Markets must abide by all applicable sections of Food Service Establishments, OAC 310:257 of the regulations including acquiring a license from the department.

"FDA" means the U.S. Food and Drug Administration.

"Fish" means fresh or saltwater finfish, crustaceans and other forms of aquatic life (including alligator, frog, aquatic turtle, jellyfish, sea cucumber, and sea urchin and the roe of such animals) other than birds or mammals, and all mollusks, if such animal life is intended for human consumption. Fish includes an edible human food product derived in whole or in part from fish, including fish that have been processed in any manner.

"Food" means a raw, cooked, or processed edible substance, ice, beverage, or ingredient used or intended for use or for sale in whole or in part for human consumption, or chewing gum.

"Food additive" has the meaning stated in the Federal Food, Drug, and Cosmetic Act, § 201(s) and 21 CFR 170.

"Foodborne disease outbreak" means the occurrence of two or more cases of a similar illness resulting from the ingestion of a common food.

"Food-contact surface" means a surface of equipment or a utensil with which food normally comes into contact; or a surface of equipment or a utensil from which food may drain, drip, or splash into a food, or onto a surface normally in contact with food.

"Food employee" means an individual working with unpackaged food, food equipment or utensils, or food-contact surfaces.

"Food service establishment" means an operation that stores, prepares, packages, serves, vends, or otherwise provides food for human consumption: Such as a restaurant; satellite or catered feeding location; catering operation if the operation provides food directly to a consumer or to a conveyance used to transport people; market; vending location;

institution; or food bank; and that relinquishes possession of food to a consumer directly, or indirectly through a delivery service such as home delivery of grocery orders or restaurant takeout orders, or delivery service that is provided by common carriers.

(A) Food service establishment includes: An element of the operation such as a transportation vehicle or a central preparation facility that supplies a vending location or satellite feeding location unless the vending or feeding location is permitted by the regulatory authority; or an operation that is conducted in a mobile, stationary, temporary, or permanent facility or location; where consumption is on or off the premises; and regardless of whether there is a charge for the food.

(B) Food service establishment does not include:

(i) Food processing plant;

(ii) A kitchen in a private home if only food that is not potentially hazardous is prepared for sale or service at a function such as a religious or charitable organization's bake sale if allowed by law and if the consumer is informed by a clearly visible placard at the sales or service location that the food is prepared in a kitchen that is not subject to regulation and inspection by the regulatory authority;

(iii) An area where food that is prepared as specified in paragraph (2) of this definition is sold or offered for human consumption;

(iv) A kitchen in a private home, such as a small family day-care provider; or a bed-and-breakfast operation that prepares and offers food to guests if the home is owner occupied, the number of available guest bedrooms does not exceed 3, breakfast is the only meal offered

(v) A private home that receives catered or home-delivered food.

"Food service establishment - fee exempt" means a food service establishment ~~operated by a hospital, public school or government institution, which only prepares and serves food to its patients, students, employees, members or inmates and occasional visitors or guests; or as otherwise provided in paragraph (A) and (B) below, a food service establishment or operation conducted that utilizes non-paid persons~~ by a nonprofit, civic, charitable or religious organization primarily for benevolent purposes.

(A) Fee exempt licensees shall comply with the applicable sections of these rules depending upon the type of operation involved; e.g., food service, retail food, combination, temporary, or mobile.

(B) Fee exempt licenses, except temporary licenses, shall not expire but shall remain in full force and effect until revoked, suspended, annulled or withdrawn by the Commissioner in accordance with applicable law. A license is not required for a non-profit civic, charitable or religious organization, using non-paid persons to prepare or serve food on its behalf, for occasional fund-raising events sponsored and

conducted by the organization, nor shall a license be required if such an organization, using non paid persons, prepares and serves non potentially hazardous food at events sponsored or conducted by other organizations. Guidelines shall be provided for safeguarding the health of customers.

"Food processing plant" means a commercial operation that manufactures, packages, labels, or stores food for human consumption and does not provide food directly to a consumer.

"Game animal" means an animal, the products of which are food, that is not included in the definitions of 2 O.S. 2001, §§ 6-183 et seq. (cattle, bison, sheep, swine and goats). Equines are not included due to the provisions of 63 O.S. 2001, §1-1135 (prohibits the use of equine for food), 2 O.S. 2001, § 6-251 et seq. (poultry, including any domestic bird whether live or dead), 2 O.S. 2001, §§ 6-280.1 et seq. (domesticated rabbits whether live or dead), 2 O.S. 2001, § 6-290.3 et seq. (exotic livestock including commercially raised livestock and including but not limited to animals of the families bovidae, cervidae, antilocapridae, or birds of the order casuariiformes or in the definitions of fish in this Subchapter).

"General use pesticide" means a pesticide that is not classified by EPA for restricted use as specified in 40 CFR 152.175.

"Grade A standards" means the requirements of the United States Public Health Service/FDA "Grade A Pasteurized Milk Ordinance" and "Grade A Condensed and Dry Milk Ordinance" with which certain fluid and dry milk and milk products comply.

"Group residence" means a private or public housing corporation or institutional facility that provides living quarters and meals or includes a domicile for unrelated persons.

"HACCP plan" means a written document that delineates the formal procedures for following the Hazard Analysis Critical Control Point principles developed by The National Advisory Committee on Microbiological Criteria for Foods.

"Hazard" means a biological, chemical, or physical property that may cause an unacceptable consumer health risk.

"Hermetically sealed container" means a container that is designed and intended to be secure against the entry of microorganisms and, in the case of low acid canned foods, to maintain the commercial sterility of its contents after processing.

"Highly susceptible population" means persons who are more likely than other people in the general population to experience foodborne disease because they are: immunocompromised; preschool age children, or older adults; and obtaining food at a facility that provides services such as custodial care, health care, or assisted living, such as a child or adult day care center, kidney dialysis center, hospital or nursing home, or nutritional or socialization services such as a senior center.

"Imminent health hazard" means a significant threat or danger to health that is considered to exist when there is evidence sufficient to show that a product, practice, circumstance, or event creates a situation that requires immediate correction or cessation of operation to prevent injury based on the number

of potential injuries, and the nature, severity, and duration of the anticipated injury.

"Impermeable" means incapable of allowing liquids to pass through the covering.

"Injected" means manipulating a meat so that infectious or toxigenic microorganisms may be introduced from its surface to its interior through tenderizing with deep penetration or injecting the meat such as by processes which may be referred to as "injecting," "pinning," or "stitch pumping."

"Juice" means, when used in the context of food safety, the aqueous liquid expressed or extracted from one or more fruits or vegetables, purées of the edible portions of one or more fruits or vegetables, or any concentrates of such liquid or purée. Juice includes juice as a whole beverage, an ingredient of a beverage and a purée as an ingredient of a beverage.

"Kitchenware" means food preparation and storage utensils.

"Law" means applicable local, state, and federal statutes, regulations, and ordinances.

"License" means the document issued by the Department that authorizes a person to operate a food service establishment.

"License holder" means the entity that is legally responsible for the operation of the food service establishment such as the owner, the owner's agent, or other person; and possesses a valid license to operate a food service establishment.

"Linens" means fabric items such as cloth hampers, cloth napkins, table cloths, wiping cloths, and work garments including cloth gloves.

"Major food allergen" means milk, egg, fish (such as bass, flounder, cod, and including crustacean such as crab, lobster, or shrimp), tree nuts (such as almonds, pecans, or walnuts), wheat, peanuts, and soybeans; or a food ingredient that contains protein derived from a food specified above.

(A) Major food allergen does not include: Any highly refined oil derived from a food specified in Major Food Allergen definition and any ingredient derived from such highly refined oil; or

(B) Any ingredient that is exempt under the petition or notification process specified in the Food Allergen Labeling and Consumer Protection Act of 2004 (Public Law 108-282).

"Meat" means the flesh of animals used as food including the dressed flesh of cattle, swine, sheep, or goats and other edible animals, except fish, poultry, and wild game animals.

"mg/L" means milligrams per liter, which is the metric equivalent of parts per million (ppm).

"Misbranding" means the definition contained in 63 O.S. 2001, § 1-1110.

"Mobile food service establishment" means a facility that is vehicle mounted (has wheels and axles), is readily moveable and remains at one physical address for no more than 17 days at one time.

"Mobile pushcart" means a non-self propelled mobile food unit that can be manually moved, is limited to serving non-potentially hazardous foods, pre-packaged food or preparation and serving of frankfurters, and returns daily to a commissary.

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"Mobile retail food service establishment" means a facility that is vehicle mounted, remains at one physical address for no more than 17 days at a time and serves only prepackaged foods and dispensed drinks prepared in a facility that is regulated by the Good Manufacturing Practices in Title 21 of the CFR or regulated as a license holder pursuant to Chapter 310:260, Good Manufacturing Practice Regulations, or this Chapter.

"Molluscan shellfish" means any edible species of fresh or frozen oysters, clams, mussels, and scallops or edible portions thereof, except when the scallop product consists only of the shucked adductor muscle.

"Packaged" means bottled, canned, cartoned, securely bagged, or securely wrapped, whether packaged in a food service establishment or a food processing plant. It does not include a wrapper, carry-out box, or other nondurable container used to containerize food with the purpose of facilitating food protection during service and receipt of the food by the consumer.

"Person" means an association, a corporation, individual, partnership, other legal entity, government, or governmental subdivision or agency.

"Person in charge" means the individual present at a food service establishment who is responsible for the operation at the time of inspection.

"Personal care items" means items or substances that may be poisonous, toxic, or a source of contamination and are used to maintain or enhance a person's health, hygiene, or appearance. It may include items such as medicines; first aid supplies; and other items such as cosmetics, and toiletries such as toothpaste and mouthwash.

"pH" means the symbol for the negative logarithm of the hydrogen ion concentration, which is a measure of the degree of acidity or alkalinity of a solution. Values between 0 and 7 indicate acidity and values between 7 and 14 indicate alkalinity. The value for pure distilled water is 7, which is considered neutral.

"Physical facilities" means the structure and interior surfaces of a food service establishment including accessories such as soap and towel dispensers and attachments such as light fixtures and heating or air conditioning system vents.

"Plumbing fixture" means a receptacle or device that is permanently or temporarily connected to the water distribution system of the premises and demands a supply of water from the system; or discharges used water, waste materials, or sewage directly or indirectly to the drainage system of the premises.

"Plumbing system" means the water supply and distribution pipes; plumbing fixtures and traps; soil, waste, and vent pipes; sanitary and storm sewers and building drains, including their respective connections, devices, and appurtenances within the premises; and water-treating equipment.

"Poisonous or toxic materials" means substances that are not intended for ingestion and are included in 4 categories:

- (A) Cleaners and sanitizers, which include cleaning and sanitizing agents and agents such as caustics, acids, drying agents, polishes, and other chemicals;
- (B) Pesticides, except sanitizers, which include substances such as insecticides and rodenticides;

(C) Substances necessary for the operation and maintenance of the establishment such as nonfood grade lubricants and personal care items that may be deleterious to health; and

(D) Substances that are not necessary for the operation and maintenance of the establishment and are on the premises for retail sale, such as petroleum products and paints.

"Potentially hazardous food" means a food that is natural or synthetic and that requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious or toxigenic microorganisms, the growth and toxin production of *Clostridium botulinum*; or in raw shell eggs, the growth of *Salmonella Enteritidis*.

(A) Potentially hazardous food includes an animal food (a food of animal origin) that is raw or heat-treated; a food of plant origin that is heat-treated or consists of raw seed sprouts; cut melons; and garlic-in-oil mixtures that are not modified in a way that results in mixtures that do not support growth.

(B) Potentially hazardous food does not include an air-cooled hard-boiled egg with shell intact, or a shell egg that is not hard-boiled, but has been treated to destroy all viable *Salmonellae*, a food with an a_w value of 0.85 or less, a food with a pH level of 4.6 or below when measured at 24°C (75°F), a food, in an unopened hermetically sealed container, that is commercially processed to achieve and maintain commercial sterility under conditions of nonrefrigerated storage and distribution, a food for which laboratory evidence demonstrates that the rapid and progressive growth of infectious or toxigenic microorganisms or the growth of *S. Enteritidis* in eggs or *C. botulinum* can not occur, such as a food that has an a_w and a pH that are above the levels identified in this definition and that may contain a preservative, other barrier to the growth of microorganisms, or a combination of barriers that inhibit the growth of microorganisms; or a food that does not support the growth of microorganisms, even though the food may contain an infectious or toxigenic microorganism or chemical or physical contaminant at a level sufficient to cause illness.

"Poultry" means any domesticated bird (chickens, turkeys, ducks, geese, ratites, or guineas), whether live or dead, as defined in 9 CFR 381 Poultry Products Inspection Regulations; and any migratory waterfowl, game bird, such as pheasant, partridge, quail, grouse, or guinea, or pigeon or squab, whether live or dead, as defined in 9 CFR 362 Voluntary Poultry Inspection Regulations.

"Premises" means the physical facility, its contents, and the contiguous land or property under the control of the license holder; or the physical facility, its contents, and the land or property not under the control of the license holder, unless its facilities and contents are under the control of the license holder and may impact food service establishment personnel, facilities, or operations, and a food service establishment is

only one component of a larger operation such as a health care facility, hotel, motel, school, recreational camp, or prison.

"Primal cut" means a basic major cut into which carcasses and sides of meat are separated, such as a beef round, pork loin, lamb flank, or veal breast.

"Public water system" has the meaning stated in 40 CFR 141 National Primary Drinking Water Regulations.

"Ready-to-eat food" means food that is in a form that is edible without additional preparation to achieve food safety, as specified under OAC 310:257-5-46(a)-(c) or OAC 310:257-5-47 or OAC 310:257-5-49, or is a raw or partially cooked animal food and the consumer is advised as specified under OAC 310:257-5-46(d)(1) and (2); or is prepared in accordance with a variance that is granted as specified OAC 310:257-5-46(d)(1) and (3); and may receive additional preparation for palatability or aesthetic, epicurean, gastronomic, or culinary purposes.

"Ready-to-eat food" includes raw animal food that is cooked as specified under OAC 310:257-5-46 or OAC 310:257-5-47, or frozen as specified under OAC 310:257-5-49; raw fruits and vegetables that are washed as specified under OAC 310:257-5-27; fruits and vegetables that are cooked for hot holding, as specified under OAC 310:257-5-48; All potentially hazardous food that is cooked to the temperature and time required for the specific food under OAC 310:257-5-46 - OAC 310:257-5-48 and cooled as specified in OAC 310:257-5-57; Plant food for which further washing, cooking, or other processing is not required for food safety, and from which rinds, peels, husks, or shells, if naturally present are removed; substances derived from plants such as spices, seasonings, and sugar; A bakery item such as bread, cakes, pies, fillings, or icing for which further cooking is not required for food safety; The following products that are produced in accordance with USDA guidelines and that have received a lethality treatment for pathogens: dry, fermented sausages, such as dry salami or pepperoni; salt-cured meat and poultry products, such as prosciutto ham, country cured ham, and Parma ham; and dried meat and poultry products, such as jerky or beef sticks; and foods manufactured according to 21 CFR Part 113, Thermally Processed Low-Acid Foods Packaged in Hermetically Sealed Containers.

"Reduced oxygen packaging" means the reduction of the amount of oxygen in a package by removing oxygen; displacing oxygen and replacing it with another gas or combination of gases; or otherwise controlling the oxygen content to a level below that normally found in the surrounding, 21% oxygen atmosphere, and a process that involves a food for which *Clostridium botulinum* is identified as a microbiological hazard in the final packaged form. Reduced oxygen packaging includes vacuum packaging, in which air is removed from a package of food and the package is hermetically sealed so that a vacuum remains inside the package, such as sous vide; modified atmosphere packaging, in which the atmosphere of a package of food is modified so that its composition is different from air but the atmosphere may change over time due to the permeability of the packaging material or the respiration of the food. Modified atmosphere packaging includes: reduction in the proportion of oxygen, total replacement of oxygen, or

an increase in the proportion of other gases such as carbon dioxide or nitrogen; and controlled atmosphere packaging, in which the atmosphere of a package of food is modified so that until the package is opened, its composition is different from air, and continuous control of that atmosphere is maintained, such as by using oxygen scavengers or a combination of total replacement of oxygen, nonrespiring food, and impermeable packaging material.

"Refuse" means solid waste not carried by water through the sewage system.

"Regulatory authority" means the local, state, or federal enforcement body or authorized representative having jurisdiction over the food service establishment.

"Restrict" means to limit the activities of a food employee so that there is no risk of transmitting a disease that is transmissible through food and the food employee does not work with exposed food, clean equipment, utensils, linens; and unwrapped single-service or single-use articles.

"Restricted egg" means any check, dirty egg, incubator reject, inedible, leaker, or loss as defined in 9 CFR 590.

"Restricted use pesticide" means a pesticide product that contains the active ingredients specified in 40 CFR 152.175. Pesticides classified for restricted use, and that is limited to use by or under the direct supervision of a certified applicator.

"Risk" means the likelihood that an adverse health effect will occur within a population as a result of a hazard in a food.

"Safe material" means an article manufactured from or composed of materials that may not reasonably be expected to result, directly or indirectly, in their becoming a component or otherwise affecting the characteristics of any food; an additive that is used as specified in § 409 or 706 of the Federal Food, Drug, and Cosmetic Act; or other materials that are not additives and that are used in conformity with applicable regulations of the Food and Drug Administration.

"Sanitization" means the application of cumulative heat or chemicals on cleaned food-contact surfaces that, when evaluated for efficacy, is sufficient to yield a reduction of 5 logs, which is equal to a 99.999% reduction, of representative disease microorganisms of public health importance.

"Sealed" means free of cracks or other openings that allow the entry or passage of moisture.

"Seasonal food service establishment" means a facility that is open no more than 180 consecutive days per physical address per year. The seasonal food service establishment is limited to serving coffee, snow cones, raw fruits, raw vegetables, nuts in the shell, and commercially bottled syrup, sorghum, honey, sweet cider, and other non-potentially hazardous foods.

"Seasonal fruit stand" means an establishment that is open no more than 180 consecutive days per physical address per year and is limited to whole, raw fruits and vegetables and unprocessed nuts in the shell.

"Service animal" means an animal such as a guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability.

"Servicing area" means an operating base location to which

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a mobile food service establishment or transportation vehicle returns regularly for such things as vehicle and equipment cleaning, discharging liquid or solid wastes, refilling water tanks and ice bins, and boarding food.

"Sewage" means liquid waste containing animal or vegetable matter in suspension or solution and may include liquids containing chemicals in solution.

"Shellfish control authority" means a state, federal, foreign, tribal, or other government entity legally responsible for administering a program that includes certification of molluscan shellfish harvesters and dealers for interstate commerce.

"Shellstock" means raw, in-shell molluscan shellfish.

"Shiga toxin-producing Escherichia coli" means any *E. coli* capable of producing Shiga toxins (also called verocytotoxins or "Shiga-like" toxins). This includes, but is not limited to, *E. coli* reported as serotype O157:H7, O157:NM, and O157:H-.

"Shucked shellfish" means molluscan shellfish that have one or both shells removed.

"Single-service articles" means tableware, carry-out utensils, and other items such as bags, containers, placemats, stirrers, straws, toothpicks, and wrappers that are designed and constructed for one time, one person use after which they are intended for discard.

"Single-use articles" means utensils and bulk food containers designed and constructed to be used once and discarded. Single-use articles includes items such as wax paper, butcher paper, plastic wrap, formed aluminum food containers, jars, plastic tubs or buckets, bread wrappers, pickle barrels, ketchup bottles, and number 10 cans which do not meet the materials, durability, strength, and cleanability specifications under OAC 310:257-7-1, OAC 310:257-7-13 and OAC 310:257-7-15 for multiuse utensils.

"Slacking" means the process of moderating the temperature of a food such as allowing a food to gradually increase from a temperature of -23°C (-10°F) to -4°C (25°F) in preparation for deep-fat frying or to facilitate even heat penetration during the cooking of previously block-frozen food such as spinach.

"Smooth" means a food-contact surface having a surface free of pits and inclusions with a cleanability equal to or exceeding that of (100 grit) number 3 stainless steel; A non-food-contact surface of equipment having a surface equal to that of commercial grade hot-rolled steel free of visible scale; and a floor, wall, or ceiling having an even or level surface with no roughness or projections that render it difficult to clean.

"Table-mounted equipment" means equipment that is not portable and is designed to be mounted off the floor on a table, counter, or shelf.

"Tableware" means eating, drinking, and serving utensils for table use such as flatware including forks, knives, and spoons; hollowware including bowls, cups, serving dishes, and tumblers; and plates.

"Temperature measuring device" means a thermometer, thermocouple, thermistor, or other device that indicates the temperature of food, air, or water.

"Temporary food service establishment" means a food service establishment where food is offered for sale or sold

at retail from a fixed, temporary facility in conjunction with a single event or celebration not to exceed the duration of the event or celebration.

"USDA" means the U.S. Department of Agriculture.

"Utensil" means a food-contact implement or container used in the storage, preparation, transportation, dispensing, sale, or service of food, such as kitchenware or tableware that is multiuse, single-service, or single-use; gloves used in contact with food; temperature sensing probes of food temperature measuring devices; and probe-type price or identification tags used in contact with food.

"Variance" means a written document issued by the regulatory authority that authorizes a modification or waiver of one or more requirements of this Chapter if, in the opinion of the regulatory authority, a health hazard or nuisance will not result from the modification or waiver.

"Vending machine" means a self-service device that, upon insertion of a coin, paper currency, token, card, or key, or by optional manual operation, dispenses unit servings of food in bulk or in packages without the necessity of replenishing the device between each vending operation.

"Vending machine location" means the room, enclosure, space, or area where one or more vending machines are installed and operated and includes the storage areas and areas on the premises that are used to service and maintain the vending machines.

"Warewashing" means the cleaning and sanitizing of utensils and food-contact surfaces of equipment.

"Whole-muscle, intact beef" means whole muscle beef that is not injected, mechanically tenderized, reconstructed, or scored and marinated, from which beef steaks may be cut.

310:257-1-4. Exemptions

The food service establishment definition does not include a food processing plant; a facility that sells only pre-packaged, non-potentially hazardous foods, which are incidental to the business, and does not have food in storage; a kitchen in a private home if only food that is not potentially hazardous is prepared for sale or service at a function such as a religious or charitable organization's bake sale; a kitchen in a private home, such as a bed-and-breakfast operation that prepares and offers food to guests if the number of available guest bedrooms does not exceed three (3) and breakfast is the only meal offered; a lodging facility that is serving food according to OAC 310:285-3-14; a private home that receives catered or home-delivered food; or individual farmers' market vendors that are in compliance with the definition of a farmers' market and hold a food processors license from the Oklahoma Department of Health and/or small egg dealers packer license, licensed by the Oklahoma Department of Agriculture, Food and Forestry.

SUBCHAPTER 3. MANAGEMENT AND PERSONNEL

310:257-3-3. Person in charge

The person in charge shall ensure that:

- (1) Food service establishment operations are not conducted in a private home or in a room used as living or sleeping quarters as specified under OAC 310:257-11-21;
- (2) Persons unnecessary to the food service establishment operation are not allowed in the food preparation, food storage, or warewashing areas, except that brief visits and tours may be authorized by the person in charge if steps are taken to ensure that exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles are protected from contamination;
- (3) Employees and other persons such as delivery and maintenance persons and pesticide applicators entering the food preparation, food storage, and warewashing areas comply with this Chapter;
- (4) Employees are effectively cleaning their hands, by routinely monitoring the employees' handwashing;
- (5) Employees are visibly observing foods as they are received to determine that they are from approved sources, delivered at the required temperatures, protected from contamination, unadulterated, and accurately presented, by routinely monitoring the employees' observations and periodically evaluating foods upon their receipt;
- (6) Employees are properly cooking potentially hazardous food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats, through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated as specified under OAC 310:257-7-23 and OAC 310:257-7-78(b);
- (7) Employees are using proper methods to rapidly cool potentially hazardous foods that are not held hot or are not for consumption within 4 hours, through daily oversight of the employees' routine monitoring of food temperatures during cooling;
- (8) Consumers who order raw or partially cooked ready-to-eat foods of animal origin are informed as specified under OAC ~~310:257-5-41~~ 310:257-5-69 that the food is not cooked sufficiently to ensure its safety;
- (9) Employees are properly sanitizing cleaned multiuse equipment and utensils before they are reused, through routine monitoring of solution temperature and exposure time for hot water sanitizing, and chemical concentration, pH, temperature, and exposure time for chemical sanitizing;
- (10) Consumers are notified that clean tableware is to be used when they return to self-service areas such as salad bars and buffets as specified under OAC 310:257-5-35;
- (11) Except when otherwise approved as specified in 310:257-5-21(b), employees are preventing cross-contamination of ready-to-eat food with bare hands by properly using suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment; and
- (12) Employees are properly trained in food safety as it relates to their assigned duties.

SUBCHAPTER 5. FOOD

310:257-5-10. Additives

Food may not contain unapproved food additives or additives that exceed amounts specified in 21 CFR 170-180 relating to food additives, generally recognized as safe or prior sanctioned substances that exceed amounts specified in 21 CFR 181-186, substances that exceed amounts specified in 9 CFR Subpart C Section 424.21(b) food ingredients and sources of radiation, or pesticide residues that exceed provisions specified in 40 CFR 185 Tolerances for Pesticides in Food.

310:257-5-50. Records, creation and retention

- (a) Except as specified in OAC 310:257-5-49(b) and ~~(e)~~ (b) of this Section, if raw, raw-marinated, partially cooked, or marinated-partially cooked fish are served or sold in ready-to-eat form, the person in charge shall record the freezing temperature and time to which the fish are subjected and shall retain the records of the food service establishment for 90 calendar days beyond the time of service or sale of the fish.
- (b) If the fish are frozen by a supplier, a written agreement or statement from the supplier stipulating that the fish supplied are frozen to a temperature and for a time specified under OAC 310:257-5-49 may substitute for the records specified under (a) of this Section.

310:257-5-59. Potentially hazardous food, hot and cold holding

- (a) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under OAC 310:257-5-62 and except as specified in (b) of this Section, potentially hazardous food shall be maintained:
 - (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified under OAC 310:257-5-46(b) or reheated as specified in OAC 310:257-5-52(e) may be held at a temperature of 54°C (130°F); or
 - (2) At a temperature ~~and time~~ of 5°C (41°F) or less for a maximum of 7 days; or
- (b) Shell eggs that have not been treated to destroy all viable Salmonellae shall be stored in refrigerated equipment that maintains an ambient air temperature of 5°C (41°F) or less.

310:257-5-60. Ready-to-eat, potentially hazardous food, date marking

- (a) Except as specified in (d) of this Section, refrigerated, ready-to-eat, potentially hazardous food prepared and held in a food service establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature of 5°C (41°F) ~~for a maximum of 7 days and time combinations specified in 310:257-5-59(a)(2).~~ The day of preparation shall be counted as Day 1.
- (b) Except as specified in (d) and (e) of this Section, refrigerated, ready-to-eat, potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked,

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at the time the original container is opened in a food service establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature of 5°C (41°F) for a maximum of 7 days; and

- (1) The day the original container is opened in the food service establishment shall be counted as Day 1; and
 - (2) The day or date marked by the food service establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.
- (c) A refrigerated, ready-to-eat potentially hazardous food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine, may be marked as specified in (a) or (b) of this Section, or by an alternative method acceptable to the regulatory authority.
- (d) OAC 310:257-5-60(a) and (b) of this Section do not apply to individual meal portions served or repackaged for sale from a bulk container upon a consumer's request.
- (e) OAC 310:257-5-60 (b) of this Section does not apply to the following when the face has been cut, but the remaining portion is whole and intact:
- (1) Fermented sausages produced in a federally inspected food processing plant that are not labeled "Keep Refrigerated" and which retain the original casing on the product;
 - (2) Shelf stable, dry, fermented sausages; and
 - (3) Shelf stable salt-cured products such as prosciutto and Parma (ham) produced in a federally inspected food processing plant that are not labeled "Keep Refrigerated".
- (f) A refrigerated, ready-to-eat, potentially hazardous food ingredient or a portion of a refrigerated, ready-to-eat, potentially hazardous food that is subsequently combined with additional ingredients or portions of food shall retain the date marking of the earliest-prepared or first-prepared ingredient.

310:257-5-61. Ready-to-eat, potentially hazardous food, disposition

- (a) A food specified in OAC 310:257-5-60(a) or (b) shall be discarded if it:
- (1) Exceeds 5°C (41°F) ~~for more than 7 days either of the temperature and time combinations specified in 310:257-5-60 (a),~~ except time that the product is frozen;
 - (2) Is in a container or package that does not bear a date or day; or
 - (3) Is appropriately marked with a date or day that exceeds 5°C (41°F) ~~for more than 7 days a temperature and time combination as specified in 310:257-5-60(a).~~
- (b) Refrigerated, ready-to-eat, potentially hazardous food prepared in a food service establishment and dispensed through a vending machine with an automatic shutoff control shall be discarded if it exceeds 5°C (41°F) ~~for more than 7 days~~ 310:257-5-60(a).

310:257-5-69. Consumption of animal foods that are raw, undercooked, or not otherwise processed to eliminate pathogens

- (a) Except as specified in OAC 310:257-5-46(c) and OAC 310:257-5-46(d)(3) and under OAC 310:257-5-71 ~~(3)~~ (4), if an animal food such as beef, eggs, fish, lamb, milk, pork, poultry, or shellfish is served or sold raw, undercooked, or without otherwise being processed to eliminate pathogens, either in ready-to-eat form or as an ingredient in another ready-to-eat food, the ~~permit-license~~ holder shall inform consumers of the significantly increased risk of consuming such foods by way of disclosure and reminder, as specified in paragraphs (b) and (c) of this Section, using brochures, deli case or menu advisories, label statements, table tents, placards, or other effective written means.
- (b) Disclosure shall include:
- (1) A description of the animal-derived foods, such as "oysters on the half shell (raw oysters), raw-egg Caesar salad," and "hamburgers" (can be cooked to order); or
 - (2) Identification of the animal-derived foods by asterisking them to a footnote that states that the items are served raw or undercooked, or contain (or may contain) raw or undercooked ingredients.
- (c) Reminder shall include asterisking the animal-derived foods requiring disclosure to a footnote that states:
- (1) "Regarding the safety of these items, written information is available upon request;"
 - (2) "Consuming raw or undercooked meats, poultry, seafood, shellfish, or eggs may increase your risk of foodborne illness;" or
 - (3) "Consuming raw or undercooked meats, poultry, seafood, shellfish, or eggs may increase your risk of foodborne illness, especially if you have certain medical conditions."

310:257-5-71. Pasteurized foods, prohibited reservice, and prohibited food

In a food service establishment that serves a highly susceptible population:

- (1) The following criteria apply to juice:
 - (A) For the purposes of this paragraph only, children who are age 9 or less and receive food in a school, day care setting or similar facility that provides custodial care are included as highly susceptible populations;
 - (B) Prepackaged juice or a prepackaged beverage containing juice, that bears a warning label as specified in 21 CFR, Section 101.17(g) Food Labeling, or packaged juice or beverage containing juice, that bears a warning label as specified under OAC 310:257-5-53 (2) may not be served or offered for sale; and
 - (C) Unpackaged juice that is prepared on the premises for service or sale in a ready-to-eat form shall be processed under a HACCP plan that contains the information specified in OAC 310:257-15-9(2)-(5) and as specified under 21 CFR PART 120 - Hazard Analysis and Critical Control

Point (HACCP) systems, Subpart B Pathogen Reduction, Sec. 120.24 Process controls.

- (2) Pasteurized shell eggs or pasteurized liquid, frozen, or dry eggs or egg products shall be substituted for raw shell eggs in the preparation of:
 - (A) Foods such as Caesar salad, hollandaise or Béarnaise sauce, mayonnaise, eggnog, ice cream, and egg-fortified beverages, and
 - (B) Except as specified in (6) of this Section, recipes in which more than one egg is broken and the eggs are combined;
- (3) Food in an unopened original package or that has been delivered to a patient or residence room may not be re-served; and
- (4) The following foods may not be served or offered for sale in a ready-to-eat form:
 - (A) Raw animal foods such as raw fish, raw-marinated fish, raw molluscan shellfish, and steak tartare,
 - (B) A partially cooked animal food such as lightly cooked fish, rare meat, soft-cooked eggs that are made from raw shell eggs, and meringue, and
 - (C) Raw seed sprouts.
- (5) Food employees may not contact ready-to-eat foods as specified under OAC 310:257-5-21(b).
- (6) OAC 310:257-5-71(2)(B) of this Section does not apply if:
 - (A) The raw eggs are combined immediately before cooking for one consumer's serving at a single meal, cooked as specified under OAC 310:257-5-46(a)(1), and served immediately, such as an omelet, soufflé, or scrambled eggs;
 - (B) The raw eggs are combined as an ingredient immediately before baking and the eggs are thoroughly cooked to a ready-to-eat form, such as a cake, muffin, or bread; or
 - (C) The preparation of the food is conducted under a HACCP plan that:
 - (i) Identifies the food to be prepared,
 - (ii) Prohibits contacting ready-to-eat food with bare hands,
 - (iii) Includes specifications and practices that ensure:
 - (I) Salmonella Enteritidis growth is controlled before and after cooking, and
 - (II) Salmonella Enteritidis is destroyed by cooking the eggs according to the temperature and time specified in OAC 310:257-5-46(a)(2),
 - (iv) Contains the information specified under OAC 310:257-15-9(4) including procedures that:
 - (I) Control cross contamination of ready-to-eat food with raw eggs, and
 - (II) Delineate cleaning and sanitization procedures for food-contact surfaces, and
 - (v) Describes the training program that ensures that the food employee responsible for the preparation of the food understands the procedures to be used.

SUBCHAPTER 7. EQUIPMENT, UTENSILS AND LINENS

310:257-7-3. Lead in ceramic, china, and crystal utensils, use limitation

Ceramic, china, crystal utensils, and decorative utensils such as hand painted ceramic or china that are used in contact with food shall be lead-free or contain levels of lead not exceeding the limits of the following utensil categories:

- (1) Hot beverage mugs ~~or~~ or coffee mugs shall not exceed .5 milligrams of lead per liter;
- (2) Large hollowware mugs or bowls equal to or larger than 1.1 liters (1.16 quarts) shall not exceed 1 milligram per liter;
- (3) Small hollowware or bowls equal to or smaller than 1.1 liters (1.16 quarts) shall not exceed 2 milligrams per liter; and
- (4) Flat utensils or plates and saucers shall not exceed 3 milligrams per liter.

310:257-7-37. Temperature measuring devices

- (a) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.
- (b) Except as specified in (c) of this Section, cold or hot holding equipment used for potentially hazardous food shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.
- (c) ~~OAC 310:257-7-37 Paragraph~~ (b) of this Section does not apply to equipment for which the placement of a temperature measuring device is not a practical means for measuring the ambient air surrounding the food because of the design, type, and use of the equipment, such as calorimeter units, heat lamps, cold plates, bainmaries, steam tables, insulated food transport containers, and salad bars.
- (d) Temperature measuring devices shall be designed to be easily readable.
- (e) Food temperature measuring device and water temperature measuring device on warewashing machines shall have a numerical scale, printed record, or digital readout in increments no greater than 1°C or 2°F in the intended range of use.

310:257-7-43. Warewashing machines, flow pressure device

- (a) Warewashing machines that provide a fresh hot water sanitizing rinse shall be equipped with a pressure gauge or similar device such as a transducer that measures and displays the water pressure in the supply line immediately before entering the warewashing machine; and
- (b) If the flow pressure measuring device is upstream of the fresh hot water sanitizing rinse control valve, the device shall be mounted in a 6.4 millimeter or one-fourth inch Iron Pipe Size (IPS) valve.

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(c) ~~OAC 310:257-7-43~~ Paragraphs(a) and (b) of this Section do not apply to a machine that uses only a pumped or recirculated sanitizing rinse.

310:257-7-53. Ventilation hood systems, adequacy

Ventilation hood systems and devices shall be sufficient in number and capacity to prevent grease or condensation from collecting on walls and ceilings and to prevent the collection of smoke and noxious odors in the food service establishment. Ventilation hoods meeting the requirements listed ~~in the code of mechanical regulations as adopted by the Oklahoma State Board of Health~~ in OAC 158:50, Mechanical Industry Regulations shall be installed above commercial heat-processing equipment that causes grease vapors and smoke. This equipment includes but is not limited to deep fat fryers, broilers, griddles, and fry grills. The provisions of this Section shall not require the removal, alteration or abandonment of, nor prevent the continued utilization and maintenance of, an existing mechanical system lawfully in existence at the time of adoption of these regulations.

310:257-7-75. Manual and mechanical warewashing equipment, chemical sanitization - temperature, pH, concentration, and hardness

A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at exposure times specified under OAC 310:257-7-95(3) shall be listed in 21 CFR 178.1010 sanitizing solutions, shall be used in accordance with the EPA-approved manufacturer's label use instructions, and shall be used as follows:

- (1) A chlorine solution shall have a minimum temperature based on the concentration and pH of the solution as follows:
 - (A) If the pH is 10 or less, the temperature and concentration shall be:
 - (i) Forty-nine (49) degrees Celsius (120 degrees Fahrenheit) or greater with a concentration of twenty-five (25) milligrams per liter or higher;
 - (ii) Thirty-eight (38) degrees Celsius (100 degrees Fahrenheit) or greater with a concentration of fifty (50) milligrams per liter or higher;
 - (iii) Thirteen (13) degrees Celsius (55 degrees Fahrenheit) or greater with a concentration of one hundred (100) milligrams per liter or higher;
 - (B) If the pH is 8 or less, the temperature and concentration shall be:
 - (i) Forty-nine (49) degrees Celsius (120 degrees Fahrenheit) or greater with a concentration of twenty-five (25) milligrams per liter or higher;
 - (ii) Twenty-four (24) degrees Celsius (75 degrees Fahrenheit) or greater with a concentration of fifty (50) milligrams per liter or higher;
 - (iii) Thirteen (13) degrees Celsius (55 degrees Fahrenheit) or greater with a concentration of one hundred (100) milligrams per liter or higher.
- (2) An iodine solution shall have a:

- (A) Minimum temperature of 24°C (75°F),
 - (B) pH of 5.0 or less or a pH no higher than the level for which the manufacturer specifies the solution is effective, and
 - (C) Concentration between 12.5 mg/L and 25 mg/L;
- (3) A quaternary ammonium compound solution shall:
 - (A) Have a minimum temperature of 24°C (75°F),
 - (B) Have a concentration as specified under ~~OAC 310:257-7-26~~ OAC 310-257-13-7 and as indicated by the manufacturer's use directions included in the labeling, and
 - (C) Be used only in water with 500 mg/L hardness or less or in water having a hardness no greater than specified by the manufacturer's label;
 - (4) If another solution of a chemical specified under (1) through (5) of this Section is used, the license holder shall demonstrate to the regulatory authority that the solution achieves sanitization and the use of the solution shall be approved; or
 - (5) If a chemical sanitizer other than chlorine, iodine, or a quaternary ammonium compound is used, it shall be applied in accordance with the manufacturer's use directions included in the labeling.

310:257-7-83. Equipment food-contact surfaces and utensils

- (a) Equipment food-contact surfaces and utensils shall be cleaned and sanitized:
 - (1) Except as specified in (b) of this Section, before each use with a different type of raw animal food such as beef, fish, lamb, pork, or poultry;
 - (2) Each time there is a change from working with raw foods to working with ready-to-eat foods;
 - (3) Between uses with raw fruits and vegetables and with potentially hazardous food;
 - (4) Before using or storing a food temperature measuring device; and
 - (5) At any time during the operation when contamination may have occurred.
- (b) OAC 310:257-7-83(a)(1) of this Section does not apply if the food-contact surface or utensil is in contact with a succession of different raw animal foods each requiring a higher cooking temperature as specified under OAC 310:257-5-46 than the previous food, such as preparing raw fish followed by cutting raw poultry on the same cutting board.
- (c) Except as specified in (d) of this Section, if used with potentially hazardous food, equipment food-contact surfaces and utensils shall be cleaned throughout the day at least every 4 hours.
- (d) Surfaces of utensils and equipment contacting potentially hazardous food may be cleaned less frequently than every 4 hours if:
 - (1) In storage, containers of potentially hazardous food and their contents are maintained at temperatures specified under Subchapter 5 and the containers are cleaned when they are empty;

(2) Utensils and equipment are used to prepare food in a refrigerated room or area that is maintained at one of the temperatures as specified in (A) of this Section.

(A) The utensils, ~~and equipment, and are cleaned at the frequency in the following chart that corresponds to the temperature:~~ food under preparation at temperatures of greater than 10°C to 12.8°C (50° to 55°F) shall be cleaned at least every 10 hours. Preparation temperatures of between 7.2°C and 10°C (45° to 50°F) shall be cleaned at least every 16 hours. Preparation temperatures of between 5° and 7.2°C (41° to 45°F) shall be cleaned at least every 20 hours. Preparation temperatures of less than 5°C (41°F) shall be cleaned at least every 24 hours; and

(B) The cleaning frequency based on the ambient temperature of the refrigerated room or area is documented in the food service establishment.

(3) Containers in serving situations such as salad bars, delis, and cafeteria lines hold ready-to-eat potentially hazardous food that is maintained at the temperatures specified under Subchapter 5, are intermittently combined with additional supplies of the same food that is at the required temperature, and the containers are cleaned at least every 24 hours;

(4) Temperature measuring devices are maintained in contact with food, such as when left in a container of deli food or in a roast, held at temperatures specified under Subchapter 5;

(5) Equipment is used for storage of packaged or un-packaged food such as a reach-in refrigerator and the equipment is cleaned at a frequency necessary to preclude accumulation of soil residues;

(6) The cleaning schedule is approved based on consideration of:

- (A) Characteristics of the equipment and its use,
- (B) The type of food involved,
- (C) The amount of food residue accumulation, and
- (D) The temperature at which the food is maintained during the operation and the potential for the rapid and progressive multiplication of pathogenic or toxigenic microorganisms that are capable of causing foodborne disease; or

(7) In-use utensils are intermittently stored in a container of water in which the water is maintained at 57°C (135°F) or more and the utensils and container are cleaned at least every 24 hours or at a frequency necessary to preclude accumulation of soil residues.

(e) Except when dry cleaning methods are used as specified under OAC 310:257-7-86, surfaces of utensils and equipment contacting food that is not potentially hazardous shall be cleaned:

- (1) At any time when contamination may have occurred;
- (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles;

(3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and

(4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment:

- (A) At a frequency specified by the manufacturer, or
- (B) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.

310:257-7-92. Returnables, cleaning for refilling

(a) Except as specified in (b) and (c) of this Section, returned empty containers intended for cleaning and refilling with food shall be cleaned and refilled in a regulated food processing plant.

(b) A food-specific container for beverages may be refilled at a food service establishment if:

- (1) Only a beverage that is not a potentially hazardous food is used as specified under OAC 310:5-36(a);
- (2) The design of the container and of the rinsing equipment and the nature of the beverage, when considered together, allow effective cleaning at home or in the food service establishment;
- (3) Facilities for rinsing before refilling returned containers with fresh, hot water that is under pressure and not recirculated are provided as part of the dispensing system;
- (4) The consumer-owned container returned to the food service establishment for refilling is refilled for sale or service only to the same consumer; and
- (5) The container is refilled by:
 - (A) An employee of the food service establishment, or
 - (B) The owner of the container if the beverage system includes a contamination-free transfer process that can not be bypassed by the container owner.

(~~c~~) Consumer-owned containers that are not food-specific may be filled at a water vending machine or system.

SUBCHAPTER 9. WATER, PLUMBING AND WASTE

310:257-9-18. Numbers and capacities, handwashing facilities

(a) Except as specified in (b) and (c) of this Section, at least 1 handwashing lavatory, a number of handwashing lavatories necessary for their convenient use by employees in areas specified under OAC 310:257-9-23, and not fewer than the number of handwashing lavatories required by law shall be provided. Handwashing sinks required in any establishment shall be a minimum size of eighty (80) square inches ~~with no side less than eight (8) inches in length~~ if it is a square or rectangular design or not less than a diameter of ten (10) inches if circular

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in design. The sink compartments shall be a minimum of four (4) inches in depth. Temporary establishments can meet the handwashing lavatory requirement by containing hot water in a not less than 5 gallon container equipped with a hands free operation spigot.

(b) If approved and capable of removing the types of soils encountered in the food operations involved, automatic handwashing facilities may be substituted for handwashing lavatories in a food service establishment that has at least one handwashing lavatory.

(c) If approved, when food exposure is limited to prepackaged products where no food preparation takes place and handwashing lavatories are not conveniently available, such as in some mobile or temporary food service establishments or at some vending machine locations, employees may use chemically treated towelettes for handwashing.

310:257-9-32. Enclosed system, sloped to drain

A mobile water tank shall be:

- (1) Enclosed from the filling inlet to the discharge outlet; and
- (2) Sloped to an outlet that allows complete drainage of the tank; and
- (3) ~~Be~~ At least the capacity as specified in OAC 310:257-9-8.

310:257-9-69. Maintaining refuse areas and enclosures

A storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items, as specified under ~~OAC 310:257-9-28~~ OAC 310:257-11-53, and clean.

SUBCHAPTER 11. PHYSICAL FACILITIES

310:257-11-2. Outdoor areas, surface characteristics

(a) The outdoor walking and driving areas shall be surfaced with concrete, asphalt, or gravel or other materials that have been effectively treated to minimize dust, facilitate maintenance, and prevent muddy conditions.

(b) Exterior surfaces of buildings and mobile ~~where~~ food service establishments shall be of weather-resistant materials and shall comply with law.

(c) Outdoor storage areas for refuse, recyclables, or returnables shall be of materials specified under OAC 310:257-9-55 and OAC 310:257-9-56.

310:257-11-5. Floor and wall junctures, coved, and enclosed or sealed

(a) In food service establishments in which cleaning methods other than water flushing are used for cleaning floors, the floor and wall junctures shall be coved and closed to no larger than 1mm (one thirty-second inch).

(b) The floors in food ~~Food~~ food service establishments in which water flush cleaning methods are used shall be provided with

drains and be graded to drain, and the floor and wall junctures shall be ~~coved~~ coved and sealed.

310:257-11-28. Disposable towels, waste receptacle

A handwashing lavatory or group of adjacent lavatories that is provided with disposable towels shall be provided with a waste receptacle as specified under OAC 310:257-9-60(c).

SUBCHAPTER 15. COMPLIANCE AND ENFORCEMENT

310:257-15-4. Documentation of proposed variance and justification

(a) Variance requests are subject to ~~inspection~~ review by the Department. During this process, the inspector must confirm the following in writing:

- (1) The nature and extent of the nonconforming use;
- (2) That the equipment or portion of the facility in question is in an operable and sanitary condition, and can be maintained in satisfactory condition during the term of the variance;
- (3) That no public health threats or food-related illness will result if the variance is granted.

(b) If a HACCP plan is required, as specified in OAC 257-15-8, the license holder must supply the inspector with the information specified in OAC 310:257-15-9 as it is relevant to the variance requested. The relevant information must be provided prior to approval of the variance.

310:257-15-8. When a HACCP plan is required

(a) Before engaging in an activity that requires a HACCP plan, a license applicant or license holder shall submit to the regulatory authority for approval a properly prepared HACCP plan as specified under OAC 310:257-15-9 and the relevant provisions of this Chapter if:

- (1) Submission of a HACCP plan is required according to law;
- (2) A variance is required as specified under OAC 310:257-5-63, ~~OAC 310:257-7-35(1)~~ OAC 310:257-7-35(b), or OAC 310:257-5-46 (d)(3); or
- (3) The regulatory authority determines that a food preparation or processing method requires a variance based on a plan submittal specified under OAC 310:257-15-7, an inspectional finding, or a variance request.

(b) A license applicant or license holder shall have a properly prepared HACCP plan as specified under OAC 310:257-5-64.

310:257-15-32. Ceasing operations and reporting

(a) Except as specified in (b) of this Section, a license holder shall immediately discontinue operations and notify the regulatory authority if an imminent health hazard exists because of an emergency such as a fire, flood, sewage backup, no hot water in the facility, insufficient refrigeration and/or hot food storage facilities available, substantial evidence or presence of

a large number of insects or evidence of rodents in food or on food preparation surfaces, interruption of safe potable water supply to the facility, misuse of poisonous or toxic materials, onset of an apparent foodborne illness outbreak, interruption of electrical service for more than 4 hours, severe structural damage in the facility, an employee working with a Salmonella, Shigella, E. coli 0157:H7 or Hepatitis A infection, gross unsanitary occurrence or condition, or other circumstance as determined by the Commissioner of Health, or his designee, that shall endanger public health.

(b) A license holder need not discontinue operations in an area of an establishment that is unaffected by the imminent health hazard.

[OAR Docket #09-798; filed 4-29-09]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 320. PUBLIC BATHING PLACES
PLACE OPERATIONS**

[OAR Docket #09-799]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 1. General Provisions
310:320-1-3 [NEW]
- Subchapter 5. Forms and Tables
310:320-5-5 [AMENDED]

AUTHORITY:

Oklahoma State Board of Health; 63 O.S. Sections 1-104 and, § 1-1014.

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SUPERSEDED EMERGENCY ACTIONS:

"n/a"

INCORPORATION BY REFERENCE:

"n/a"

ANALYSIS:

The current fee schedule for Public Bathing Place Construction Permits is set forth in Rule in and is being moved to the License Classifications and Associated Fees for Consumer Health Services. The rule change will clarify that an operator must possess a construction permit in order to operate a public bathing place open to the public, as set forth in the process to apply for a license. This proposal is necessary to establish all fees assessed by Consumer Protection Division within the Department to be in one location of Rule. This

change will help the Consumers of Oklahoma determine the cost of doing business in Oklahoma within in one area and prevent searching documents for fee schedules.

CONTACT PERSON:

Tressa Madden, Director, Consumer Protection Division, Oklahoma State Department of Health, 1000 Northeast 10th Street, Oklahoma City, OK 73117-1299,(405)271-5243,:tressam@health.ok.gov

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

310:320-1-3. Operational license

(a) No person shall operate a public bathing place without obtaining a license from the Commissioner of Health pursuant to 63 O.S.Supp. 2004, § 1-1013.1.

(b) A license to operate a public bathing place is not required for those public or semipublic baths where the main object is the external cleansing of the body, to bathing places maintained by an individual for the use of family and friends, or to bathing places owned or managed by a group or association of the owners of thirty or fewer homes, the use of which is limited to the homeowner group and their nonpaying guests.

(c) A public bathing place that must be licensed may be inspected by representatives of the Department at any reasonable time in order to determine if the public bathing place complies with applicable statutes and rules administered by the Department.

SUBCHAPTER 5. FORMS AND TABLES

310:320-5-5. Application for permit license

~~The four pages of the current water facilities permit application form follow this page. These may be copied and used as a formal application for permit. Note that Item C-6 need not be completed in applications for public bathing place permits, unless the facility is to be municipally owned. The third page of the application form does not apply to privately owned public bathing places. Also, note the detailed guidance provided in Regulations Section 310:320-5-6.~~

(a) The applicant shall file an application for a license to operate a public bathing place on the forms provided by the Department, as set forth in this Chapter as Appendix A and Appendix B, with the filing fee payable to the Oklahoma State Department of Health, prior to operating a public bathing place. The filing fee is established by rule in Chapter 310:250 of the Oklahoma Administrative Code, Fee Schedule For Consumer Health Services.

(b) The application for a license to operate a public bathing place must include a copy of the permit to construct the public

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bathing place for which the applicant seeks a license, or reference the construction permit in the application, in order to be eligible for a license to operate a public bathing place.

OKLAHOMA STATE DEPARTMENT OF HEALTH

APPLICATION FOR PERMIT TO CONSTRUCT
PUBLIC BATHING PLACE, WATER POLLUTION CONTROL AND
PUBLIC WATER SUPPLY FACILITIES AND/OR SUPPLY POTABLE WATER

AS APPROVED BY THE STATE BOARD OF HEALTH

This application is to be submitted to obtain a permit for construction of; Sanitary Sewer, Sewage Treatment Facility, Public Water Supply Facility or Waterworks, Public Bathing Place, and Additions, Modifications, or Extensions Thereof and/or to provide a potable water supply.

TO THE COMMISSIONER OF HEALTH Date _____

OKLAHOMA STATE DEPARTMENT OF HEALTH
1000 NORTHEAST 10th STREET
P.O. BOX 53551
OKLAHOMA CITY, OKLAHOMA 73152

ATTENTION: WATER FACILITIES ENGINEERING SERVICE

A. The applicant, _____
hereby makes application for a permit to provide a supply of potable water to

(NO FEE REQUIRED, EXECUTE APPLICANT SIGNATURE SECTION ONLY, DO NOT COMPLETE SECTIONS B thru E)

B. The applicant, _____
proposes the construction of the facilities checked on "Fee Schedule" to serve

located at _____
(finding location or legal description) and, as required by the Oklahoma State Health Code at 63 Oklahoma Statutes 1971, Sections 1-906, 1-907, 1-908 and 1-1017, hereby makes application for approval of the accompanying plans and specifications and for a permit to construct the facilities in accordance with the same plans and specifications.

C. In making this application the applicant certifies and states the following:

1. The applicant has been supplied with copies of all rules and standards promulgated by the Oklahoma State Board of Health for the construction and operation of the facility in question.
2. To the best of the knowledge and belief of the applicant, the plans, specifications, and engineering report comply with the requirements of the aforementioned rules and standards.
3. The applicant agrees to be responsible for the construction and operation of the facility in accordance with the aforementioned rules and standards, and in accordance with state law agrees that the Oklahoma State Department of Health shall have access to the facility at any time during and after construction for the purpose of inspection for compliance with the provisions of the State Health Code, 63 O.S. 1971, Sections 1-101 and following.
4. The applicant intends to own and operate the facility after construction is completed. () Yes () No If "No", provide information on responsibility for operation.

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February 7, 1985
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- 5. The applicant is holder of or will obtain a deed or easement to the land upon which construction is planned. () Yes () No If "No", explain.
- 6. The land upon which construction is planned is within the corporate limits of a municipality. () Yes () No If "Yes", application should be executed by authorized agent of the municipality. If "Yes" and applicant is other than municipality, PRIVATE APPLICANT WITHIN MUNICIPALITY section must be completed. (DOES NOT APPLY TO PRIVATELY OWNED PUBLIC BATHING PLACES.)
- 7. The entity receiving, transporting or treating the wastewater generated by the area served is the applicant. () Yes () No If "No" the RECEIPT, TRANSPORT OR TREATMENT section must be completed.
- 8. Upon transfer of ownership of the facility, the applicant agrees to immediately notify the Commissioner in writing at the above address.
- 9. The applicant agrees to supply the Department and its agents and employees with any information requested by them concerning the design, construction, and operation of the facility in accordance with the State Health Code.
- 10. All local zoning and other ordinances of public entities having jurisdiction concerning the construction of the proposed improvements have been satisfied. Yes () No (). If "No", explain.

D. Following is a list of the documents supplied for review:

E. Enclosed is a check or money order (no cash) in the amount of \$_____.00, which is the total of the checked items. (Make checks and money orders payable to the Oklahoma State Department of Health. Maximum fee - \$500 for individual or \$1000 for combination water and sewer)

APPLICANT SIGNATURE

Note: Application must be signed by the authorized chief elective or executive officer of the applicant, or by the applicant himself if a sole proprietorship. Information must be legible.

Signature Name of Organization (Print or Type)

Name of Authorized Signature (Print or Type) Street Address

Title City/State/Zip Code

Subscribed and sworn to before me this _____, day of _____, 19 ____.

Seal

Notary Public/Corp. Secretary/City Clerk

My Commission expires _____

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PRIVATE APPLICANT WITHIN MUNICIPALITY

Note: To be completed if proposed construction lies within the boundaries of a municipality or other responsible public entity and is to be owned, operated, and maintained by a private entity.

_____, hereby indicates awareness and approval of the proposed construction within its jurisdictional boundaries of the facilities addressed by this application. The concept, plans and specifications have been reviewed and are approved in accordance with this entity's rules, regulations, laws and ordinances.

Signature Name of Organization (Print or Type)

Name of Authorized Signature (Print or Type) Street Address

Title City/State/Zip Code

Subscribed and sworn to before me this _____, day of _____, 19 ____.

Seal

Notary Public/Corp. Secretary/City Clerk

My Commission expires _____

RECEIPT, TRANSPORT OR TREATMENT

Note: To be completed if proposed construction involves the receipt, transport or treatment of wastewater by an entity other than the applicant.

_____, hereby agrees to receive, transport and treat the wastewater generated from the area served by the proposed construction of this application. It is further stated that this entity's facilities have sufficient capacity to provide this service and are permitted under the rules and regulations of the State Health Department.

Signature Name of Organization (Print or Type)

Name of Authorized Signature (Print or Type) Street Address

Title City/State/Zip Code

Subscribed and sworn to before me this _____, day of _____, 19 ____.

Seal

Notary Public/Corp. Secretary/City Clerk

My Commission expires _____

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"FEE SCHEDULE"

Note: Place a check mark in the box(s) by each type of facility(s) proposed. One project may contain several items. Maximum fee for individual wastewater or water project is \$500. Maximum fee for wastewater and water combination project is \$1000.

WATER

New Treatment Facilities		
<input type="checkbox"/> Non-Community		\$250
<input type="checkbox"/> Community*		\$500
<input type="checkbox"/> Package Plant (design previously approved)		\$250
Modification to Existing Treatment		
<input type="checkbox"/> Chlorination or fluoridation		\$150
<input type="checkbox"/> Minor Renovation		\$300
<input type="checkbox"/> Major renovation		\$500
Supply Facilities		
<input type="checkbox"/> Wells (maximum \$500)		\$125 each
<input type="checkbox"/> Storage Tanks (maximum \$450)		\$150 each
<input type="checkbox"/> Raw water transmission lines		\$150
Distribution Facilities		
<input type="checkbox"/> Line extensions (rounded to the nearest 100 feet)		\$5/100 ft. (\$50 minimum)
<input type="checkbox"/> Booster station(s) (maximum \$500)		\$100 each

WASTEWATER

Treatment Facilities (New or Modifications)		
<input type="checkbox"/> Nine or less connections and/or 5000 gpd or less flow		\$250
<input type="checkbox"/> All others		\$500
Collection Facilities		
<input type="checkbox"/> Line extensions (rounded to the nearest 100 feet)		\$5/100 ft. (\$50 minimum)
<input type="checkbox"/> Lift Station(s) (rounded to nearest MGD peak capacity)		\$100/MGD (\$100 minimum)

PUBLIC BATHING PLACES

<input type="checkbox"/> New pools		\$500 each
<input type="checkbox"/> New spas		\$250 each
<input type="checkbox"/> Modification to existing facilities		\$150

*Any public water supply system which serves residents on at least 10 service connections, or regularly serves 25 residents at least 60 days out of the year.

"FEE SCHEDULE"
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AFFIDAVIT OF RESPONSIBILITY

THIS AFFIRMS THAT _____ will
NAME OF ORGANIZATION, PRINTED
be responsible for operating, maintaining, and controlling the use
of the bathing facility located at _____,
ENTITY SERVED, PRINTED
_____ in
STREET ADDRESS, PRINTED CITY OR TOWN
accordance with the Oklahoma Public Bathing Place Interpretive
Code.

Signature of Authorizing Official

Name of Authorizing Official, Printed

Title of Authorizing Official

Address

City and Zip Code

(NOTARY SEAL)

Subscribed and sworn to before me this _____ day of _____,
19____.

Notary Public/Corp. Sec./City Clerk

My Commission Expires: _____

[OAR Docket #09-799; filed 4-29-09]

**TITLE 310. OKLAHOMA STATE
DEPARTMENT OF HEALTH
CHAPTER 530. FAMILY PLANNING
CENTERS**

[OAR Docket #09-800]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

310:530-1-4 [AMENDED]

AUTHORITY:

Oklahoma State Board of Health; 62 O.S. 2001, Sections 41.16A.

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"n/a"

INCORPORATION BY REFERENCE:

"n/a"

ANALYSIS:

This proposal amends the existing rule. This action will clarify the process for inclusion of an inflationary adjustment in development of the schedule of fees.

CONTACT PERSON:

Suzanna Dooley, MS, ARNP Chief, Maternal and Child Health Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1299, telephone:(405) 271-4480; electronic mail: suzannad@health.ok.gov

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A) WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

310:530-1-4. Methods and Procedures

(a) **General.** Fees will be charged for services based upon client's ability to pay, and upon the potential for payments or contribution from the client's third party health insurance provider. Clients will not be denied family planning services, or be subjected to any variation in quality or delivery of family planning services, because of inability to pay. The Commissioner of Health must approve the schedule of fees for family planning services annually and prior to implementation. The calculation of the maximum recommended fee assessment will be completed before July 1 implementation each year.

(b) **Determining the base unit cost.**

(1) **Examination services component.** The base unit cost for the examination service component is derived by dividing the total dollar amount attributable to the medical cost center by the sum of the collective weighted values of each examination service. The collective weighted value of each examination service is derived by multiplying the relative value for the examination service by the frequency of encounters for that service during the attributable analysis period.

(2) **Laboratory service component.** The base unit cost for the laboratory service component is derived by dividing the total dollar amount attributable to the laboratory cost center by the sum of the collective weighted values of each laboratory service. The collective weighted value of each laboratory service is derived by multiplying the relative value for the laboratory service by the frequency of encounters for that service during the attributable analysis period.

(c) **Deriving the applicable ancillary unit cost.**

(1) **Allocated unit indirect costs.** Allocated unit indirect costs are those indirect unit costs attributable to the family planning program and are prorated and added as an ancillary cost to each examination service provided by family planning centers. The allocated unit indirect cost is derived by dividing the sum of all indirect costs approved by the Commissioner for allocation to family planning during the attributable analysis period by the relative proportion of the collective weighted value of a given examination service to the total collective weighted value of the examination service component.

(2) **Unit clinical supply costs.** Unit clinical supply costs are prorated and added as an ancillary cost to each examination service provided by family planning centers. The unit clinical supply cost is derived by dividing the sum of all non-laboratory supplies consumed by family planning during the attributable analysis period by the relative proportion of the collective weighted value of a given examination service to the total collective weighted value of the examination service component.

(3) **Unit laboratory supply costs.** Unit laboratory supply costs are prorated and added as an ancillary cost to each laboratory service provided by family planning centers. The unit laboratory supply cost is derived by dividing the sum of all laboratory supplies consumed by family planning during the attributable analysis period by the relative proportion of the collective weighted value of a given laboratory service to the total collective weighted value of the laboratory service component.

(d) **Deriving the inflationary adjustment modifier.** The inflationary adjustment modifier is derived by first consulting the annual percentage change in the Medical Care expenditure category reported for the South Region in the latest Consumer Price Index Detailed Report published by the United States Department of Labor prior to the time the maximum RFA is due to be calculated by the Department for the upcoming fiscal year. The annual percentage change reported is multiplied

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by the subtotal of the sum of ancillary unit costs and the product of the base unit cost and the weighted value attributed to the service.

(de) **Deriving the sliding fee scale adjustment.** The sliding fee scale adjustment is used to convert the maximum RFA into the adjusted RFA. The scale is divided into seven (7) increments that correspond to incremental levels of poverty ranging from 100% to 250% of poverty based upon the annual Federal Poverty Guidelines. The base increment of the sliding fee scale shall correspond to 100% of poverty and cause the maximum RFA to be reduced to zero. The next increment of the sliding fee scale shall correspond to approximately 118.75% of poverty and cause the assessment to be reduced to a sum that is 10% of the maximum RFA. The next increment of the sliding fee scale shall correspond to approximately 137.5% of poverty and cause the assessment to be reduced to a sum that is 20% of the maximum RFA. Successive increments of the sliding fee scale shall correspond to successive incremental increases of approximately 37.5 percentage points of poverty and cause incremental 20 percentage point increases of the percentage of the maximum RFA to be assessed to the client.

(ef) **Deriving the maximum recommended fee assessment for utilization of services (RFA).**

(1) **Examination services.** The maximum RFA for a given examination service is derived by multiplying the base unit cost determined for the examination service by the weighted value attributed to the service. This product is then added to the sum of the ancillary unit costs derived for the service. The subtotal derived is then added to the inflationary adjustment modifier to derive the maximum RFA. ~~The total~~ The maximum RFA is then applied to the sliding fee scale adjustment applicable to the client and adjusted as indicated. to derive the adjusted RFA for a given examination service.

(2) **Laboratory services.** The maximum RFA for a given laboratory service is derived by multiplying the base unit cost determined for the laboratory service by the weighted value attributed to the service. This product is then added to the sum of the ancillary unit costs derived for the service. The subtotal derived is then added to the inflationary adjustment modifier to derive the maximum RFA. ~~The total~~ The maximum RFA is then applied to the sliding fee scale adjustment applicable to the client and adjusted as indicated. to derive the adjusted RFA for a given laboratory service.

(3) **Delivered products.** The maximum RFA for a delivered product is the average unit cost incurred by the Department for the product during the most recently completed purchasing cycle. This amount is then applied to the sliding fee scale adjustment applicable to the client and adjusted as indicated.

(fg) **Waiver.** The family planning center may waive in whole or in part an adjusted RFA for any client who is unable, for good cause, to pay for the family planning service or product provided.

[OAR Docket #09-800; filed 4-29-09]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 641. EMERGENCY MEDICAL SERVICES

[OAR Docket #09-801]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Ambulance Services

Part 1. General Provisions

310:641-3-2 [AMENDED]

Part 7. Air Ambulances

310:641-3-31 [AMENDED]

310:641-3-32 [AMENDED]

310:641-3-33 [AMENDED]

310:641-3-34 [AMENDED]

310:641-3-35 [AMENDED]

310:641-3-36 [AMENDED]

310:641-3-37 [AMENDED]

310:641-3-38 [AMENDED]

310:641-3-39 [AMENDED]

Part 9. Specialty Care

310:641-3-43 [AMENDED]

310:641-3-47 [NEW]

Part 11. Medical Control

310:641-3-50 [AMENDED]

Part 19. Inspection, Correction, Actions

310:641-3-91 [AMENDED]

Subchapter 5. Personnel Licenses and Certification

Part 3. Emergency Medical Personnel Licenses

310:641-5-11 [AMENDED]

310:641-5-13 [AMENDED]

310:641-5-14 [AMENDED]

310:641-5-14.1 [NEW]

310:641-5-15 [AMENDED]

310:641-5-17 [AMENDED]

Part 5. ~~Instructor Qualifications~~ Procedures Authorized

310:641-5-30 [AMENDED]

Subchapter 7. Training Programs

Part 3. Training Programs

310:641-7-10 [AMENDED]

310:641-7-13 [AMENDED]

310:641-7-15 [AMENDED]

AUTHORITY:

Oklahoma State Board of Health; 63 O.S. Section 1-104; 63 O.S., Section 1-2501 et seq.

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SUPERSEDED EMERGENCY ACTIONS:

"n/a"

INCORPORATION BY REFERENCE:

"n/a"

ANALYSIS:

The proposed changes establish specific criteria that describe "specialty care" as used in the rule. They eliminate potential for conflict between Oklahoma's air ambulance standards and prevailing federal law. They ensure appropriate training and equipment for persons providing care during a specialty transport. They clarify the training and documentation required to serve as an EMS medical director. They define the requirements for a sufficient plan of correction including acceptable time frames for responses and corrections and the consequences for failure to respond in accordance with the new requirements. They allow EMTs and EMRs to re-certify and re-license using the process employed by the National Registry of EMTs. They also allow EMTs to submit and receive National Registry re-certification materials prior to Oklahoma re-licensure by extending the licensure period for three months. They establish a simplified re-licensure process for EMTs holding certification by the National Registry of EMTs and a separate re-licensure track for EMTs not holding such certification. They clarify the Department's discretion to allow an extension of the re-licensure period due to hardship. They establish a process to regain licensure for those persons who have allowed their licenses to lapse for failure to timely renew. They update the scope of practice for EMT-Basic and EMT-Intermediate by specifying additional medications and procedures that may be administered at these two licensure levels. They clarify the types of courses that may be taught in various levels of EMT training institutions. They delete language that is no longer used in the rules. They clarify the period and process for amending rosters for EMT training courses.

CONTACT PERSON:

R. Shawn Rogers, Director, Emergency Medical Service, Oklahoma State Department of Health, 1000 Northeast 10th Street, Oklahoma City, OK 73117-1299; telephone: (405) 271-4027; facsimile: (405) 271-4240 electronic mail: shawnr@health.ok.gov

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A) WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 3. AMBULANCE SERVICES

PART 1. GENERAL PROVISIONS

310:641-3-2. Definitions

The following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**ACLS**" means Advanced Cardiac Life Support.

"**Act**" means the "Oklahoma Emergency Response Systems Development Act".

"**Advanced Life Support (ALS) Emergency Medical Services Training Program**" means an organization approved by the Department to conduct the following ALS training: Emergency Medical Technician Intermediate, Emergency Medical Technician Intermediate Refresher, Emergency Medical Technician Paramedic, Emergency Medical Technician Paramedic Refresher, Continuing Education at the Emergency Medical Technician Intermediate and Paramedic levels, and such other courses of instruction that may be designated by the Department.

"**AMLS**" means Advanced Medical Life Support.

"**ATLS**" means Advanced Trauma Life Support.

"**Base Station**" means the primary location from which ambulances and crews respond to emergency calls on twenty-four (24) hour basis. The Base Station may include the principal business office, living quarters for personnel, training institution, and/or communications center.

"**Basic Life Support (BLS) Emergency Medical Services Training Program**" means an organization approved by the Department to conduct the following BLS training: First Responder, First Responder Refresher, Emergency Medical Technician Basic, Emergency Medical Technician Basic Refresher, Continuing Education at the Emergency Medical Technician Basic level, and such other courses of instruction that may be designated by the Department.

"**BLS**" means Basic Life Support, and includes cardiopulmonary resuscitation (CPR) and utilization of Semi-Automated advisory defibrillator (SAAD).

"**BTLS**" means Basic Trauma Life Support.

"**Board**" means the State Board of Health.

"**Certificate**" means any certification or certificate issued by the Department, pursuant to the Act, or this Chapter.

"**Clinical Coordinator**" means the individual designated in writing by a training program as responsible for coordination and supervision of clinical experiences.

"**Clinical Experience**" means all supervised learning experiences required and included as part of a training course in which the student provides or observes direct patient care. This includes vehicular experiences with a licensed ambulance service.

"**Council**" means the Oklahoma Emergency Response Systems Development Advisory Council.

"**Department**" means the State Department of Health.

"**Distance Learning**" is instruction of didactic portions of curriculum which requires participation of the instructor and students but does not require the students to be physically present in the same location as the instructor.

"**Distributive Education**" means educational activity in which the learner, the instructor, and the educational materials are not all present in the same place at the same time, e.g., continuing education activities that are offered on the Internet, via CD ROM or video, or through journal articles or audio tapes.

"**DOT**" means the United States Department of Transportation.

"**Division**" means the Emergency Medical Services Division.

"**Emergency medical personnel**" means all certified and licensed personnel which provide emergency medical care for an ambulance service.

"**Emergency medical responder**" means a person who has successfully completed a state-approved course using the national standard emergency medical responder curriculum and passed a competency-based examination from a state approved testing agency such as the National Registry of EMT's.

"**EMS**" means Emergency Medical Services.

"**Emergency medical technician**" EMT means an individual licensed by the Department as Basic, Intermediate, or Paramedic.

"**EMT-B**" means Emergency Medical Technician-Basic as licensed pursuant to the Act, or this Chapter.

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"**EMT-I**" means Emergency Medical Technician-Intermediate as licensed pursuant to the Act, or this Chapter.

"**EMT-P**" means Emergency Medical Technician-Paramedic as licensed pursuant to the Act, or this Chapter.

"**Emergency Medical Dispatcher (EMD)**" means a person trained using a Department-approved curriculum for the management of calls for emergency medical care.

"**Emergency transfer**" means the movement of an acutely ill or injured patient from the scene to a health care (pre-hospital), or the movement of an acutely ill or injured patient from one health care facility to another health care facility (inter-facility).

"**En Route Time**" means the elapsed time from the time the emergency call is received by the EMS agency until the ambulance and complete crew is en route to the scene of the emergency.

"**License**" means any license issued by the Department, pursuant to the Act, or this Chapter.

"**NHTSA**" means National Highway Traffic Safety Administration.

"**National Registry**" means the National Registry of Emergency Medical Technicians, Columbus Ohio.

"**Non-emergency transfer**" means the movement of any patient in an ambulance other than an emergency transfer.

"**PALS**" means Pediatric Advanced Life Support.

"**PEPP**" means Pediatric Education for the Prehospital Professional.

"**PHTLS**" means Prehospital Trauma Life Support.

"**PIC**" means Pilot in Command

"**PPC**" means Prehospital Pediatric Care.

"**Post**" means a location where an ambulance may be positioned for an unspecified period of time while awaiting dispatch.

"**Preceptor**" means an individual with education, experience and expertise in healthcare and approved by a training program to supervise and provide instruction to EMS students during clinical experiences.

"**Program Administrator**" means the individual designated in writing by a training program as responsible for all aspects of EMS training.

"**Program Coordinator**" means the individual designated in writing by a training program as responsible for all aspects of a specified course(s) or EMS program. This individual shall have at least two (2) years experience of full-time equivalent employment as a healthcare practitioner.

"**Response time**" means the time from which a call is received by the EMS agency until the time the ambulance and complete crew arrives at the scene, unless the call is scheduled in advance.

"**Specialty Care Transports**" means interfacility transfers of critically ill or injured patients requiring specialized interventions such as IV infusions including vasopressors, vasoactive compounds, antiarrhythmics, fibrinolytics, tocolytics, and/or any other parenteral pharmaceutical unique to the patient's special health care needs or special monitors or procedures such as mechanical ventilation multiple monitors, cardiac balloon pump, external cardiac support (Ventricular assist

devices, etc) or any other specialized device or procedure outside the paramedic scope of practice certified by the referring physician as unique to the patient's health care needs.

"**Statewide Ambulance coverage area**" means a map of all ambulance response areas, maintained by the Department.

"**Stretcher aid van**" means any ground vehicle, which is or should be approved by the State Commissioner of Health, which is designed and equipped to transport individuals on a stretcher or gurney type apparatus [63 O.S. § 1-2503].

"**Stretcher aid van patient**" means any person who is or will be transported in a reclining position on a stretcher or gurney, who is medically stable, non-emergent and does not require any medical monitoring equipment or assistance during transport [63 O.S. § 1-2503].

"**Substation**" means a permanent structure where a(an) ambulance(s) is/are stationed and available for calls on a twenty-four (24) hour basis.

"**Training**" means that education which is received through training programs as authorized by emergency medical services rule and regulation for training programs (Subchapter 7 of this Chapter).

"**Transfer**" means the movement of a patient in an ambulance.

"**Trauma transfer and referral center**" means an organization certified by the Department and staffed and equipped for the purpose of directing trauma patient transfers within a region that consists of a county with a population of three hundred thousand (300,000) or more and its contiguous communities, and facilitating the transfer of trauma patients into and out of the region for definitive trauma care at medical facilities that have the capacity and capability to appropriately care for the emergent medical needs of the patient.

PART 7. AIR AMBULANCES

310:641-3-31. Air medical service

(a) Air medical services shall be developed and maintained, at all times, to provide medical treatment, stability and transportation to ambulance patients. This care shall meet the needs of the ambulance patient, and the capability of the medical crew and aircraft.

(b) Air medical services shall be under the direction of a physician as indicated in section 310:641-3-35 of this rule.

~~(c) Air medical service should be available twenty four (24) hours per day, but extenuating exceptions which shall be granted are inclement weather, aircraft maintenance, mandatory crew rest, or non availability of aircraft and/or medical crew.~~

~~(d)~~ Air medical service shall operate within the statewide emergency medical response system, coordinating all prehospital responses with the appropriate local emergency resources through at least the following means:

- (1) immediate verbal contact with the ambulance and first response agencies closest to the patient;
- (2) radio and telephone coordination with ground personnel to ensure the most timely response to the patient;

~~(3) regularly scheduled post event reviews of all pre-hospital cases with ground agencies to refine response processes. The air ambulance provider shall report reviews on Department approved forms at quarterly intervals.~~

(ed) Air medical utilization protocols shall be developed by all licensed ambulance and certified first response agencies and submitted for approval by the Department.

310:641-3-32. Air ambulance vehicles

(a) An air ambulance vehicle (aircraft) may be fixed wing, single or multi-engine, or rotary wing. ~~Single engine aircraft shall be turbine powered.~~

(b) Operations of the aircraft shall be under the provisions of Part 91 and Part 135 of the Federal Aviation Regulations (FAR).

(c) The operator of an air ambulance service declares the capability of providing quality air ambulance services. These services include qualified flight crews, aircraft maintenance, patient configuration, space allocated for medical attendants and equipment as designated in Section 310:641-3-33.

(d) The aircraft design and configuration shall not compromise patient stability in loading, unloading or in-flight operations.

(1) The aircraft shall have an entry that allows loading and unloading without excessive maneuvering (no more than 45 degrees about the lateral axis and 30 degrees about the longitudinal axis) of the patient, and does not compromise functioning of monitoring systems, intravenous lines, and manual or mechanical ventilation.

(2) A minimum of one stretcher shall be provided that can be carried to the patient.

(3) Aircraft stretchers and the means of securing it in-flight must be consistent with FAR's.

(4) The type and model of stretcher indicates the maximum gross weight allowed (inclusive of patient and equipment) as labeled on the stretcher.

(5) The stretcher shall be large enough to carry the 95th percentile adult patient, full length in the supine position. (The 95th percentile adult American male is 6 ft. and 212 lbs.)

(6) The stretcher shall be sturdy and rigid enough that it can support cardiopulmonary resuscitation. If a back-board or equivalent device is required to achieve this, such device will be readily available.

(7) The head of the stretcher is capable of being elevated at least 30 degrees for patient care and comfort.

(8) If the ambulance stretcher is floor supported by its own wheels, there is a mechanism to secure it in position under all conditions. These restraints permit quick attachment and detachment for patient transfer.

(e) Patients transported by air will be restrained with a minimum of three straps, including shoulder straps, that must comply with FAA regulations. The following additional requirements shall apply to achieve patient stability.

(1) Patients less than 60 pounds (27kg) shall be provided with an appropriately sized restraining device (for patient's height and weight) which is further secured by a locking device. All patients under 40 pounds must be

secured in a five-point safety strap device that allows good access to the patient from all sides and permits the patient's head to be raised at least 30 degrees. Velcro straps are not encouraged for use on pediatric devices.

(2) If a car seat is used, it shall have an FAA approved sticker.

(3) There shall be some type of restraining device within the isolette to protect the infant in the event of air turbulence.

(f) A Supplemental lighting system shall be installed in the aircraft/ambulance in which standard lighting is insufficient for patient care.

(1) A self-contained lighting system powered by a battery pack or portable light with a battery source must be available.

(2) ~~Aircraft shall have a~~ A means to protect the pilot's night adaptation visions shall be provided for night operations either through the medical configuration or a dividing curtain. (Use of red lighting or low intensity lighting in the patient care area is acceptable if to isolate the patient care area.)

(g) An electric power outlet shall be provided with an inverter or appropriate power source of sufficient output to meet the requirements of the complete specialized equipment packages without compromising the operation of any other system or equipment. A back-up power source to enable use of equipment may be provided by an extra battery of appropriate voltage and capacity.

(h) ~~Aircraft operational controls and communications equipment shall be physically protected~~ A means to protect the pilot and controls from any intended or accidental interference by the patient, medical transport personnel, or equipment and supplies shall be provided.

(i) Appropriately sized helmets shall be worn (by all rotor wing personnel on the aircraft except for the patient) OR the interior modification of the aircraft shall be clear of objects/projections OR the interior of the aircraft shall be padded to protect the head-strike envelope of the medical personnel and patients as appropriate to the aircraft.

(j) There shall be access and necessary space to ensure any onboard patient's airway is maintained and to provide adequate ventilatory support from the secured, seat-belted position of medical transport personnel.

(k) ~~Oxygen shall be installed according to FAA regulations in the aircraft and according to state and federal regulations for ambulances.~~ Medical transport personnel shall be able to determine if medical oxygen is on by in-line pressure gauges mounted in the patient care area.

(1) Each gas outlet shall be clearly marked for identification.

(2) Oxygen flow shall be capable of being started and stopped at or near the oxygen source from inside the aircraft.

(3) The following indicators shall be accessible to medical transport personnel while enroute:

- (A) Quantity of oxygen remaining.
- (B) Measurement of liter flow.

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- (l) A variety of medical oxygen delivery devices consistent with the service's medical protocols shall be available.
- (m) An appropriately secured portable medical oxygen tank with a delivery device shall be carried on the aircraft. Portable medical oxygen tank may not be secured between patient's legs while the aircraft is in motion.
- (n) There shall be a back-up source of medical oxygen sufficient to allow completion of the transport in the event the main system fails. For air transports, this back-up source can be the required portable tank as long as the portable tank is accessible in the patient care area during flight.
- (o) Storage of oxygen shall comply with applicable OSHA standards.—~~(p) Oxygen flow meters and outlets shall be padded, flush mounted, or so located to prevent injury to medical transport personnel.~~
- ~~(p) Any occurrence which requires reporting to the FAA of emergency conditions or operations shall require a report in writing to the Department within ten business days. Oxygen flow meters and outlets shall be padded, flush mounted, or so located to prevent injury to medical transport personnel.~~
- (q) The licensee shall notify the Department prior to placing a substitute aircraft into operation. Any vehicle initially placed in service after a purchase, lease, contract and/or refurbish shall be inspected, approved, and permitted by the Department ~~prior to utilization.~~

310:641-3-33. Air ambulance equipment

- (a) Medical control shall determine the patient's needs and level of care required when deciding what equipment shall be aboard each flight and the type of aircraft required for transport. Equipment kits, cases and/or packs which are carried on any given flight shall be available for the following categories: trauma, cardiac, burn, toxicologic, pediatric, neonatal, and obstetrics.
- (b) The following medical equipment shall be required to be on board every aircraft certified by the Department for air medical services:
- (1) IV supplies and fluids, readily available.
 - (2) Hangers/hooks to secure IV solutions in place and equipment to provide high flow fluids if needed. Glass IV containers shall not be used unless required by specific medications and properly secured.
 - (3) A minimum of three IV infusion pumps, on the aircraft or immediately available for critical care transports.
 - (4) Accessible medications, consistent with the service's medical protocols.
- (c) Medications shall be easily accessible. Controlled substances shall be in a locked system and kept in a manner consistent with 310:641-3-70.
- (d) Storage of medications shall allow for protection from extreme temperature changes if environment deems it necessary.
- (e) Medical supplies and equipment shall be consistent with approved medical protocols and scope of care. The following equipment shall be on the aircraft/ambulance and immediately available for all Critical Care or ALS providers.

- (1) A cardiac monitor, defibrillator and external pacemaker shall be secured and positioned so that displays are visible.
 - (2) Extra batteries or power source shall be available for cardiac monitor / defibrillator or external pacemaker.
 - (3) The defibrillator shall be secured and positioned for easy access. Pediatric paddles shall be available.
 - (4) An external pacemaker shall be on-board.
 - (5) The pulse generator pacemaker shall be on-board or immediately available as a carry-on item.
- (f) The aircraft shall be configured for effective CPR.
- (g) Each air ambulance service shall carry the following advanced airway and ventilatory support equipment.
- (1) Laryngoscope and tracheal intubation supplies, including laryngoscope blades, bag-valve-mask and oxygen supplies, including PEEP valves; appropriate for ages and potential needs of patient transported.
 - (2) A mechanical ventilator appropriate for critical care transports.
 - (3) Two suction units, one of which is portable and both of which are capable of delivering adequate suction to clear the airway.
 - (4) Pulse oximetry, on-board and immediately available.
 - (5) End-tidal CO₂ monitoring capabilities and equipment.
 - (6) Automatic blood pressure device, sphygmomanometer, Doppler or arterial line monitoring capability, on-board and immediately available.
 - (7) Devices for decompressing a pneumothorax and performing an emergency cricothyroidotomy.
- (h) ~~All aircraft medical equipment (including specialized equipment) and supplies shall be secured according to FAR's. Equipment shall be secured by an appropriate clamp, strap, or other mechanism to the vehicle, stretcher or isolette to prevent movement during a crash or abrupt stop.~~

310:641-3-34. Air ambulance medical staffing

- (a) Each air ambulance flight originating in Oklahoma shall have, as a minimum, one of the following aeromedical crew member (ACM) attending the patient:
- (1) (ACM-4) Physician licensed to practice in the State of Oklahoma. This crew member should be oriented educationally in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Advanced Trauma Life Support (ATLS), altitude physiology, and on-board treatment modalities.
 - (2) (ACM-3) Registered nurse licensed to practice in the State of Oklahoma. This crew member should be oriented educationally in critical care modalities (obstetrics, neonatology, pediatrics, burns, cardiology, neurosurgery, toxicology and infectious disease specialties), altitude physiology, aircraft safety, crash and survival procedures, mapping/aircraft orientation, aviation communications.
 - (3) (ACM-2) EMT Paramedic licensed to practice in the State of Oklahoma. This crew member should be oriented educationally in altitude physiology, aircraft safety, crash and survival procedures, mapping/aircraft

orientation, aviation communications, ACLS, PALS and Pre-hospital Trauma Life Support (PHTLS) or equivalent as approved by the Department.

(b) Aeromedical crew members (ACMs) are required to participate in continuing education training for, but not limited to, the following: altitude physiology, emergency medical services and aviation communications, aircraft and flight safety, use of patient care equipment, protocol and procedure review and legal aspects of air transportation.

(1) Didactic continuing education shall include an annual review of:

- (A) Aviation - safety issues.
- (B) Hazardous materials recognition and response.
- (C) Human factors - Crew Resource Management
- (D) Infection control
- (E) State EMS rules and regulations regarding ground and air transport.
- (F) Stress recognition and management.
- (G) Survival training.

(2) Appropriate continuing education shall be developed and documented on an annual basis and must include:

- (A) Critical care (adult, pediatric, neonatal).
- (B) Emergency / trauma care.
- (C) Invasive procedure labs.
- (D) Labor and delivery.
- (E) Prehospital experience.

(c) Scene or pre-hospital transports of air ambulance service shall have as a minimum, one aeromedical crew member licensed as an emergency medical technician - Paramedic.

310:641-3-35. Air medical director

(a) An air medical director shall be a physician, fully licensed to practice in the State of Oklahoma, with a background in flight medicine, pre-hospital and/or emergency medicine. Physician shall know the aircraft limitations for in-flight patient care.

(b) An air ambulance service based in another state may have as its air medical director a physician who is not licensed to practice in the State of Oklahoma but is fully licensed in good standing in the home state of the air ambulance service. The air medical director shall meet all other qualifications listed in Section 310:641-3-35(a).

(c) The air medical director is responsible for protocols (on-line and off-line) for standards of patient care and shall review these annually. Written protocols shall be submitted to the Department for approval.

(d) The ~~aeromedical~~air medical director shall review all medical records from patient care flights.

(e) The air medical director is responsible for the aeromedical transfer. The air medical director may designate aeromedical crew members to determine needs for individual patient care flights, but shall be available for consultation, if required by the designee(s).

(f) The air medical director is responsible for reviewing the quality assurance program for air ambulance service.

310:641-3-36. Operational protocols

(a) There shall be written policies and procedures with documentation of training in the following areas:

(1) Equipment shall be annually tested and inspected by a certified clinical engineer.

(2) Documentation of equipment inspections shall be available for review by the Department.

(b) Medical personnel shall be in seatbelts (and shoulder harnesses if installed) that are properly worn and secured for all take-offs and landings according to FAA regulations. The written policy shall define when medical personnel may get out of restraints.

(c) A written policy shall be in place for patient loading and unloading procedures for medical transports as follows: A written policy shall be utilized for rapid patient loading and unloading if practiced.

~~(d) A written Protocol shall be in place for emergency refueling with the engine running, rotors turning, and/or passengers onboard. This refueling protocol shall address the following:~~

~~(1) Refueling with engine(s) running and/or shut down.~~

~~(2) Refueling with medical transport personnel or patient(s) on board which includes a requirement that at least one medical transport person shall remain with the patient at all times during refueling or stopover.~~

~~(3) Fire hazard policies pertinent to refueling procedures that are documented in the certificate holder's Operations Specifications Manual.~~

~~(e) A written policy shall be developed and in place with limitations on nighttime "scene" landings if the searchlight or the radar altimeter are not functioning.~~

~~(f) A written protocol shall be developed and in place to address the combative patient.~~

(1) Additional physical and/or chemical restraints shall be available and used for combative patients who potentially endanger himself, the personnel or the aircraft.

(2) The written protocol shall address refusal to transport patients, family members or others who may be considered a threat to the safety of the transport personnel.

~~(g) A list of contaminated materials, which could pose a threat to the medical transport team or render transport inappropriate, shall be readily available.~~

~~(h) The LZ or aircraft operational area shall be a safe distance to avoid any downwind danger when approaching or departing.~~

~~(i) The aircraft shall be equipped with a 180 degree controllable searchlight of at least 400,000 candle power (RW).~~

~~(j) The aircraft shall be equipped with a functioning radar altimeter.~~

~~(k) The aircraft shall be equipped with a functioning emergency locator transmitter (ELT) and in compliance with the applicable FAR's.~~

~~(l) The aircraft shall be equipped with survival gear appropriate to the coverage area and the number of occupants.~~

(1) Survival gear shall be maintained appropriately and shall be available to personnel on board.

(2) The survival kit and contents shall be included on the daily check sheet.

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~~(mh)~~ A fire extinguisher shall be accessible to medical transport personnel and pilot(s) or driver while in motion.

~~(mi)~~ The interior of the aircraft or ambulance shall be climate controlled to avoid adverse affects on patients and personnel on board.

310:641-3-37. Communications

(a) All air ambulance aircraft shall have radio capability to communicate air to ground, air to air, and ground to air. This radio system should include two-way communications with physicians who are responsible for directing patient care in transit, and with ground personnel who coordinate the transfer of the patient by surface transportation. The aircraft shall also have the capability to communicate between the medical attendant and pilot, be in compliance with the Oklahoma Area Wide Communications Plan, and provide documentation that the aircraft can communicate with hospitals as specified in OAC 310:641-3-22(d).

(b) All communications equipment shall be maintained in full operating condition and in good repair. Ambulance communications equipment shall be capable of transmitting and receiving clear and understandable voice communications to and from the base station at a reasonable distance. Radios on aircraft shall be capable of transmitting and receiving the following traffic:

- (1) Medical direction.
- (2) Communication Center.
- (3) Air traffic control (aircraft).
- (4) EMS and law enforcement agencies.

(c) The pilot shall be able to control and override radio transmissions from the cockpit in the event of an emergency situation. If cellular phones are part of the on-board communications equipment, they shall be used in accordance with FCC regulations.

~~(d) Providers whose medical director(s) require biomedical telemetry in their medical protocols may utilize the cellular telephone system for such communications. Other communications equipment such as cellular phones shall be in addition to and not in place of the radio equipment and shall not be used in the presence of pacemakers or other equipment sensitive to interference.~~

~~(ed)~~ The medical team shall be able to communicate with each other during flight.

~~(fe)~~ A communication Specialist shall be assigned to receive and coordinate all requests for the medical transport service. Training of the designated person shall be commensurate with the scope of responsibility of the Communications Center personnel and include:

- (1) EMT certification, or the equivalent in knowledge or experience which minimally includes:
- (2) Medical terminology.
- (3) Knowledge of EMS - roles and responsibilities of the various levels of training - BLS/ALS, EMT/EMT-Paramedic.
- (4) State and local regulations regarding EMS.
- (5) Familiarization with equipment used in the field setting.

(6) Knowledge of Oklahoma State EMS Rules and regulations.

(7) General safety rules and emergency procedures pertinent to medical transportation and flight following procedures.

(8) Navigation techniques/terminology and understanding weather interpretation. This shall include an understanding of GPS navigation.

(9) Types of radio frequency bands used in EMS systems.

(10) A knowledge of the hazardous materials response and recognition procedure using appropriate reference materials.

(11) Stress recognition and management.

~~(gf)~~ Aircraft shall communicate, when possible, with ground units securing unprepared landing sites prior to landing. A readily accessible post incident/accident plan shall be part of the flight following protocol so that appropriate search and rescue efforts may be initiated in the event the aircraft is overdue, radio communications can not be established not location verified. There shall be a written plan to initiate assistance in the event the ambulance is disabled.

~~(hg)~~ Initial coordination shall be documented and continuous flight following (or initiating and following ground transport) shall be monitored and documented, and shall consist of the following:

- (1) Time of call (Time request/inquiry received).
- (2) Name and phone number of requesting agency.
- (3) Age, diagnosis or mechanism of injury.
- (4) Referring and receiving physician and facilities (for interfacility requests) as per policy of the medical transport service.
- (5) Verification of acceptance of patient and verification of bed availability by referring physician and facility.
- (6) Destination airport, refueling stops (if necessary) location of transportation exchange and hours of operation
- (7) Ground transportation coordination at sending and receiving areas.
- (8) Time of Dispatch (Time crew notified flight is a go, post pilot OK's flight).
- (9) Time depart base (time of lift-off or other site).
- (10) Number and names of persons on board.
- (11) Amount of fuel on board.
- (12) Estimated time of arrival (ETA)
- (13) Pertinent LZ information.
- (14) Time arrive location.
- (15) Time helicopter arrives at landing zone or helipad).
- (16) Time depart location.
- (17) Time helicopter lifts off from landing zone or helipad.
- (18) Time arrive destination.
- (19) Time depart destination.
- (20) Time arrive base.
- (21) Time aborted.

~~(i) Flight following and communications during a mission shall direct and/or relay communications to communication center (while in motion) specifying locations and ETA's, and deviations, if available.~~

(j) A "sterile cockpit" shall be maintained below pre-determined altitudes so that the pilot shall be able to transmit and receive vital information and to minimize distractions during any critical phase of flight. No external communications are permitted, and no patient information is transmitted at this time unless radios for medical transport are appropriately isolated.

- (1) ~~There shall be a policy/procedure for diversions from original destinations.~~
- (2) ~~Direct or relayed communications to communication center specifying all take-off and arrival times.~~
- (3) ~~Time between each communication shall be documented.~~
- (4) ~~Time between each communication shall not exceed 15 minutes while in flight. If an IFR or VFR flight plan has been filed, communication with air traffic control shall fulfill this requirement.~~
- (5) ~~Time between communications shall not exceed 45 minutes while on the ground.~~
- (6) ~~Alternate agencies shall be used to relay communications when direct contact is not possible.~~

(kh) Communications Center shall contain the following:

- (1) At least one dedicated phone line for the medical transport service.
- (2) A method to keep noise and other distractions (traffic) from the communications area while the communications specialist is involved with a medical transport mission.
- (3) A system for recording all incoming and outgoing telephone and radio transmissions with time recording and playback capabilities. Recordings to be kept for three (3) years.
- (4) Capability to immediately notify the medical transport team and on-line medical direction (through radio, pager, telephone, etc.)
- (5) Back-up emergency power source for communications equipment, or a policy delineating methods for maintaining communications during power outages and in disaster situations.
- (6) A status board with information about pre-scheduled flights/patient transports, the medical transport team on duty, weather, and maintenance status.
- (7) Local aircraft service area maps and navigation charts shall be readily available. Road maps must be available for ground transport services.

310:641-3-38. Aircraft utilization

(a) Each air ambulance service shall have in place a protocol to insure no delay in aircraft response. The air ambulance shall provide to the caller a point of origin and an accurate ETA. In such cases where a delay is anticipated, the air ambulance service called has a responsibility to notify the caller and assist in referral to another licensed ambulance service.

(b) There shall be a policy / procedure for diversions from original destinations.

(bc) The air ambulance service shall ensure appropriate utilization and medical benefit to the patient. A documented review process shall be developed and utilized.—~~Utilization review of scene transports shall include the following triage~~

~~criteria. This is to minimize over utilization of air services: On scene transports—The following types of criteria shall be used in the triage plan for on scene transports to minimize over triage:~~

- (1) ~~Anatomic and physiological identifiers.~~
- (2) ~~Mechanism of injury identifiers.~~
- (3) ~~Situational identifiers.~~
- (4) ~~Air vs. ground times.~~
- (5) ~~Road conditions.~~
- (6) ~~Entrapment or multiple injured.~~
- (7) ~~Capability of local ground provider verses patient needs.~~
- (8) ~~Safety of the transport environment.~~

(ed) The air ambulance service shall be integrated with and communicate with other public safety agencies, including ground emergency service providers. This shall include participation in regional quality improvement reviews, regional disaster planning and mass casualty incident drills to include an integrated response to terrorist events.

(de) Air ambulance services shall conduct quarterly scheduled post event reviews of cases with ground agencies and receiving facilities to enhance performance improvement.

(ef) Air transport services shall develop and demonstrate use of a written code of ethical conduct that demonstrates ethical practices in business, marketing, and professional conduct.

(f) ~~Air ambulance services shall report aviation incidents and accidents to the appropriate aviation authority immediately and the Department within 24 hours.~~

(g) A Flight Safety Committee/Work Group shall be established composed of a pilot and an appointed representative from each of the Oklahoma licensed air ambulance services, and shall submit a summary report of it's activities to the EMS Division annually.

310:641-3-39. Rotorwing standards - certificate of the aircraft operator

(a) Licensed air ambulances shall meet all Federal Aviation Regulations, and shall hold a FAR Part 135 Certificate and Ambulance Operations Specifications specific to EMS operations.

(b) ~~VFR weather minimums shall be specified for day and night local, and day and night cross-country.~~

(c) ~~The "local flying area" shall be determined by the operator based upon the operating environment.~~

(d) ~~There shall be a written policy for obtaining and documenting pertinent weather information.~~

(1) ~~The pilot in command shall be responsible for obtaining weather information according to policy that shall address at a minimum:~~

- (A) ~~Routine weather checks.~~
- (B) ~~Weather checks during marginal conditions.~~
- (C) ~~Weather trending.~~

(2) ~~Communication between pilots, medical personnel, and communication specialists at shift change regarding the most current and forecasted weather shall be part of a formal briefing.~~

(e) ~~VFR "response" weather minimums to begin a transport shall be no less than:~~

- (1) ~~Conditions—Day/Local:~~

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- (A) ~~Ceiling—500 ft.~~
- (B) ~~Visibility—1 mile~~
- (2) ~~Conditions—Day/Xcountry:~~
 - (A) ~~Ceiling—1000 ft.~~
 - (B) ~~Visibility—1 mile~~
- (3) ~~Conditions—Night/Local:~~
 - (A) ~~Ceiling—800 ft.~~
 - (B) ~~Visibility—2 miles~~
- (4) ~~Conditions—Night/Xcountry:~~
 - (A) ~~Ceiling—1000 ft.~~
 - (B) ~~Visibility—3 miles~~
- (f) ~~A pilot in Command shall have a commercial rotorcraft helicopter and instrument helicopter rating.~~
- (g) ~~The PIC shall possess 2000 total flight hours with a minimum of 1500 helicopter flight hours prior to assignment with a medical service with the following stipulations.~~
- (h) ~~There shall be a mechanic primarily assigned to each specific aircraft who is FAR 135 qualified to maintain the aircraft operated by the medical service and who possesses 2 years of rotorcraft experience as a certified airframe and powerplant mechanic prior to assignment with the medical service.~~

PART 9. SPECIALTY CARE

310:641-3-43. Personnel

- (a) It shall be the responsibility of the licensee to insure that qualified staff is utilized on each transport. The licensee shall be held responsible to see that personnel licenses and/or certification and specialty training are kept current. Also, that the staffing patterns comply with the specialty, approved by the Department, at the time of license issuance.
- (b) ~~Drivers—Emergency vehicle operators~~ shall be as a minimum, certified Oklahoma registered or licensed emergency medical personnel capable to assist the attendants, should the need arise, except for air ambulance.
- (c) Any changes in staffing patterns after initial licensing shall require prior written approval by the Department.
- (d) Each specialty care patient shall be attended by at least one currently licensed paramedic with the following additional training.
 - (1) Evidence of successful completion of Department - approved post paramedic training such as Critical Care Paramedic (CCP) training; and
 - (2) Appropriate periodic skills verification in management of patients on ventilators, 12 lead EKG and/or critical care monitoring devices, drug infusion pumps, and cardiac and/or other critical care medications, or any other specialized procedures or devices determined at the discretion of the provider's medical director and approved by the Department; or
- (e) A currently licensed paramedic accompanied by at least one of the following:
 - (1) A registered nurse with special knowledge of the patient's care needs;
 - (2) A certified respiratory therapist;
 - (3) A licensed physician;

- (4) Any licensed health care professional with special skills outside the paramedic scope of practice designated by the transferring physician.

310:641-3-47. Equipment

All specialized equipment and supplies appropriate to the required interventions shall be available at the time of the transport.

PART 11. MEDICAL CONTROL

310:641-3-50. Requirement

- (a) While performing with a licensed ambulance service and/or a certified emergency medical response agency, emergency medical personnel shall perform authorized procedures, which may not exceed the level of license or certification.
- (b) Each licensed ambulance service and/or certified emergency medical response agency shall have a physician medical director who is a fully licensed, non-restricted doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) in the State of Oklahoma. Medical direction for a certified emergency medical response agency shall be provided by or approved by the sponsoring licensed ambulance service. The Department shall be notified within twenty four (24) hours of any lapse of medical direction by the respective agency.
 - (1) The physician medical director of an air, ground, specialty care ambulance service and/or emergency medical response agency based in another state shall not be required to be licensed to practice in the State of Oklahoma, but shall be fully licensed in good standing in the home state of that air, ground, or specialty care ambulance service and/or certified first response agency.
 - (2) The physician medical director for an ambulance service and/or emergency medical response agency operated by the federal government shall be fully licensed in good standing in Oklahoma or another state. If not licensed in Oklahoma, the physician shall be actively employed by the federal agency responsible for the operation of the ambulance service or emergency medical response agency.
- (c) The physician director shall:
 - (1) Demonstrate appropriate training and experience in adult and pediatric emergency medical services. Demonstrated training and experience may include appropriate board certification approved by the Department or successful completion of training programs such as Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Advanced Trauma Life Support (ATLS), Advanced Disaster Life Support (ADLS) or other equivalent training.
 - (2) Be familiar with the design and operation of pre-hospital emergency medical services systems, and knowledgeable about the capabilities of the different levels of licensed personnel and of the established protocols.
 - (3) Have experience in the emergency department management of the acutely ill or injured patient(s), ~~in the urban setting.~~ In the rural setting, the physician shall

routinely and actively participate in the care for acutely ill or injured patient(s).

(4) Be knowledgeable and actively involved in quality assurance and the educational activities of the emergency medical technician, and supervise a quality assurance (QA) program by either direct involvement or appropriate designation and surveillance of his responsible designee. The QA program, or policy, shall be submitted with treatment protocols for approval by the Department. The Department may require quality assurance documentation for review, and shall protect the confidentiality of that information.

(5) Have knowledge and a relationship with the licensed ambulance service(s) and/or certified emergency medical response agency(ies) and their primary service area coverage. A physician may be the medical director for more than one (1) licensed ambulance service and/or certified emergency medical Response agency.

(6) Provide a written statement, to the Department, which includes: ~~consent to be the medical director, address, an Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) number or appropriate state equivalent, medical license and a curriculum vitae, and be actively involved in pre-hospital care.~~

(A) Agreement to provide medical direction and establish the standard of care provided by the service;

(B) Regular mail and email addresses;

(C) An Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) number or appropriate state equivalent;

(D) Current medical license;

(E) A curriculum vitae, and be actively involved in pre-hospital care.

(7) Develop medical protocols for patient care techniques, both on-line and off-line standing orders and present written EMT Intermediate, and EMT Paramedic life support protocols to the Department for approval, before use. Protocols shall include medications to be used, treatment modalities for patient care procedures, and appropriate security procedures for controlled and dangerous drugs.

(8) List all medications with quantities to be carried on each emergency vehicle.

~~(9) Supervise a quality assurance (QA) program. The QA program, or policy, shall be submitted with treatment protocols, for approval by the Department. Quality assurance documentation may be requested by the Department.~~

(409) Participate in the statewide emergency medical services system.

This time period shall not exceed one hundred twenty (120) days, for any deficiency.

(b) Written notification, ~~within the time period cited,~~ shall be forwarded to the Department when a deficiency has been corrected. If this notice is not forthcoming within thirty (30) days, then the Department shall notify the service, by certified mail, that they are out of compliance. If no plan of correction is received within thirty (30) days, then action for remedy against the service may be undertaken by administrative procedure [Title 75 O.S., Sec. 301-et seq.].

(c) Plans of correction that are not deemed acceptable by the Department shall not be considered a sufficient response to a correction order. Plans of correction shall include at least the following:

(1) When the correction was or will be completed;

(2) How the correction was or will be made;

(3) What measures will prevent a recurrence;

(4) Who will be accountable to ensure future compliance.

(d) If no acceptable plan of correction is received within thirty (30) days, and/or if the deficiency is not corrected within one hundred twenty (120) days, action for remedy against the service may be undertaken by administrative procedure [Title 75 O.S., Sec 301-et seq].

(ee) Violations which appear to be hazardous to the health and welfare of the public and/or employees shall require immediate correction.

(1) If such a violation is not, or cannot be, corrected immediately, the vehicle shall be removed from service and the ambulance permit shall be removed until such time as the vehicle is in compliance and has been re-inspected and permitted by the Department.

(2) Violations that may justify immediate removal of an ambulance vehicle permit include:

(A) Inadequate sanitation, including the presence of contamination by blood and/or body fluids;

(B) Inoperable heater/air conditioner;

(C) Inoperable AED or defibrillator;

(D) Tires in poor condition;

(E) Inoperable emergency lighting and/or siren;

(F) Inoperable oxygen system or less than 200psi in onboard oxygen tank;

(G) Inoperable suction apparatus;

(H) Carbon monoxide levels of greater than (50 ppm) fifty parts per million, or broken exhaust pipe;

(I) Lapse of required vehicle liability insurance; and

(J) Lapse of required worker compensation insurance.

PART 19. INSPECTION, CORRECTION, ACTIONS

310:641-3-91. Correction orders

(a) Violation of Oklahoma Statutes, the Act or the rules constitute grounds to issue a correction order, citing the deficiency, indicating the time period in which a correction shall be made.

SUBCHAPTER 5. PERSONNEL LICENSES AND CERTIFICATION

PART 3. EMERGENCY MEDICAL PERSONNEL LICENSES

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310:641-5-11. License qualification

Persons applying for initial license shall meet the requirements for qualification, application, and procedure as follows:

- (1) Applicant shall be at least eighteen (18) years of age.
- (2) Applicant shall submit the following:
 - (A) An appropriate State application form specifying true, correct and complete information as to eligibility and character.
 - (B) A copy of a current active National Registry of Emergency Medical Technicians (NREMT) certification card. An application fee as listed below:
 - (i) ~~License fees for persons trained in Oklahoma, confirmed by a final course roster from a certified Oklahoma EMS Training Institution, including practical skills testing:~~
 - (I) ~~EMT Basic Licensure is Seventy five dollars (\$75.00).~~
 - (II) ~~EMT Intermediate or EMT Paramedic Licensure is One Hundred Fifty dollars (\$150.00).~~
 - (ii) ~~Practical skills retest fee:~~
 - (I) ~~Partial: Fifty dollars (\$50.00).~~
 - (II) ~~Full: One Hundred dollars (\$100.00)~~
 - (iii) ~~License fee for persons holding current active status National Registry of EMT Certification:~~
 - (I) ~~EMT Basic Licensure is Seventy five dollars (\$75.00).~~
 - (II) ~~EMT Intermediate licensure including airway testing is One Hundred Seventy five dollars (\$175.00).~~
 - (III) ~~EMT Paramedic licensure is Two Hundred dollars (\$200.00).~~
 - (C) A signed "Affidavit of Lawful Presence" Form.
- (3) A license fee of seventy-five dollars (\$75.00) for EMT Basic, one hundred fifty dollars (\$150.00) for EMT Intermediate, and two hundred dollars (\$200.00) for Paramedic shall be submitted with the application. Fees shall be in an acceptable form, made payable to the Oklahoma State Department of Health - Emergency Medical Services Division (OSDH/EMS). Fees are non-refundable except if the application is rejected. Candidates who fail to appear at the scheduled examination will be charged the full fee when a new application is made.
- (4) A license application may be denied on the basis of a felony which includes any conviction of assault, battery, or assault and battery with a dangerous weapon; aggravated assault and battery; murder or attempted murder; manslaughter, except involuntary manslaughter; rape, incest, or sodomy; indecent exposure and indecent exhibition; pandering; child abuse; abuse, neglect or financial exploitation of any person entrusted to his care or possession; burglary in the first or second degree; robbery in the first or second degree; robbery or attempted robbery with a dangerous weapon, or imitation firearm; arson, substance abuse, ~~and/or any~~ such other convictions or circumstances which in the opinion of the Department would render the applicant unfit to provide emergency medical

care to the public. Each decision shall be determined on a case-by-case basis.

(5) A license application may be denied on the basis of any falsification. Application for initial licensure pursuant to the Act shall constitute authorization for an investigation by the Department.

(6) Candidates for Oklahoma licensure shall successfully complete the NREMT certification examinations. Practical and written examinations shall adhere to current policies of NREMT and the Department. Candidates shall demonstrate competency in all required skills. The Department reserves the right to review and require additional practical examination of any candidate.

(A) Approved Training Programs shall conduct practical examinations for the EMT Basic.

(B) The Department shall conduct practical examinations for the EMT Intermediate and Paramedic using Department approved evaluators. The fee for the initial practical examinations attempt is included within the applicant's initial license fee. Subsequent examination fees are one hundred dollars (\$100.00) for a full practical retest and fifty (\$50.00) for a partial practical retest. An Advanced Life Support (ALS) practical examination application and appropriate fee must be submitted to the Department for this purpose.

(C) Agencies approved by the Department shall administer National Registry emergency medical responder practical examinations.

(57) An applicant may request a review of adverse decisions, made within this section, by applying in writing within thirty (30) calendar days after the notice of rejection. Review, by the Department, shall be held in accordance with the Administrative Procedures Act.

(6) ~~Candidates are required to successfully complete the National Registry of Emergency Medical Technicians certification examinations.~~

(A) ~~Practical examinations shall adhere to the policies of the National Registry and the Department. Candidates shall demonstrate an acceptable level of competency in all respective skill areas. The Department reserves the right to review and require additional practical examination of any candidate.~~

(i) ~~A candidate for EMT-B shall complete a practical examination before applying for an examination. The practical examination may be conducted at an approved training program in accordance with National Registry policies and shall be separate from the completion of training. Verification of successful completion and the measured competency of each of the required skill areas shall be kept on file for a period of three (3) years at the training program, and summaries shall be submitted to the Department with the final course documentation.~~

(ii) ~~A candidate for EMT-I shall apply for both the certification examinations. The examinations shall be administered in accordance with policies~~

currently established by the National Registry of Emergency Medical Technicians.

(iii) A candidate for EMT-P shall apply for both the certification examinations. The examinations shall be administered in accordance with policies currently established by the National Registry of Emergency Medical Technicians.

(B) Candidates are allowed three full attempts to pass the practical examination (one "full attempt" is defined as completing all six (6) stations and two retests if so entitled). Candidates who fail a full attempt or any portion of a second retest must submit official documentation of remedial training over all skills before starting the next full attempt of the practical examination and re-examining over all six (6) stations. This official documentation must be signed by the EMT Paramedic Training Program Director or medical director of training/operations which verifies remedial training over all skills has occurred since the last unsuccessful attempt and the candidate has demonstrated competence in all skills. Should a candidate fail the third full and final attempt of the practical examination, the candidate must complete a new, entire, state approved EMT Paramedic Training Program.

(C) Successful completion of the practical examination is valid for one (1) year only.

(7) The written examination is based on the respective national standard emergency medical technician curriculum, as developed and promulgated by the United States Department of Transportation including State approved changes. Each candidate shall realize an overall passing minimum score, and in the case of EMT-P a passing minimum score for each section. Candidates who fail the written examination may re-apply, if eligible, for subsequent examination by submitting another application and fee, and meet current entry requirements.

(A) Candidates are allowed three (3) opportunities to successfully complete the written examination, within the two (2) year limitation on training and within the one (1) year limitation of the practical examination.

(B) Candidates who opt to attempt a fourth written examination shall submit proof of successful completion of a Department approved emergency medical technician refresher course, at the respective level of training.

(C) No oral examination of the written test shall be permitted. Only special examination accommodations approved by the National Registry will be provided for examinations.

(8) The Department shall administer all National Registry EMT-I and EMT-P practical examinations. Training programs shall administer National Registry basic practical examinations. Agencies approved by the Department

shall administer National Registry first responder practical examinations. All practical examinations are administered after completion of a State approved training course at all levels.

(9) Department approved evaluators shall be used for all EMT-I and EMT-P practical examinations.

(10) The Department may issue a license to any Nationally Registered EMT with active status who meets all other State requirements.

310:641-5-13. Issuance of licenses

(a) Upon successful completion of the examinations, an Oklahoma license at the respective level of emergency medical technician, shall be issued. Concurrent registration with the National Registry is included during the initial license period. NREMT certification shall be maintained by EMT's licensed after April 1, 2010. Oklahoma emergency medical technician licenses will be extended to meet the new expiration date for a two year transition period.

(b) The initial expiration date of a license shall coincide with the National Registry expiration date, plus three (3) months. This initial license period may range from eighteen (18) to twenty-one (21) months to thirty (30) to thirty-three (33) months. Subsequent license periods, if a licensee meets renewal requirements, shall be for a two (2) year period beginning April/July 1st and continuing through March/June 30th of the respective expiration year.

(c) A licensed emergency medical technician shall either have their State license card, or a copy, on their person or in the vehicle while on duty. If the card has been lost, or destroyed, or is in transit, a thirty (30) day period shall be allowed for compliance. A duplicate license may be obtained from the Department upon request and verification of status. A five (\$5.00) dollar fee shall be charged for a duplicate license, or license re-issued ~~issued~~ due to a name or address change.

310:641-5-14. Renewal requirements

(a) An application for the renewal of all emergency medical technician licenses shall be submitted to the Department ~~on or before March 31st, of the license expiration year if renewal is desired.~~ A notice of expiration and application for renewal shall be mailed to each licensee, at the address of record. Licensees are solely responsible for meeting all requirements for renewal.

(1) Applicants for renewal shall submit, on an application form provided by the Department, true, correct, and complete information as to eligibility and character. Incorrect or incomplete documentation shall be cause for rejection.

(A) Applicants who are licensed in Oklahoma and hold current active NREMT certification shall forward an appropriate license renewal application, fee and "Affidavit of Lawful Presence" with a copy of their NREMT certification card for the appropriate level of licensure to the Department on or before March 31st of the expiration year.

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(B) Applicants who are licensed in Oklahoma and do not hold current NREMT certification must submit an appropriate license renewal application, fee, "Affidavit of Lawful Presence" and documentation as required by 310:641-5-14.1 by March 31st of the year of license expiration.

(2) The fee for renewal is twenty dollars (\$20.00) for EMT-B, twenty-five dollars (\$25.00) for EMT-I, and thirty dollars (\$30.00) for EMT-P. Concurrent national registration is not included within the Oklahoma emergency medical technician renewal fee. Fees shall be in an acceptable form made payable to the Oklahoma State Department of Health - Emergency Medical Services Division (OSDH-EMS).

(2) Requirements for renewal, in general, include current and continuous certification in basic life support (BLS), specified hours of continuing education, refresher training, and continued skill competency. In the case of EMT I and EMT P, skill competency shall be verified by a physician, and for EMT P, advanced cardiac life support (ACLS) shall be documented.

(3) The EMT B renewal requires the licensee to:

(A) Complete a basic refresher course adhering to Department standards. Ten (10) hours of the refresher may be completed through distributive education as defined at OAC 310:641 3 2.

(B) Complete at least forty eight (48) hours of Department approved continuing education training. Twenty four (24) hours of continuing education may be obtained through distributive education as defined in OAC 310:641 3 2. The maximum number of hours allowed for any one topic is twelve (12) hours. Department pre approved continuing education includes any subject covered in the National Standard EMT Basic course, and the following topics—pneumatic trousers, shock management, communications, hypothermia and other environmental injuries, air ambulance emergency care, child abuse, sexual assault, industrial accidents, explosion injuries, electrical hazards, neonatal care/SIDS, domestic violence, crime scene response, athletic injuries, rappelling, hazardous materials, crisis intervention, protective breathing apparatus, farm machinery extrication, medical terminology, radioactive materials, medico legal aspects, and special rescue (diving, aerial, mountain). Bio terrorism, EMS Geriatrics, ACLS, PALS, PPC, and Pediatric Education for the Prehospital Professional (PEPP) or any other State approved courses will be allowed the number of hours specified on the course completion certificate up to 16 hours unless otherwise approved by the Department. Successful completion of the following National Standard courses—PHTLS (16hrs), BTLS (16hrs), Auto Extrication (16hrs), Emergency Driving (12hrs), and/or Dispatcher Training (12hrs)—with the specified number of hours shown above may be applied to Continuing Education. These topics may be presented utilizing critiques, didactic

sessions, practical drills, workshops, seminars, or other approved in service training sessions. Any topic which is not specified above shall require prior written approval from the Division. Successful completion of a Department approved Paramedic or Intermediate course shall fulfill the refresher and all continuing education requirements for the EMT Basic;

(C) Maintain basic life support (BLS) certification for health care providers, current through March 31 of licensure expiration. The BLS course shall adhere to the current standards of the American Heart Association CPR for the Health Care Provider, the American Red Cross CPR for the Professional Rescuer, the National Safety Council CPR for the Health Care Provider, or Department approved equivalent. BLS/CPR training shall not be applied toward the forty eight (48) hours of required continuing education training for Basic EMT's.

(D) Complete the Department renewal application with all required documentation and fee.

(4) The EMT I renewal requires the licensee to:

(A) Complete an intermediate refresher course adhering to Department standards. Ten (10) hours of the refresher may be completed through distributive education as defined in OAC 310:641 3 2. Refresher course modules met by successfully completing ACLS (initial course), AMLS, PHTLS, BTLS, PALS, or PEPP courses disqualify these courses from being applied to continuing education hours.

(B) Complete at least thirty six (36) hours of Department approved continuing education training. Eighteen (18) hours of continuing education may be obtained through distributive education as defined at OAC 310:641 3 2. The maximum number of hours allowed for any one topic is twelve (12) hours. Department pre approved continuing education includes any subject covered in the National Standard EMT Basic, EMT Intermediate, and/or EMT Paramedic course, and the following topics:—air ambulance emergency care, sexual assault, industrial accidents, explosion injuries, electrical hazards, crime scene response, communications, athletic injuries, rappelling, hazardous materials, crisis intervention, domestic violence, protective breathing apparatus, farm machinery extrication, medical terminology, radioactive materials, and special rescue (diving, aerial, mountain). Bio terrorism, EMS Geriatrics, ACLS, PALS, PPC, and Pediatric Education for the Prehospital Provider (PEPP) or any other State approved courses will be allowed the number of hours specified on the course completion certificate up to 16 hours unless otherwise approved by the Department. Successful completion of the following National Standard courses—PHTLS (16hrs), BTLS (16hrs), Auto Extrication (16hrs), Emergency Driving (12hrs), and/or Dispatcher Training (12hrs)—with the specified number of hours shown above may be

applied to Continuing Education. These topics may be presented utilizing critiques, didactic sessions, practical drills, workshops, seminars, or other approved inservice training sessions. Any topic which is not specified above shall require prior written approval from the Division. Successful completion of a Department approved Paramedic course shall fulfill the refresher and all continuing education requirements for the EMT Intermediate;

(C) Maintain basic life support (BLS) certification for health care providers, current through March 31 of licensure expiration. The BLS course shall adhere to the current standards of the American Heart Association CPR for the Health Care Provider, the American Red Cross CPR for the Professional Rescuer, the National Safety Council CPR for the Health Care Provider or Department approved equivalent. BLS/CPR training shall not be applied toward the thirty six (36) hours of required continuing education training for Intermediate EMT's;

(D) Complete a skills review and maintenance verification for EMT I by medical control, and;

(E) Complete the Department renewal application with all required documentation and fee.

(5) The EMT P renewal requires the licensee to:

(A) Complete a paramedic refresher course adhering to Department standards. Ten (10) hours of the refresher may be completed through distributive education as defined at OAC 310:641-3-2. Refresher course modules met by successfully completing ACLS (initial course), AMLS, PHTLS, or BTLS, PALS, or PEPP. Use of these courses disqualify these courses from being applied to continuing education hours.

(B) Complete at least twenty four (24) hours of Department approved continuing education training. Twelve (12) hours of continuing education may be obtained through distributive education as defined at 310:641-3-2. The maximum number of hours allowed for any one topic is twelve (12) hours. Department pre approved continuing education includes any subject covered in the National Standard EMT Paramedic course, and the following topics: —air ambulance emergency care, sexual assault, industrial accidents, explosion injuries, electrical hazards, crime scene response, athletic injuries, hazardous materials, crisis intervention, domestic violence, hypothermia and other environmental injuries, protective breathing apparatus, farm machinery extrication, medico legal aspects, radioactive materials, and special rescue (diving, aerial, mountain). Bio terrorism, EMS Geriatrics, PALS, PPC, and Pediatric Education for the Prehospital Professional (PEPP) or any other State approved courses will be allowed the number of hours specified on the course completion certificate up to 16 hours unless otherwise approved by the Department. Successful completion of the following National Standard

courses —PHTLS (16hrs), BTLS (16hrs), Auto Extrication (16hrs), Emergency Driving (12hrs), PALS (16 hrs.) and/or Dispatcher Training (12hrs) with the specified number of hours shown above may be applied to Continuing Education. These topics may be presented utilizing critiques, didactic sessions, practical drills, workshops, seminars, or other approved inservice training sessions. Any topic which is not specified above shall require prior written approval from the Division;

(C) Maintain basic life support (BLS) certification for health care providers, current through March 31 of licensure expiration. The BLS course shall adhere to the current standards of the American Heart Association CPR for the Health Care Provider, the American Red Cross CPR for the Professional Rescuer, the National Safety Council CPR for the Health Care Provider or Department approved equivalent. BLS/CPR training shall not be applied toward the twenty four (24) hours of required continuing education training for paramedics;

(D) Complete biennial certification requirements for Advanced Cardiac Life Support (ACLS), in accordance with the American Heart Association. If a structured ACLS course is not available, the medical control may affirm, in writing, that ACLS skills and knowledge has been demonstrated;

(E) Complete a skills review and maintenance verification for EMT P by medical control, and;

(F) Complete the Department renewal application with all required documentation and fee.

(b) Emergency medical technicians shall declare and provide documents on any felony conviction since their last issuance of a license. Denial of renewal, may be made upon any basis consistent with the provisions contained within Paragraph 310:641-5-11(6).

(c) The fee for renewal is ten (\$10.00) dollars for EMT B, fifteen (\$15.00) for EMT I, and twenty (\$20.00) for EMT P. Concurrent national registration is not included within the Oklahoma emergency medical technician renewal. Fees shall be in an acceptable form made payable to the Oklahoma State Department of Health —Emergency Medical Services Division (OSDH/EMS).

(d) Successful retests of the National Registry exam shall suffice for re licensure requirements at all levels.

(e) An applicant may request a review of adverse decisions, made within this section, by applying in writing within thirty (30) calendar days after the notice of rejection. Review, by the Department, shall be held in accordance with the Administrative Procedures Act, otherwise the decision shall be considered final to both parties.

310:641-5-14.1. Renewal requirements for non-NREMT certified licensees.

(a) Requirements for renewal of Oklahoma EMT licenses for non-NREMT certified personnel include current and continuous certification in basic life support (BLS), specified

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hours of continuing education, refresher training, and continued skill competency. In the case of EMT-I and EMT-P, skill competency shall be verified by a physician, and for EMT-P, advanced cardiac life support (ACLS) shall be documented.

- (1) The EMT-B renewal requires the licensee to:
 - (A) Complete a basic refresher course adhering to Department standards. Ten (10) hours of the refresher may be completed through distributive education as defined at OAC 310:641-3-2.
 - (B) Complete at least forty eight (48) hours of Department approved continuing education training. Twenty-four (24) hours of continuing education may be obtained through distributive education as defined in OAC 310:641-3-2. The maximum number of hours allowed for any one topic is twelve (12) hours. Department pre-approved continuing education includes any subject covered in the National Standard EMT Basic course, and the following topics -- pneumatic trousers, shock management, communications, hypothermia and other environmental injuries, air ambulance emergency care, child abuse, sexual assault, industrial accidents, explosion injuries, electrical hazards, neonatal care/SIDS, domestic violence, crime scene response, athletic injuries, rappelling, hazardous materials, crisis intervention, protective breathing apparatus, farm machinery extrication, medical terminology, radioactive materials, medico-legal aspects, and special rescue (diving, aerial, mountain). Bio-terrorism, EMS Geriatrics, ACLS, PALS, PPC, and Pediatric Education for the Prehospital Professional (PEPP) or any other State approved courses will be allowed the number of hours specified on the course completion certificate up to 16 hours unless otherwise approved by the Department. Successful completion of the following National Standard courses-- PHTLS (16hrs), BTLS (16hrs), Auto Extrication (16hrs), Emergency Driving (12hrs), and/or Dispatcher Training (12hrs)--with the specified number of hours shown above may be applied to Continuing Education. These topics may be presented utilizing critiques, didactic sessions, practical drills, workshops, seminars, or other approved in-service training sessions. Any topic which is not specified above shall require prior written approval from the Division. Successful completion of a Department approved Paramedic or Intermediate course shall fulfill the refresher and all continuing education requirements for the EMT Basic;
 - (C) Maintain basic life support (BLS) certification for health care providers, current through March 31 of licensure expiration. The BLS course shall adhere to the current standards of the American Heart Association CPR for the Health Care Provider, the American Red Cross CPR for the Professional Rescuer, the National Safety Council CPR for the Health Care Provider, or Department approved equivalent. BLS/CPR training shall not be applied toward the

forty-eight (48) hours of required continuing education training for Basic EMT's.

- (D) Complete the Department renewal application with all required documentation and fee.
- (2) The EMT-I renewal requires the licensee to:
 - (A) Complete an intermediate refresher course adhering to Department standards. Ten (10) hours of the refresher may be completed through distributive education as defined in OAC 310:641-3-2. Refresher course modules met by successfully completing ACLS (initial course), ATLS, PHTLS, BTLS, PALS, or PEPP courses disqualify these courses from being applied to continuing education hours.
 - (B) Complete at least thirty six (36) hours of Department approved continuing education training. Eighteen (18) hours of continuing education may be obtained through distributive education as defined at OAC 310:641-3-2. The maximum number of hours allowed for any one topic is twelve (12) hours. Department pre-approved continuing education includes any subject covered in the National Standard EMT Basic, EMT Intermediate, and/or EMT Paramedic course, and the following topics: -- air ambulance emergency care, sexual assault, industrial accidents, explosion injuries, electrical hazards, crime scene response, communications, athletic injuries, rappelling, hazardous materials, crisis intervention, domestic violence, protective breathing apparatus, farm machinery extrication, medical terminology, radioactive materials, and special rescue (diving, aerial, mountain). Bio-terrorism, EMS Geriatrics, ACLS, PALS, PPC, and Pediatric Education for the Prehospital Provider (PEPP) or any other State approved courses will be allowed the number of hours specified on the course completion certificate up to 16 hours unless otherwise approved by the Department. Successful completion of the following National Standard courses-- PHTLS (16hrs), BTLS (16hrs), Auto Extrication (16hrs), Emergency Driving (12hrs), and/or Dispatcher Training (12hrs)--with the specified number of hours shown above may be applied to Continuing Education. These topics may be presented utilizing critiques, didactic sessions, practical drills, workshops, seminars, or other approved inservice training sessions. Any topic which is not specified above shall require prior written approval from the Division. Successful completion of a Department approved Paramedic course shall fulfill the refresher and all continuing education requirements for the EMT Intermediate;
 - (C) Maintain basic life support (BLS) certification for health care providers, current through March 31 of licensure expiration. The BLS course shall adhere to the current standards of the American Heart Association CPR for the Health Care Provider, the American Red Cross CPR for the Professional Rescuer, the National Safety Council CPR for the Health Care Provider or Department approved equivalent.

BLS/CPR training shall not be applied toward the thirty-six (36) hours of required continuing education training for Intermediate EMT's;

(D) Complete a skills review and maintenance verification for EMT-I by medical control, and;

(E) Complete the Department renewal application with all required documentation and fee.

(3) The EMT-P renewal requires the licensee to:

(A) Complete a paramedic refresher course adhering to Department standards. Ten (10) hours of the refresher may be completed through distributive education as defined at OAC 310:641-3-2. Refresher course modules met by successfully completing ACLS (initial course), AMLS, PHTLS, or BTLS, PALS, or PEPP. Use of these courses disqualify these courses from being applied to continuing education hours.

(B) Complete at least twenty four (24) hours of Department approved continuing education training. Twelve (12) hours of continuing education may be obtained through distributive education as defined at 310:641-3-2. The maximum number of hours allowed for any one topic is twelve (12) hours. Department pre-approved continuing education includes any subject covered in the National Standard EMT Paramedic course, and the following topics: -- air ambulance emergency care, sexual assault, industrial accidents, explosion injuries, electrical hazards, crime scene response, athletic injuries, hazardous materials, crisis intervention, domestic violence, hypothermia and other environmental injuries, protective breathing apparatus, farm machinery extrication, medico-legal aspects, radioactive materials, and special rescue (diving, aerial, mountain). Bio-terrorism, EMS Geriatrics, PALS, PPC, and Pediatric Education for the Prehospital Professional (PEPP) or any other State approved courses will be allowed the number of hours specified on the course completion certificate up to 16 hours unless otherwise approved by the Department. Successful completion of the following National Standard courses-- PHTLS (16hrs), BTLS (16hrs), Auto Extrication (16hrs), Emergency Driving (12hrs), PALS (16 hrs.) and/or Dispatcher Training (12hrs)-- with the specified number of hours shown above may be applied to Continuing Education. These topics may be presented utilizing critiques, didactic sessions, practical drills, workshops, seminars, or other approved inservice training sessions. Any topic which is not specified above shall require prior written approval from the Division;

(C) Maintain basic life support (BLS) certification for health care providers, current through March 31 of licensure expiration. The BLS course shall adhere to the current standards of the American Heart Association CPR for the Health Care Provider, the American Red Cross CPR for the Professional Rescuer, the National Safety Council CPR for the Health

Care Provider or Department approved equivalent. BLS/CPR training shall not be applied toward the twenty-four (24) hours of required continuing education training for paramedics;

(D) Complete biennial certification requirements for Advanced Cardiac Life Support (ACLS), in accordance with the American Heart Association. If a structured ACLS course is not available, the medical control may affirm, in writing, that ACLS skills and knowledge has been demonstrated;

(E) Complete a skills review and maintenance verification for EMT-P by medical control, and;

(F) Complete the Department renewal application with all required documentation and fee.

(b) Emergency medical technicians shall declare and provide documents on any felony conviction since their last issuance of a license. Denial of renewal, may be made upon any basis consistent with the provisions contained within Paragraph 310:641-5-11(4).

(c) Applicants for renewal must be in good standing with the Oklahoma Tax Commission as required in Oklahoma State Statute §68-238.1, Notification of a "Tax Hold" problem will be mailed to the address of record. It is the sole responsibility of the licensee to resolve a "Tax Hold".

(d) A license renewal may be denied on the basis of falsification found on the application or any documentation. Any application for license renewal submitted by an applicant pursuant to the Act, shall constitute authorization for an inspection or investigation by the Department.

(e) An applicant may request a review of adverse decisions, made within this section, by applying in writing within thirty (30) calendar days after the notice of rejection. Review, by the Department, shall be held in accordance with the Administrative Procedures Act, otherwise the decision shall be considered final to both parties.

310:641-5-15. Expired license

Any person who fails to renew his Oklahoma emergency medical technician license within the time frame and other requirements as specified in Section 310:641-5-14 or 310:641-5-14.1, shall be considered an expired or lapsed licensee, and therefore no longer licensed as an emergency medical technician in the State of Oklahoma. Applications for renewal shall be postmarked no later than midnight March 31st of the respective license year of expiration. Hardships and unforeseen circumstances to the process deadline may be submitted in writing to the Department for an exception, ~~but in no case shall an Oklahoma emergency medical technician license be renewed which has been expired more than ninety (90) calendar days. Extensions may only be granted by the EMS Director in writing for a period not to exceed ninety (90) days after June 30th. (For reinstatement see 310:641-5-17 Lapsed License).~~

310:641-5-17. Lapsed licenses

To reinstate an emergency medical technician license which has expired, lapsed, or which has not been renewed,

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an individual shall comply with the requirements of 310:641-5-11, accomplish one of the following:

- ~~(1) If the expiration date is within a two (2) year period, the person shall successfully complete a Department approved USDOT / NHTSA national standard emergency medical technician refresher course, submit an initial application, appropriate fee, and successfully complete the Department approved written and practical examinations, respective to the level of training and original license, or;~~
- ~~(2) If the expiration date is beyond a two (2) year period, the person shall successfully complete a Department approved USDOT / NHTSA national standard emergency medical technician training course, submit an initial application, appropriate fee, and successfully complete the Department approved written and practical examinations, respective to the level of training and original license.~~
- ~~(3) Emergency medical technician paramedic if previously certified by the national registry may apply for re entry. Re entry will be conducted by, and consistent with the standards of, the National Registry of Emergency Medical Technicians.~~

PART 5. INSTRUCTOR QUALIFICATIONS PROCEDURES AUTHORIZED

310:641-5-30. Standard of care

- (a) A licensed emergency medical technician basic (EMT-B) may perform to the following level or standard of care;
 - (1) Patient assessment, including the determination of vital signs, diagnostic signs, and triage;
 - (2) Bandaging, splinting, and the control of hemorrhage;
 - (3) Treatment of shock, including the use of pneumatic anti-shock trousers (PASG);
 - (4) Cardiopulmonary resuscitation (CPR) and the use of only adjunctive airway devices and the use of a semi-automated external defibrillator (SAED);
 - (5) The maintenance of intravenous fluids, without medications and/or drugs added;
 - (6) Rescue and extrication procedures;
 - (7) Assistance of patient prescribed medications, including sublingual nitroglycerin, epinephrine auto injector and hand held aerosol inhalers;
 - (8) Administration of agency supplied oral glucose, activated charcoal, aspirin, agency supplied epinephrine auto injector, and albuterol or approved substitute per medical direction;
 - (9) All other emergency medical care skills and measures included in the standard United States Department of Transportation basic emergency medical technician training curriculum which are not specifically listed above, and;
 - (10) Upon the approval of the Department, and recommendation of the Council, additional skills may be authorized upon the written request of a local medical

director. Authorized skills for the EMT-B may be reduced or limited by medical direction.

- (b) A licensed emergency medical technician intermediate (EMT-I) may perform to the following level or standard of care;
 - (1) All skills listed in Subsection 310:641-5-30(a) for the EMT-B;
 - (2) Establishment of vascular or interosseous access for the administration of intravenous fluids, without medications and/or drugs added;
 - (3) Administration of medications per medical direction and approved by the Department;
 - (4) Venipuncture to obtain blood samples;
 - (5) The use and placement of definitive airway adjuncts for adults, children and infants;
 - (6) Upon the approval of the Department, and recommendation of the Council, additional skills may be authorized upon the written request of a local medical director.
- (c) A licensed emergency medical technician paramedic (EMT-P) may perform to the following level or standard of care;
 - (1) All skills listed in Subsection 310:641-5-30(a), for the EMT-B and Subsection 310:641-5-30(b), for the EMT-I;
 - (2) The recognition, interpretation, treatment of cardiac arrhythmias using a cardiac monitor/defibrillator/external pacemaker;
 - (3) The advanced management of pediatric emergencies, including resuscitation, advanced airway placement, and administration of pediatric medication;
 - (4) The advanced management of obstetric and gynecologic emergencies, including medication administration;
 - (5) Advanced intervention of psychiatric patients, including medication administration;
 - (6) All other emergency medical care skills and measures included in the standard United States Department of Transportation paramedic emergency medical technician training curriculum, which are not specifically listed above, and;
 - (7) Upon the approval of the Department, and recommendation of the Council, additional skills may be authorized upon the written request of a medical director.

SUBCHAPTER 7. TRAINING PROGRAMS

PART 3. TRAINING PROGRAMS

310:641-7-10. Training programs

- (a) All training programs shall be in compliance with the requirements of this Subchapter.
- (b) Each training program shall submit to the Department an application for approval to conduct emergency medical services training. The application shall be on forms provided by

the Department. Training programs must be currently certified to teach EMS in Oklahoma before beginning courses.

(c) Training programs approved for training may include colleges, universities, junior colleges, technology centers, or other institutions acceptable to the Department.

(d) An institution may apply for certification as a Basic EMT program, an Intermediate EMT Program or a Paramedic program or a combination of any of these levels. Intermediate EMT and Paramedic are considered "advanced level" programs. A separate certificate will be issued for each training level. Training approval at any level includes approval for lower-level courses such as Emergency Medical Responder and corresponding refreshers.

(e) Application for new advanced level programs require the following:

(1) Completion of a full basic certification period of two (2) years, of which at least three (3) full basic courses are instructed.

(2) Student average first time pass rate of 50% on the National Registry examination.

(f) Training programs shall use Department approved curricula for all approved courses of instruction.

(g) An application for certification as a training program constitutes agreement to participate in a Department quality assurance program.

(h) Records shall be available for inspection by Department representatives during normal working hours.

310:641-7-13. Training program responsibilities

(a) Each training program sponsoring emergency medical services training shall be responsible for course completion, respond to student complaints, and resolve student grievances.

(b) Each training program conducting emergency medical services training shall use the United States Department of Transportation, National Highway Traffic Safety Administration (USDOT, NHTSA) curricula and curricula supplements as adopted by the Department. Each training program which desires to use a curriculum not approved by the Department shall submit the curriculum to the Department for approval prior to use in any course.

(c) Each training program is responsible for quality assurance of its training, and shall disseminate all Department training updates to the students and instructors.

(d) Each training program shall inspect and verify that each class facility used for any course at any locations is adequate for instructional purposes prior to scheduling a course at the location.

(e) Each training program shall ensure that all Department required equipment is in good, safe and operational condition. Sufficient quantities shall be made available for each course conducted. Equipment for Basic EMT, and Intermediate EMT courses must be dedicated for training purposes. Equipment for Paramedic courses must be owned by the training program. Equipment shall be available for inspection by Department representatives at any time during a regularly scheduled class.

(f) Each training program shall ensure that an instructor/student ratio of 1:10 is maintained during all practical classroom lab activities.

(g) Each training program shall ensure that a qualified preceptor supervises each student during scheduled clinical experiences.

(h) Each training program shall issue a course completion certificate and/or course transcript, including the course authorization number, to each student successfully completing an approved course.

(i) Each training program shall assist all of their students eligible for National Registration with the completion of all required applications.

(j) Each training program shall administer a final written and practical examination for each course, and provide National Registry of EMT's practical examinations for both first emergency medical responder and basic courses after course completion.

(k) The training program shall require instructors to follow the Department approved course syllabus, use lesson plans and provide instruction for all course objectives.

(l) For all courses which require a practical examination, as specified in OAC 310:641-5-11(9), the training program shall follow the National Registry Practical Examination Standards.

(m) Records for each course offered shall be maintained by the training program for at least three (3) years. Records shall include at a minimum attendance records, clinical experience summaries, student evaluations, student grades, a record of lab assistants and their documentation of qualifications, and skill sheets for both course and national registry practical examinations. National registry practical examination skill sheets are required for first emergency medical responder and basic courses only.

310:641-7-15. Course approval

(a) Each training program shall submit a written course application to the Department on forms provided by the Department. The application shall be submitted at least thirty (30) days prior to the course start date and shall include, but not be limited to:

(1) Course information including type of course, location, start and end date, class session days and times, course coordinator, and instructors, final practical examination date, and time and location;

(2) Course outline including date and time, topic, curriculum division and section number, instructor and location if different than those listed on the application for each class session;

(3) A list of locations and site coordinator for each location, if multiple locations via distance learning technology are used; and

(4) The Department may approve course requests submitted that do not meet the requirements of OAC 310:641-7-15(a) if non-approval would be detrimental to the interest of the public health and safety.

(b) A course application submitted by a training program in good standing which meets all course requirements will be issued a course authorization number by the Department.

(c) Courses must be instructed by Department approved emergency medical services instructors. Persons other than certified emergency medical services instructors recognized as

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experts in a specific area may instruct in an emergency medical services course with prior approval from the Department. The content and effectiveness of the presentation remain the responsibility of the training program and primary emergency medical services instructor.

(d) For each course conducted by a training program rosters reflecting the students participating in a given course shall be submitted to the Department under the following guidelines:

(1) An initial student roster within twenty-one (21) calendar days of the course start date; Amendments to the initial student roster may be made after the twenty-one (21) day requirement only with Department approval. In no case will a student be accepted on a final student roster that does not appear on an initial student roster for that course.

(2) A final student roster within twenty-one (21) calendar days of the course end date. This roster shall identify students who have successfully completed all course requirements, withdrawn from the course, failed the course, or whose class work was incomplete;

(3) Amendments to the final student roster for incomplete course objectives may be made after the twenty-one (21) day requirement only with Department approval. In no case will an amended final student roster be accepted after ninety (90) calendar days of the course ending date. A request for Department approval shall include a description of the circumstances requiring additional time. In exceptional circumstances, an amended roster may be submitted within forty five (45) days of the original filing deadline, provided that the amendment be accompanied by the following:

~~(A) A written request for approval by the Training Institution EMS Coordinator;~~

~~(B) A statement describing the exigency or exceptional circumstance that necessitated the amendment; and;~~

~~(C) A change to a written request for additional extension may be submitted on forms provided by the Department.~~

~~(D) In cases of an amendment to a final roster, evidence that any added students have satisfactorily fulfilled and completed all of the course content and requirements.~~

(e) The Department may conduct quality management visits to any training program. Visits may include, but not be limited to class visits, instructor evaluations, student surveys, review of required records, and visits to clinical experience sites.

(f) The Department may invalidate all or any portion of a course conducted where a violation of the Act or rules has been substantiated.

[OAR Docket #09-801; filed 4-29-09]

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 664. HOME CARE ADMINISTRATOR CERTIFICATION

[OAR Docket #09-802]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Initial Certificate Process

310:664-3-3 [AMENDED]

310:664-3-5 [AMENDED]

310:664-3-6 [AMENDED]

Subchapter 5. Preparedness Program

310:664-5-2 [AMENDED]

Subchapter 11. Renewal of Certification

310:664-11-1 [AMENDED]

310:664-11-3 [NEW]

AUTHORITY:

Oklahoma State Board of Health; 63 O.S. Section 1-104, 63 O.S. 1-106.1, and 63 O.S. Section 1-1962a

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"n/a"

INCORPORATION BY REFERENCE:

"n/a"

ANALYSIS:

310:664-3-3, certificate by completion of the OHCAPA (Oklahoma Home Care Administrator Preparedness Assessment), this rule sets forth the requirements and fee for applying for an initial certificate as a Home Care Administrator. 310:664-3-5, deeming application process, this rule sets forth the requirements and fee for applying for deemed status on the Home Care Administrator registry. 310:664-3-6, provisional certificate, this rule sets forth the requirements and fee for applying for provisional status on the Home Care Administrator registry. 310:664-5-2, approved programs, this rule sets forth the approval process and fee for a Home Care Administrator preparedness program. 310:664-11-1, certification renewal process, this rule sets forth the renewal process and fee for a Home Care Administrator certificate. 310:664-11-3, re-issuance of certificate, this new rule sets forth the process and fee to obtain a duplicate or amended Home Care Administrator certificate. This proposal amends the fees in each of the sections listed to reflect the costs of processing the application. 310:664-11-3, re-issuance of certificate, this new rule sets forth the process and fee to obtain a duplicate or amended Home Care Administrator certificate. These changes are necessary because the current fees do not reflect agency costs. The effect of the Rule change will be to have fees commensurate with the cost of providing the service and having the regulated profession pay for a greater portion of their costs of regulation thereby reducing the re-allocation of funds from other public health services.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 3. INITIAL CERTIFICATE PROCESS

310:664-3-3. Certificate by completion of the OHCAPA

An individual who has successfully completed the Department-approved preparedness program and the OHCAPA or who is otherwise deemed to meet the preparedness program standards and passed the OHCAPA may apply for a home care administrator certificate. An individual shall apply for an initial home care administrator certificate within six (6) months after passing the OHCAPA. Failure to submit an application during the required time frame will result in the individual having to meet the deeming criteria and repeating the OHCAPA. The individual shall apply on the Department form. The application shall include, but not be limited to, the following information:

- (1) Name, complete home mailing address, and telephone number, of the applicant;
- (2) A copy of the results of a criminal arrest check conducted by the OSBI completed within sixty (60) days prior to the date of the application;
- (3) Evidence of successful completion of the OHCAPA; and
- (4) A non-refundable fee of fifteen one hundred forty dollars ~~(\$15.00)~~ ~~(\$140)~~ per month from the date of application until July 31.

310:664-3-5. Deeming application process

(a) An individual who desires to apply for deemed status shall apply on the Department form which shall include, but not be limited to, the following:

- (1) Name, complete home mailing address, and telephone number of the applicant;
- (2) Copies of credentials which provide evidence of meeting any of the criteria specified in 310:664-3-4; and
- (3) A non-refundable fee of fifty eighty dollars ~~(\$50.00)~~ ~~(\$80.00)~~.

(b) The Department shall notify the individual of the decision to approve or disapprove the application within ninety (90) days.

310:664-3-6. Provisional certificate

(a) An individual may function as an administrator no longer than six (6) months with a provisional certificate, provided that

one (1) of the deeming criteria as specified in OAC 310:664-3-4 has been acknowledged by the Department.

(b) An individual shall apply on the Department form which shall include, but not be limited to, the following:

- (1) Name, complete home mailing address, and telephone number;
- (2) The name and address of the agency where employed;
- (3) A copy of written authorization by the administrator or member of the governing board allowing the individual to temporarily function as the administrator;
- (4) Evidence of meeting the deeming criteria specified in OAC 310:664-3-4;
- (5) A one (1) time, non-refundable fee of one hundred eighty dollars ~~(\$100.00)~~ ~~(\$80.00)~~; and
- (6) A copy of the results of a criminal arrest check conducted by the OSBI within sixty (60) days prior to submission of the application.

(c) The Department shall notify the applicant of its decision within thirty (30) days from receipt of the application.

(d) Any individual that alters any administrator certificate or allows alteration of any administrator certificate shall be denied a home care administrator certificate upon application.

SUBCHAPTER 5. PREPAREDNESS PROGRAM

310:664-5-2. Approved programs

(a) The Department shall approve a preparedness program that meets the requirements specified in this Chapter.

(b) An institution seeking approval shall apply on the Department form and submit the application fee of fifty one hundred twenty five dollars ~~(\$50.00)~~ ~~(\$125.00)~~ to the Department.

(c) The Department shall review, approve, or disapprove a preparedness program and notify the applicant of its action within ninety (90) days.

(d) An approved preparedness program shall allow a Department proctor or representative to make unannounced visits to review the program.

SUBCHAPTER 11. RENEWAL OF CERTIFICATION

310:664-11-1. Certification renewal process

(a) A home care administrator is responsible for filing for certificate renewal before the expiration date.

(b) Each certificate shall expire on each July 31 following its issuance.

(c) Failure to renew by October 31st shall result in presumed non

renewal of certificate and the individual shall not provide services as a home care administrator until and unless the individual files an application and meets requirements for renewal as follows.

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- (1) If the individual applies within one year after expiration of the certificate, the individual shall provide proof of successful completion of twelve (12) hours of continuing education completed prior to the expired year;
 - (2) If the individual applies within two years after expiration of the certificate, the individual shall provide proof of successful completion of 12 hours of continuing education for the previous expired year and an additional twelve (12) hours of continuing education for the current year in which renewal is requested;
 - (3) If the individual applies more than two years but not more than five years after expiration of the certificate, the individual shall be required to pass the OHCAPA; and
 - (4) If the individual applies more than five years after expiration of the certificate, the individual must successfully complete a preparedness program and the OHCAPA to be reinstated.
- (d) The renewal application shall include, but not be limited to, the following:
- (1) Documentation of the continuing education as specified in OAC 310:664-9-4;
 - (2) Renewal fee of fifty-five dollars (~~(\$50.00)~~—~~(\$55.00)~~) payable to the Department;
 - (3) Disclosure of any felony conviction since the previous application for certification or renewal;
 - (4) If the renewal is filed on or after August 31 and on or before September 30, a penalty of twenty-five dollars (\$25.00) payable to the Department; and
 - (5) If the renewal is filed on or after October 1 and before October 31, a penalty of fifty dollars (\$50.00) payable to the Department. An applicant shall submit \$50.00 each year up to \$100.00 for failing to renew within a two (2) year time frame as addressed at OAC 310:664-11-1(1) and (2).

310:664-11-3. Re-issuance of certificate

An individual may request a duplicate or amended certificate by submitting a written request with applicable supporting documentation and a nonrefundable fifteen dollar (\$15.00) fee.

[OAR Docket #09-802; filed 4-29-09]

TITLE 360. OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #09-847]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions
360:1-1-2. [AMENDED]
360:1-1-3. [AMENDED]
Subchapter 3. The Board
360:1-3-8. [AMENDED]
360:1-3-13. [NEW]

Subchapter 5. Hearing Procedures
360:1-5-2. [AMENDED]

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None

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n/a

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Changes to Chapter 1 clarify definitions, conform rules to recent benefit changes, clarify language, and clarify existing plan exclusions.

CONTACT PERSON:

Gary Goff, Attorney, Assistant Administrator, (405) 717-8744

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JANUARY 1, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

360:1-1-2. Rules, cumulative

The Oklahoma State and Education Employees Group Insurance Board hereinafter "OSEGIB" will, from time to time, adopt handbooks, policies and procedures for the implementation of the rules set forth herein. Nothing in this chapter shall be read, interpreted, understood or applied so as to affect the validity and enforceability of any additional requirements, statutes, rules or regulations of any other governmental entity, public agency or instrumentality which may be otherwise applicable to those transactions, conduct and facilities regulated herein. The rules in this title shall not be deemed cumulative and supplemental but shall replace all previously promulgated rules of this agency.

360:1-1-3. Amending of rules

This chapter may be amended or repealed from time to time and new ~~rules~~ Rules adopted by the Board pursuant to the Administrative Procedures Act.

SUBCHAPTER 3. THE BOARD

360:1-3-8. Confidentiality of medical records

(a) All information, documents, medical reports and copies thereof contained in a member's insurance file held by OS-EEGIB shall be confidential and shall not be reviewed by unauthorized parties, without written permission of the individual or provider, or by court order. The confidentiality of a member's information is maintained when the member's information held by OSEEGIB is utilized for health management and communicated among:

- (1) employees of OSEEGIB;
- (2) OSEEGIB's contracted third party administrators and consultants;
- (3) providers to the member and
- (4) the member, according to statutory provisions for privilege and confidentiality or written agreements to protect the confidentiality and non-disclosure of the information.

(b) OSEEGIB will honor only medical ~~releases~~ Authorizations signed by a covered employee or dependent within ~~one hundred eighty [180] days~~ one [1] year of the date the ~~release~~ Authorization was signed, unless rescinded or a shorter period of time has been specified.

(bc) A member's health information is protected by this rule and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations as codified in 45 Code of Federal Regulations Parts 160 and 164.

360:1-3-13. Electronic records and facsimile, electronic or copies of signatures

Use of electronic records, electronic signatures, facsimile signatures and handwritten signatures executed to electronic records.

(1) Electronic records, electronic signatures, handwritten signatures executed to sign electronic records, handwritten signatures used to effectuate an electronic record for network contracting purposes, and facsimile or copies of signatures on OSEEGIB forms received from participating entities or members, may be used as an alternative or duplicate of paper records and handwritten signatures executed on paper to comply with any of the record and signature requirements of 12A O.S. §15-101 et seq. these rules or applicable Oklahoma law.

(2) Combinations of paper records and electronic records, electronic records and handwritten signatures executed on paper, or paper records and electronic signatures or handwritten signatures executed to sign electronic records, may be used to comply with any of the record and signature requirements of 12A O.S. §15-101 et seq. these rules or applicable Oklahoma law.

(3) The acting OSEEGIB Administrator or a Deputy Administrator may utilize a facsimile signature stamp to execute OSEEGIB contracts of any kind.

SUBCHAPTER 5. HEARING PROCEDURES

360:1-5-2. Notice of hearing

Upon receipt of a Request for Hearing form, a hearing number shall be assigned thereto and notice shall be forwarded to the claims administration contractor by mail at its closest office. The employee shall be notified of the hearing date by certified mail, return receipt requested. A copy of all ~~Rules~~ rules pertinent to the hearing shall be forwarded with the Notice, along with a statement of claimant's rights and the basis for denial.

[OAR Docket #09-847; filed 5-6-09]

**TITLE 360. OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD
CHAPTER 10. STATE AND EDUCATION EMPLOYEES HEALTH, DENTAL, VISION AND LIFE PLANS**

[OAR Docket #09-849]

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- Subchapter 1. General Provisions
- 360:10-1-2. [AMENDED]
- Subchapter 3. Administration of Plans
- 360:10-3-3.5. [AMENDED]
- 360:10-3-24.1 [AMENDED]
- 360:10-3-25. [AMENDED]
- Subchapter 5. Coverage and Limitations
- Part 3. The Plans
- 360:10-5-16. [AMENDED]
- 360:10-5-20. [AMENDED]
- Part 5. Life Benefits
- 360:10-5-34. [AMENDED]
- Part 15. Subrogation
- 360:10-5-100. [AMENDED]
- Subchapter 9. COBRA Health Insurance Continuation
- 360:10-9-1. [AMENDED]
- 360:10-9-2 [AMENDED]

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Permanent Final Adoptions

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n/a

ANALYSIS:

Changes to Chapter 10 clarify definitions, conform rules to recent benefit changes, clarify language, and clarify existing plan exclusions.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JANUARY 1, 2010:

360:10-1-2. Definitions

The following words and terms as defined by OSEEGIB, when used in this chapter, shall have the following meaning, unless the content clearly indicates otherwise:

"Current employee" means an employee in the service of a participating entity who receives compensation for services actually rendered and is listed on the payrolls and personnel records of said employer, as a current and present employee, including employees who are otherwise eligible who are on approved leave without pay, not to exceed twenty-four [24] months. An education employee absent from employment, not to exceed eight [8] years, because of election or appointment as local, state, or national education association officer who is otherwise eligible prior to taking approved leave without pay will be considered an eligible, current employee. A person elected by popular vote will be considered an eligible employee during his tenure of office. Eligible employees are defined by statute. [74 O.S. §1303 and §1315]

"Administrative error" occurs when the coverage elections the member makes are not the same as those entered into payroll for deduction from the member's paycheck. This does not include untimely member coverage elections or member misrepresentation. When such an administrative error results in underpaid premiums, full payment to OSEEGIB shall be required before coverage elected by the member can be made effective. If overpayment occurs, OSEEGIB shall refund overpaid funds to the appropriate party.

"Administrator" means the Administrator of the Oklahoma State and Education Employees Group Insurance Program or his designee.

"Allowable fee" means the maximum allowed amount that OSEEGIB may pay to a provider for a specific procedure, service or supply based on the HealthChoice Network Provider Contracts payable to a provider by OSEEGIB and the member for covered services.

"Attorney representing OSEEGIB" means any attorney designated by the Administrator to appear on behalf of OSEEGIB.

"The Board" means the eight [8] members designated by statute [74 O.S. §1303(1)].

"Business Associate" shall have the meaning given to "Business Associate" under the Health Insurance Portability and Accountability Act of 1996, Privacy Rule, including, but not limited to, 45 CFR §160.103.

"Carrier" means the State of Oklahoma.

"Comprehensive benefits" means benefits which reimburse the expense of facility room and board, other hospital services, certain out-patient expenses, maternity benefits, surgical expense, including obstetrical care, in-hospital medical care expense, diagnostic radiological and laboratory benefits, providers' services provided by house and office calls, treatments administered in providers' office, prescription drugs, psychiatric services, Christian Science practitioners' services, Christian Science nurses' services, optometric medical services for injury or illness of the eye, home health care, home nursing service, hospice care and such other benefits as may be determined by OSEEGIB. Such benefits shall be provided on a copayment or coinsurance basis, the insured to pay a proportion of the cost of such benefits, and may be subject to a deductible that applies to all or part of the benefits as determined by OSEEGIB. [74 O.S. §1303 (14)]

"Cosmetic procedure" means a procedure that primarily serves to improve appearance.

"Current employee" means an employee in the service of a participating entity who receives compensation for services actually rendered and is listed on the payrolls and personnel records of said employer, as a current and present employee, including employees who are otherwise eligible who are on approved leave without pay, not to exceed twenty-four [24] months. An education employee absent from employment, not to exceed eight [8] years, because of election or appointment as local, state, or national education association officer who is otherwise eligible prior to taking approved leave without pay will be considered an eligible, current employee. A person elected by popular vote will be considered an eligible employee during his tenure of office. Eligible employees are defined by statute. [74 O.S. §1303 and §1315]

"Custodial care" means treatment or services regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled. These services are designed mainly to help the patient with daily living activities. These activities include but are not limited to: personal care as in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing, using toilet, preparing meals or special diets, moving the patient, acting as companion or sitter, and supervising medication which can usually be self-administered.

"Dependent" means the primary member's spouse (if not legally separated by court order), including common-law. Dependents also include a member's unmarried child up to the child's ~~twenty third~~ [23rd] ~~twenty-fifth~~ [25th] birthday, regardless of residence, provided that the primary member is primarily responsible for the child's support. This includes a stepchild or child who lives with the member in a regular parent-child relationship, or a child living with the member in a normal parent-child relationship where the member has adopted the child, or has been appointed guardian by a court. It also includes a stepchild who does not live with the member, when the primary member's spouse is covered by the Plan and has been ordered by a court to provide health insurance for his/her children, regardless of residence. A child may also be covered regardless of age if the child is incapable of self-support because of mental or physical incapacity that existed prior

to reaching age ~~twenty-three [23]~~twenty-five [25]. Coverage is not automatic and must be approved with a review of medical information. A disabled dependent deemed disabled by Social Security does not automatically mean that this disabled dependent will meet the Plan requirements. [74 O.S. §1303(13)]. See additional eligibility criteria for disabled dependents over the age of twenty-five [25] at 360:10-3-24.1.

"Durable medical equipment" means medically necessary equipment, prescribed by a provider, which serves a therapeutic purpose in the treatment of an illness or an injury. Durable medical equipment is for the exclusive use of the afflicted member and is designed for prolonged use. Specific criteria and limitations apply.

"Emergency" means a sudden and unexpected symptom that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual or others in serious jeopardy.

"Enrollment period" means the time period in which an individual may make an election of coverage or changes to coverage in effect.

"Facility" means any hospital, rehabilitation facility, skilled nursing facility, midwifery center, ambulatory surgical center, home health agency, infusion therapy entity, hospice program, durable medical equipment vendor, radiology facility, dialysis facility, or laboratory which is duly licensed under the laws of the state of operation, Medicare certified as applicable, and accredited by a nationally recognized accreditation organization that is approved by state or federal guidelines, for example, The Joint Commission (formerly JCAHO) or The Commission on Accreditation of Rehabilitation Facilities (CARF).

"Fee schedule" means a listing of one or more allowable fees.

"Former participating employees and dependents" means eligible former employees who have elected benefits within thirty [30] days of termination of service and includes those who have retired, or vested through an eligible State of Oklahoma retirement system, or who have completed the statutory required years of service, or who have other coverage rights through Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Oklahoma Personnel Act. An eligible dependent is covered through the participating former employee or the dependent is eligible as a survivor or has coverage rights through COBRA.

~~**"The Plan or Plans"** means the self-insured Plans by the State of Oklahoma for the purpose of providing health benefits to eligible members and may include such other benefits as may be determined by OSEEGIB. Such benefits shall be provided on a coinsurance basis and the insured pays a proportion of the cost of such benefits.~~

"Health information" means any information, whether oral or recorded in any form or medium: (1) that relates to the past, present or future physical or mental condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and (2) that identifies the member or with respect to

which there is a reasonable basis to believe the information can be used to identify the member.

"Home health care" means a plan of continued care of an insured person who is under the care of a provider who certifies that without the Home health care, confinement in a hospital or skilled nursing facility would be required. Specific criteria and limitations apply.

"Hospice care" means a concept of supportive care for terminally ill patients. Treatment focuses on the relief of pain and suffering associated with a terminal illness. Specific criteria and limitations apply.

"Initial enrollment period" means the first thirty [30] days following the employee's entry-on-duty date. A group initial enrollment period is defined as the thirty [30] days following the enrollment date of the participating entity.

"Insurance Coordinator" means Insurance/Benefits Coordinator for Education, Local Government, and State Employees.

"Maintenance care" means there is no measurable progress of goals achieved, no skilled care required, no measurable improvement in daily function or self-care, or no change in basic treatment or outcome.

"Medically necessary" means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health/substance abuse condition and complies with criteria adopted by OSEEGIB. Direct care and treatment are within standards of good medical practice within the community, and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. The services or supplies must be the most appropriate supply or level of service, which can safely be provided. For hospital stays, this means that inpatient acute care is necessary due to the intensity of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The services or supplies cannot be primarily for the convenience of the member, caregiver, or provider. The fact that services or supplies are medically necessary does not, in itself, assure that the services or supplies are covered by the Plan.

"Members" means all persons covered by one or more of the group insurance plans offered by OSEEGIB including eligible current and qualified former employees of participating entities and their eligible covered dependents.

"Mental health and substance abuse" means conditions including a mental or emotional disorder of any kind, organic or inorganic, and/or alcoholism and drug dependency.

"Network provider" means a practitioner who or facility that is duly licensed under the laws of the state in which the "Network provider" operates and/or is accredited by a nationally recognized accrediting organization such as The Joint Commission (formerly JCAHO) or The Commission on Accreditation of Rehabilitation Facilities (CARF) approved by state or federal guidelines, and has entered into a contract with OSEEGIB to accept scheduled reimbursement for covered health care services and supplies provided to members, ~~for example, The Joint Commission (formerly JCAHO) or The Commission on Accreditation of Rehabilitation Facilities (CARF).~~

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"Non-Network out-of-pocket" means the member's expenses include the total of the member's deductibles and coinsurance costs plus all amounts that continue to be charged by the non-Network provider after the HealthChoice allowable fees have been paid.

"Open enrollment period" means a limited period of time as approved by either the Board or the Legislature in which a specified group of individuals are permitted to enroll.

"Option period" means the time set aside at least annually by OSEEGIB in which enrolled plan members may make changes to their enrollments. Eligible but not enrolled employees may also make application for enrollment during this time. Enrollment is subject to approval by OSEEGIB.

"Orthodontia limitation" means an individual who enrolls in the Dental Plan without prior group dental coverage being in effect the day before Dental Plan coverage begins will not be eligible for any orthodontia benefits for services occurring within the first twelve [12] months after the effective date of coverage. Services continuing or occurring after the twelve [12] month waiting period will be paid by prorating or according to plan benefits.

"OSEEGIB" means the Oklahoma State and Education Employees Group Insurance Board.

"Other hospital services and supplies" means services and supplies rendered by the hospital that are required for treatment, but not including room and board nor the professional services of any provider, nor any private duty, special or intensive nursing services, by whatever name called, regardless of whatever such services are rendered under the direction of the hospital or otherwise.

"Participating entity" means any employer or organization whose employees or members are eligible to be participants in any plan authorized by or through the Oklahoma State and Education Employees Group Insurance Act.

"The Plan or Plans" means the self-insured Plans by the State of Oklahoma for the purpose of providing health benefits to eligible members and may include such other benefits as may be determined by OSEEGIB. Such benefits shall be provided on a coinsurance basis and the insured pays a proportion of the cost of such benefits.

"Primary insured" means the member who first became eligible for the insurance coverage creating eligibility rights for dependents.

"Prosthetic appliance" means an artificial appliance that replaces body parts that may be missing or defective as a result of surgical intervention, trauma, disease, or developmental anomaly. Said appliance must be medically necessary.

"Provider" means a physician or other practitioner who is duly licensed or certified under the laws of the state in which the Provider practices and is recognized by this Plan, to render health and dental care services and/or supplies.

"Schedule of benefits" means the OSEEGIB plan description of one or more covered services.

"Skilled care" means treatment or services provided by licensed medical personnel as prescribed by a provider. Treatment or services that could not be given safely or reasonably by a person who is not medically skilled and would need continuous supervision of the effectiveness of the treatment

and progress of the condition. Specific criteria and limitations are applied.

SUBCHAPTER 3. ADMINISTRATION OF PLANS

360:10-3-3.5. Responsibility for premium payment

(a) **Participating entity premiums.** Employer and employee premiums for participating entities are due to OSEEGIB no later than the tenth [10th] day of each month following the month of coverage. The first payroll deductions for insurance premiums of individuals paid bi-weekly will be withheld from the first pay period that extends into the month during which insurance coverage begins. It is ultimately the employing agency's responsibility to check and verify that premiums paid to OSEEGIB are a true and accurate accounting of the member's approved coverage selections. If premium for coverage selected by the employee differs from the amount deducted from the member's check, then the participating entity is responsible for payment to OSEEGIB for any deficiencies in premium for the member's coverage. Any shortage of premiums due and payable will result in suspension of benefits for Plan participants.

(1) An employee may continue coverage while on approved leave without pay status for up to twenty-four [24] months as long as the entity continues to remit premiums with the entity's monthly payment. The twenty-four [24] month limitation shall be extended to eight [8] years for education employees who are absent from employment because of election or appointment as a local, state, or national education association officer. Except as protected by federal statute, employees on leave whose premiums are not remitted in a timely manner shall have their coverage terminated at the end of the month for which last payment was received. If coverage is terminated for non-payment all coverage is terminated. Upon return to work, the employee may re-enroll. All Plan limitations apply and evidence of insurability is required to re-enroll in any life coverage.

(2) Provided that if a State employee is on leave without pay due to an injury or illness arising out of the course of his employment, the employee may continue the insurance during the maximum period of the time allowed by law, and the employing agency shall pay the entire employee premium.

(3) An employee may continue coverage while on suspension without pay for up to ninety [90] days following the date of suspension or the duration of the administrative appeals process, whichever is greater, as long as premiums are remitted by the entity for the coverage.

(4) Collecting any employee share from an employee on leave without pay or suspension without pay is the responsibility of the entity.

(b) **Premiums remitted by retirement systems.** Any State of Oklahoma retirement system establishing a withholding system for its retired employees shall forward the retirement contribution and employees' withholding to OSEEGIB by the tenth [10th] of the month following the month for which

payment is due. This same time frame also applies to members receiving disability benefits.

(c) **Premiums remitted by former employees, COBRA participants or survivors.** Premiums are due by the twentieth [20th] day of the month of coverage. All premiums due, in excess of the retirement system contributions, shall be paid by the member. The member may elect to have the premiums withheld from their retirement benefit if the retirement benefit is sufficient to cover the entire premium. When a former employee begins to receive retirement benefits, all premiums due, in excess of the retirement system contributions, shall be paid by the member. If the total monthly premium for a retired member is the same as or greater than the retirement benefit, the member shall remit the entire amount due directly to OSEEGIB.

360:10-3-24.1. Eligibility criteria for disabled dependent children over the age of twenty-five [25]

Eligibility criteria for covering a disabled dependent child over the age of twenty-five [25] pursuant to 74 O. S. §1303(13) are as follows, provided all other eligibility requirements are also satisfied:

(1) It is intended that the following dependent children over the age of twenty-five [25] are eligible for coverage under this provision:

(A) A child who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-five [25] years; and

(B) The child is the primary member's natural child, an adopted child, a child for whom the primary member has been granted guardianship, or a child of the primary member's spouse when the spouse has been ordered by a Court to provide health insurance for the child; and

(i) Eligibility through court appointed guardianship will be accepted only for individuals considered to be the primary member's immediate family members (such as a child or grandchild). Guardianship for others not listed herein will not be considered as documentation supporting eligibility for coverage as a disabled dependent. The assessment/application for coverage must be submitted within thirty [30] days of obtaining legal guardianship. Power of attorney, including durable power of attorney, does not qualify as guardianship; and

(ii) Coverage ceases at the end of the month in which the primary member's appointment as guardian is terminated.

(2) Other criteria required for disabled dependent status are:

(A) For an individual who is a new hire or a re-hire, assessment/application for disabled dependent status must be completed and submitted to OSEEGIB within thirty [30] days of primary member's initial enrollment;

(B) Primary members must submit a copy of their federal and/or state income tax returns for the prior year reflecting their support of the dependent.

(C) Dependents are eligible only for the coverage in which the primary insured is enrolled. Only dependent life insurance can be carried by both parents if each is a primary member under the plan; and

(D) Primary members must apply for disabled dependent status for an eligible child at least thirty [30] days prior to the dependent's twenty-fifth [25th] birthday.

(3) Disabled dependent status must be continued for a minimum of one [1] year. If the dependent having the disabled status is dropped from coverage, the primary member may not reapply for disabled dependent status for the dependent for a period of twelve [12] months. The twelve [12] month requirement does not apply when the dependent has lost other group coverage.

360:10-3-25. Termination of dependent coverage

(a) **Waiting period of twelve [12] months.** If coverage is discontinued for dependents, the employee cannot reapply for the discontinued coverage for any dependents again for at least twelve [12] months. Reinstated coverage shall be subject to penalty for orthodontia limitations.

(b) **Loss of other group health, dental, vision or life insurance coverage.** The twelve [12] month requirement does not apply when the dependent has lost other group health, dental, vision and/or life insurance coverage and is seeking reinstatement pursuant to Rule 360:10-3-24(4).

(c) **Dependent reaches age ~~twenty-three [23]~~twenty-five [25].** Coverage will be terminated for dependents reaching age ~~twenty-three [23]~~twenty-five [25] on the first [1st] day of the month following their twenty-fifth [25th] birthday, except disabled dependents who are incapable of self-support and who have been deemed eligible for coverage by OSEEGIB.

SUBCHAPTER 5. COVERAGE AND LIMITATIONS

PART 3. THE PLANS

360:10-5-16. Plan limits

(a) **Deductible.** Covered members or dependents may be required to meet a calendar year deductible. Only covered charges will apply to the deductible.

(b) **Family deductible.** The family deductible is met when covered family medical expenses combined exceed the Plan's specified amount. No further deductible will be required from any covered participant for the remainder of the calendar year.

(c) **Out-of-pocket expenses.** Per person and family ~~maximum~~ calendar year out-of-pocket expenses are limited under HealthChoice to the percentage based coinsurance only. Copayments which have been established at specific dollar amounts will continue to apply after the out-of-pocket percentage based coinsurance ~~maximum~~ has been met.

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(d) **Network out-of-pocket maximum.** When the member or dependent exceeds the specified out-of-pocket calendar year maximum OSEEGIB will pay one hundred percent [100%] of the allowable fee for treatment provided by a Network provider. The one hundred percent [100%] payment of the allowable fee will be made by HealthChoice for the remainder of the calendar year. Network out-of-pocket maximum accumulations also apply to the non-Network out-of-pocket ~~maximum accumulations.~~

(e) **Non-Network out-of-pocket, ~~maximum.~~** The Plan will pay one hundred percent [100%] of the allowable fee for treatment provided by a non-Network provider, once the member or dependent exceeds the specified out-of-pocket calendar year ~~maximum threshold.~~ The one hundred percent [100%] payment of the allowable fee will be made by the Plan for the remainder of the calendar year. Specific HealthChoice plans may apply non-Network out-of-pocket accumulations to the Network out-of-pocket maximums. Unlike Network providers, non-Network providers have no contractual obligation to limit members' financial responsibility after HealthChoice has paid the claim. HealthChoice processes claims based on limited allowable fees to Network and non-Network providers. Allowable fees are not the same as charges billed by providers. Network providers have agreed with HealthChoice to write off the remainder of their fees after all payments from HealthChoice and the member's deductible, copay and coinsurance have been determined. However, non-Network providers have no write-off agreement with HealthChoice, which means the member remains responsible for paying all outstanding billed costs for treatment which have not been paid by HealthChoice. In most cases, this leaves the member responsible for paying a substantial out-of-pocket fee for treatment by the non-Network provider.

(f) **Lifetime maximum benefit.** There is a lifetime maximum benefit that will be paid by the Plan for a member or dependent, with regard to pharmacy benefits.

(g) **Treatment by non-Network providers.** Any treatment at a non-Network provider will remain subject to the fee schedule or any other form of maximum claim payment limitation. Claims paid pursuant to the benefit administration procedures or guidelines as adopted by OSEEGIB at any non-Network hospital or provider are subject to the limited maximum allowable fee in every case, regardless of the reason why the member sought and received treatment at the non-Network provider, and will usually result in substantial out-of-pocket expenses to the insured. Exceptions allowed by Statute at 74 O.S. §1304(12) and (13) may be made, when appropriate.

360:10-5-20. Health plan limitations and exclusions

For the health plans provided by OSEEGIB, there is no coverage for expenses incurred for or in connection with any of the items listed below:

- (1) Expenses incurred prior to the effective date of an individual's coverage, or for expenses incurred during a period of confinement which had its inception prior to the effective date of an individual's coverage hereunder.
- (2) Injury or any sickness which is covered under an "extended benefits" provision of the previous group health

coverage, until such time as such individual has exhausted all extended benefits available thereunder.

(3) Hospitalization or other medical treatment furnished to the insured or dependent after coverage has terminated.

(4) Confinement to a facility unless approved by OSEEGIB or its designee.

(5) Medical and surgical services and supplies which are in excess of the fee schedule for such service and supply.

(6) Expenses to the extent that the insured person is reimbursed or is entitled to reimbursement; or is in any way indemnified for such expenses by or through any public program, State or Federal, or any such program of medical benefits sponsored and paid for by the Federal Government or any agency or subdivision thereof.

(7) Bodily injury or illness arising out of or in the course of any employment not specifically excluded by 85 O.S. §2.1 or 2.6 (of the Workers' Compensation Act).

(8) Any treatment or procedure considered experimental or investigational. This restriction will also apply to any facility, appliance, device, equipment or medication.

(9) Medical and/or mental health treatment of any kind, including hospital care, medications, or any medical care or medical equipment which is excessive or where medical necessity has not been proven.

(10) Medications available for purchase without a written prescription.

(11) Medical care and supplies for which no charge is made or no payment would be requested if the insured individual did not have this coverage.

(12) Complications from any non-covered or excluded treatments, items or procedures.

(13) Any medication, device, or procedure, not FDA approved for general use or sale in the United States.

(14) Surgical procedures or treatment performed for cosmetic or elective reasons unless such procedure is specifically included as a covered charge or is necessary as a result of an accident. Coverage must have been continuous from the date of the accident to the date of corrective surgery.

(15) Dental expenses unless incurred as the result of an accidental bodily injury to natural teeth or gums while the coverage is in effect. Coverage must have been continuous from the date of the accident to the date of corrective surgery. Broken or lost artificial teeth, bridges or dentures, are not ~~eligible covered.~~

(16) Illness, injury, or death as a result of committing or attempting to commit an assault or felony, including participation in a riot or insurrection as an aggressor.

(17) Intentionally self-inflicted injury, or for attempted suicide whether sane or insane except when the injury results from a physical or mental medical condition covered under the health plan.

(18) Wrongful act or negligence of another when an employee or dependent has released the responsible party, unless subrogation has been waived or reduced in writing

in an individual case, solely at OSEEGIB's option, and only for good cause.

(19) All other conditions, services, procedures, treatments, expenses, items, and supplies excluded by OSEEGIB's benefit guidelines.

PART 5. LIFE BENEFITS

360:10-5-34. Rights of retired and vested employees to continue life insurance coverage

(a) **Continuation of coverage.** Any person who retires or who has elected to receive a vested benefit under the provisions of the Oklahoma Public Employees Retirement System, the Oklahoma Teachers Retirement System, the Uniform Retirement System for Justices and Judges, or the Oklahoma Law Enforcement Retirement system or is eligible to continue in force the life insurance coverage following retirement or termination of employment with the required minimum years of service with a participating employer, or who meets each and every requirement of the State Employees Disability Plan, or the spouse or dependent of any such employee, may continue in force life benefits purchased prior to severance in a face amount of no less than one-fourth [1/4] of the basic life coverage amount in five thousand dollar [\$5,000.00] increments, and the full amount of any additional life insurance that was in effect prior to the date of retirement. Said individual shall pay actuarially determined cost of such coverage and shall make such election within thirty [30] days following the date of severance. Said election to continue coverage becomes effective on the first [1st] day of the month following termination of current employment.

(b) **Decrease or termination of coverage.** Coverage may be decreased or terminated after severance from current employment, but shall not be increased or reinstated after severance, except as permitted by rule or statute.

(c) **Unavailability to retirees, vested or eligible non-vested members or dependents.** accidental death and dismemberment and loss of sight benefits are not available to retired, vested, or eligible non-vested members or dependents.

(d) **Retirees returning to active employment.** When an individual has retired and then returns to active employment, that individual may not retain any more life insurance upon termination of active employment than the amount that was retained when the individual initially retired, unless the period of active employment is for at least three [3] years.

PART 15. SUBROGATION

360:10-5-100. Right of subrogation

(a) OSEEGIB reserves the right to recover funds from members, dependents, tortfeasors, liability policies, underinsured/uninsured motorist policies, medical payments policies and/or other identifiable sources of funds, in amounts equal to any and all claim payments made on behalf of a member or dependent for injury caused by a third party's wrongful act or negligence.

(b) OSEEGIB has the right to recover any sums collected by or on behalf of a member or dependent even if the member or dependent has not been made whole. OSEEGIB is entitled to reimbursement from any recovery even if the recovery does not fully compensate the member or dependent for their injury. The make-whole doctrine shall not apply. The sole exception to this paragraph exists only to the limited extent that OSEEGIB voluntarily elects to invoke its exclusive statutory authority to waive or reduce OSEEGIB's subrogation interest in an individual case.

(c) The act of submitting claims by or on behalf of a member or dependent constitutes notice and acceptance of OSEEGIB's right of recovery against the third party and creates a lien upon any identifiable funds referenced in (a) above.

(d) A member or dependent will not take any action to prejudice OSEEGIB's right of subrogation, such as settlement of the claim without first giving notice of OSEEGIB's subrogation rights to the responsible party and any and all known liability or other insurers.

(e) The member or dependent will cooperate in doing what is reasonably necessary to assist OSEEGIB in any recovery, including but not limited to promptly providing all information requested by OSEEGIB.

(f) Subrogation will exist only to the extent of plan benefits paid.

(g) Claims submitted after a member or dependent has released the responsible party may be denied at the option of OSEEGIB, by the issuance of routine written notice to the member, dependent, or their attorney.

(h) If claims relating to a specified injury are paid by OSEEGIB after the member or dependent has released the responsible party, when the member or dependent has failed to inform OSEEGIB in a timely manner prior to executing a release, OSEEGIB, at its option, may require reimbursement from the member, dependent or provider.

(i) Claims submitted will initially be pended as incomplete and subsequently denied if information regarding possible third party responsibility is not voluntarily provided to OSEEGIB within a reasonable time period [not less than ninety (90) days] after the date the information was first requested in writing by or on behalf of OSEEGIB.

SUBCHAPTER 9. COBRA HEALTH INSURANCE CONTINUATION

360:10-9-1. Procedures and implementation

Notice of right to continue coverage. Each agency or employer participating in the State and Education Employees Group Insurance Plan shall advise each covered employee of his right to continue coverage under Federal COBRA provisions. COBRA coverage applies only to health, dental, and vision benefits. Life and disability coverage are not available through COBRA.

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360:10-9-2. COBRA administration

(a) **COBRA coverage is identical to coverage provided at date of the qualifying event.** The coverage elected shall be identical to the coverage provided at the date of the qualifying event, unless a beneficiary moves outside an HMO's service area. In that event, coverage is continued under HealthChoice, OSEEGIB's self-insured plan.

(b) **Payment of back premiums.** All back premiums from the termination of coverage to the election and approval of continuation must be paid before coverage is effective. Coverage will then be retroactive to provide continuous coverage. All time limits are mandatory and cannot be waived under any circumstances.

(c) **Responsibility of qualified beneficiary to inform OSEEGIB of ineligibility.** It is the responsibility of the qualified beneficiary to provide timely notice if he is not eligible for any reason. Failure to do so will result in cancellation of COBRA insurance coverage, retroactive to the time of ineligibility.

(d) **Primary member premium.** For any benefit continued under COBRA, one person must pay the primary member premium. In cases where a spouse, child, or children are insured for a particular benefit where the primary member did not retain coverage, one person will be billed at the primary member rate.

(e) **Federal regulations.** Federal regulations regarding COBRA extension of coverage shall be controlling in all situations where applicable.

[OAR Docket #09-849; filed 5-6-09]

TITLE 360. OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD CHAPTER 15. THE DISABILITY PLAN

[OAR Docket #09-848]

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None

INCORPORATIONS BY REFERENCE:

n/a

SUPERSEDED EMERGENCY ACTIONS:

None

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

Changes to Chapter 15 clarify definitions, conform rules to recent benefit changes, clarify language, and clarify existing plan exclusions.

CONTACT PERSON:

Gary Goff, Attorney, Assistant Administrator, (405) 717-8744

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JANUARY 1, 2010:

360:15-1-14.1. Direct deposit and insurance premium deductions

~~(a) For employees with disability benefit periods beginning prior to January 1, 2009, an employee may authorize OSEEGIB to deposit their monthly disability benefit directly to a checking or savings account in a bank, credit union or savings and loan by electronic fund transfer. Application for direct deposit will only be accepted on properly completed forms provided by OSEEGIB. Prior to January 1, 2010, the direct deposit may be discontinued at any time upon thirty (30) days written notice by the employee or OSEEGIB. After January 1, 2010, if the electronic fund transfer creates an undue hardship on the employee, the direct deposit may be discontinued only if the employee makes application to the Administrator of OSEEGIB to request a waiver of this requirement. The waiver will be granted only upon good cause shown when it is determined to be in the best interest of the employee. The Administrator, at his or her sole discretion, may also waive this requirement when it is necessary in the best interest of OSEEGIB to do so.~~

(b) Effective January 1, 2010, all disabled employees with receiving disability benefit periods beginning on and after that date payments from OSEEGIB shall be required to receive monthly disability payments via electronic fund transfers to checking or savings account in a bank, credit union or savings and loan designated by the employee. The employee and receiving institution must complete the form prescribed for this purpose by OSEEGIB. In the event the electronic fund transfer creates an undue hardship on the employee, the employee may make application to the Administrator to request a waiver of this requirement. The waiver will be granted only upon good cause shown when it is determined to be in the best interest of the employee. The Administrator, at his or her sole discretion, may also waive this requirement when it is necessary in the best interest of OSEEGIB to do so.

(c) In addition to all other required deductions, premiums for insurance coverage provided to disabled employees and

their dependents as authorized at Title 74 Oklahoma Statutes Section 1332(A) and 1332.1(D) shall be deducted from disability benefit payments made pursuant to this Chapter.

[OAR Docket #09-848; filed 5-6-09]

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 1. ADMINISTRATIVE
OPERATIONS**

[OAR Docket #09-833]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions
365:1-1-2. Office of the Insurance Commissioner [AMENDED]
Subchapter 13. Electronic Filings
365:1-13-1. ~~Agent and customer service representative appointment forms~~
Electronic filings [AMENDED]

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307, 307.1, and 12A O.S. § 15-118

DATES:

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January 15, 2009 to February 16, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on April 28, 2009

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SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed amendments to Rule 365:1-1-2 combine the Life, Accident and Health Division and the Property and Casualty Division into one division called the Rate and Form Compliance Division and set out a description of that division. The proposed amendments to Rule 365:1-13-1 add continuing education course completion filings, schedule of continuing education course offerings, and filings made with the Rate and Form Compliance Division to the list of filings to be made with the Insurance Department by electronic means. The proposed amendments to Rule 365:1-13-1 also add the option for regulated persons to request an exemption from electronic filing. The title of the rule is also corrected.

CONTACT PERSON:

Karl F. Kramer, Deputy Insurance Commissioner, (405) 521-2668

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

365:1-1-2. Office of the Insurance Commissioner

The office of the Insurance Commissioner is composed of the Insurance Commissioner and such employees as are required and provided for by law. The Insurance Commissioner exercises executive and administrative supervision over the Office of the Insurance Commissioner.

(1) **General description of organization.** The office of the Insurance Commissioner is divided into the following principal operating units:

- (A) Administrative Services Division
- (B) ~~Producer Agents~~ Licensing Division
- (C) Bail Bond Division
- (D) Consumer Assistance and Claims Division
- (E) Comptroller Division
- (F) Communications Division
- (G) Executive Division
- (H) Financial and Examination Division
- (I) Information Technology Division
- (J) Legal and Investigation Division
- (K) ~~Rate and Form Compliance Division~~ ~~Life, Accident and Health Division~~
- (L) ~~Property and Casualty Division~~
- (M) Real Estate Appraisers Division
- (MN) Senior Health Care Programs Division
- (NO) Utilization Review Division

(2) **Administrative Services Division.** The Administrative Services Division is under the direction of the Chief of Staff and is responsible for various administrative services as directed by the Insurance Commissioner including personnel, mail, and file maintenance.

(3) **Producer Agents Licensing Division.** The ~~Pro-~~ducer Agents Licensing Division, headed by the Director of the ~~Producer Agents~~ Licensing Division, is responsible for determining whether applicants for insurance agents, limited insurance representatives, insurance adjusters, third party administrators, life, accident and health insurance brokers and insurance consultants licenses meet the qualifications set forth in the statutes of the State of Oklahoma and is also responsible for administering the examinations given as required to applicants and for issuing renewal licenses. The ~~Producer Agents~~ Licensing Division is also responsible for monitoring continuing education requirements for ~~producers~~ agents.

(4) **Bail Bond Division.** The Bail Bond Division is composed of the Director and necessary assistants and is responsible for determining whether applicants for bail bond licenses meet the qualifications set forth in the statutes of the State of Oklahoma, for administering the examinations given to all bail bondsmen, yearly renewal of license and surety/ professional appointments, processing of monthly reports for each type of license held by bondsman, collection of 2/10 of 1% renewal fee of new liability written monthly, enforce statutory deposit requirements of professional bondsmen and initial investigation of complaints regarding possible violation of statutes.

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(5) **Consumer Assistance and Claims Division.** The Consumer Assistance and Claims Division is composed of the Director of this division and necessary Policy Analysts, and is in charge of processing and investigating all complaints lodged against insurance companies and other persons/entities by the public. Further, this division answers all routine requests for information concerning insurance companies and insurance policies.

(6) **Comptroller Division.** The Comptroller Division is composed of the Comptroller and necessary assistants and is responsible for the internal fiscal affairs of the office, including preparation of payroll, purchase of equipment, approval of all travel claims made by staff and keeping of all fiscal records required by law.

(7) **Communications.** The Communications Division consists of the Communications Manager, a Communications Specialist, a Public Information Officer and necessary support staff. This division is responsible for maintaining and furthering internal and external communications. Among the duties performed in this division are development and management of the Insurance Department website, writing and facilitating news releases, responding to media inquiries, directing the Insurance Commissioner's public event calendar and preparing needed materials for each event, production of consumer assistance and awareness events, designing collateral publications for producers and consumers, writing and releasing an internal newsletter and any other communications related duties as needed.

(8) **Executive Division.** The Executive Division, composed of the Insurance Commissioner and the Deputy Commissioner and necessary assistants, is charged with general supervision of all activities of the office including personnel and internal organization.

(9) **Financial and Examination Division.** The Financial and Examination Division is composed of the Chief Financial Examiner, the Deputy Chief Financial Examiner, the Chief Financial Analyst and various other levels of Financial Analysts and Financial Specialists and is responsible for determining whether insurance companies and other persons/entities applying for admission to do business in the State of Oklahoma meet the qualifications for admittance as set forth in the statutes of the State of Oklahoma. This division, through outside contract examiners, is responsible for conducting the statutory examination of all domestic and foreign insurance companies and other persons/entities and collects all premium taxes and statutory fees due the State. This division is also responsible for the review and analysis of all annual and quarterly financial statements of insurance companies as required by the statutes of the State of Oklahoma.

(10) **Information Technology Division.** The Information Technology Division is composed of the Director and necessary assistants and is responsible for providing all internal data processing services to the other divisions of the Insurance Department. Further, this division provides the public with both summaries and detailed information

on many of the records maintained by the Insurance Department.

(11) **Legal and Investigation Division.**

(A) The Legal Division is composed of the General Counsel and Assistant General Counsels who are the chief law officers and consultants to the Insurance Commissioner and the other divisions within the office on legal matters. The Legal Division defends or prosecutes all proceedings held before the Insurance Commissioner, including complaint hearings, as well as investigative hearings. The Legal Division is charged with the duty of representing the Insurance Commissioner in the courts in matters which are a part of his/her official duties.

(B) The Investigation Division is composed of the Chief Investigator and assistants and is responsible for investigating complaints against licensed insurance entities and forwarding its findings to the Legal Division, if evidence is found of wrongdoing or non-compliance with the insurance laws of the State of Oklahoma.

(C) The Anti-Fraud Unit is within the Legal and Investigation Division and is composed of the Chief Investigator and investigators who are commissioned by the Insurance Commissioner to serve as peace officers. It is responsible for investigating violations of statute or administrative rules of this state pertaining to insurance fraud.

(12) **Rate and Form Compliance Division.** ~~Life, Accident and Health Division.~~ The Rate and Form Compliance ~~Life, Accident and Health~~ Division is composed of the Director, ~~the Rate Analysts~~ and ~~the Policy Analysts~~. This division is responsible for the receipt of all life, annuity, and accident and health policy forms and property and casualty policy forms, manual rules and rates. ~~The Division~~ and determines whether such documents/forms conform to the statutes of the State of Oklahoma. ~~The Division is also responsible for determining whether advisory organizations applying for admission to do business in the State of Oklahoma meet the qualifications for admittance as set forth in the statutes of the State of Oklahoma.~~ All references to Life, Accident and Health Division or Property and Casualty Division shall mean Rate and Form Compliance Division. ~~This division has the duty of approving or disapproving all forms submitted to it.~~

(13) ~~Property and Casualty Division.~~ ~~The Property and Casualty Division is composed of the Director and Rate and Form Analysts.~~ This division is responsible for the receipt of most property and casualty policy forms, manual rules and rates, and determines whether such forms, manual rules and rates conform to the statutes of the State of Oklahoma.

(14) **Real Estate Appraisers Division.** The Director of the Real Estate Appraisers Division is responsible for determining whether applicants for real estate appraiser licensure/certification meet the qualifications set forth in the statutes of the State of Oklahoma and for administering the examinations given to all real estate appraisers.

(1445) **Senior Health Care Programs Division.** The Senior Health Care Programs Division is composed of two federal grant programs, SHICP and SUMMIT. The Division is composed of the Division Director and support staff. The Senior Health Insurance Counseling Program (SHICP) is responsible for providing information, counseling and assistance to Medicare and Medicaid beneficiaries so they may understand and access their health care benefits. SUMMIT Medicare/Medicaid Fraud, Abuse and Waste Program focuses on reducing Medicare/Medicaid fraud, abuse and waste by enhancing public awareness through community presentations and public education. Both programs train volunteers to assist with the programs' mission.

(1546) **Utilization Review Division.** The Director of the Utilization Review Division is responsible for determining whether applicants for Utilization Review Certificates of Registration meet the qualifications set forth in the statutes of the State of Oklahoma.

SUBCHAPTER 13. ELECTRONIC FILINGS

365:1-13-1. ~~Agent and customer service representative appointment forms~~ Electronic filings

(a) Effective January 1, 2009, the following filings, and fees relating thereto, shall be made with the Insurance Department by electronic means and format as approved by the Insurance Commissioner:

- (1) Insurance agent/producer initial and renewal license applications;
- (2) Insurance adjuster initial and renewal license applications;
- (3) Limit lines producers initial and renewal license applications;
- (4) Life, accident and health insurance brokers initial and renewal license applications;
- (5) Insurance consultants initial and renewal license applications;
- (6) Customer service representatives initial and renewal license applications;
- (7) Motor service club agent's initial and renewal license applications;
- (8) Appointments and terminations of appointments of those listed in Paragraphs 1 through 7 of this section;
- (9) Continuing education providers initial and renewal applications; and
- (10) Continuing education course submissions;
- (11) Continuing education course completion filings;
- (12) Schedule of continuing education course offerings;
- (13) Filings submitted to the Rate and Form Compliance Division of the Insurance Department.

(b) The Insurance Commissioner may exclude or exempt a specific filing, filings or categories of filings from the requirements of this section at the Commissioner's discretion.

Requests for exemption must specify the reasons that compliance with this subchapter constitutes a hardship.

[OAR Docket #09-833; filed 5-5-09]

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND
HEALTH**

[OAR Docket #09-831]

RULEMAKING ACTION:
PERMANENT final adoption

- RULES:**
- Subchapter 1. General Provisions
 - Part 1. General Provisions
 - 365:10-1-13. Notification required upon rejection
 - Subchapter 5. Minimum Standards; Contract Guidelines
 - Part 5. Long-Term Care Insurance
 - 365:10-5-42. Policy definitions [AMENDED]
 - 365:10-5-43. Policy practices and provisions [AMENDED]
 - 365:10-5-43.1. Unintentional lapse [AMENDED]
 - 365:10-5-44. Required disclosure provisions [AMENDED]
 - 365:10-5-45. Requirements for application forms and for replacement coverage [AMENDED]
 - 365:10-5-45.1. Reporting requirements [AMENDED]
 - 365:10-5-45.2. Licensing [AMENDED]
 - 365:10-5-48.6. Nonforfeiture benefit requirement [AMENDED]
 - 365:10-5-53. Contingent benefit upon lapse [AMENDED]
 - 365:10-5-54. State long-term care insurance partnership program [AMENDED]
 - 365:10-5-55. Availability of New Services or Providers [NEW]
 - 365:10-5-56. Right to Reduce Coverage and Lower Premiums [NEW]
 - Part 21. Extension and Termination of Coverage Under Group Accident and Health Policy and Contracts of Hospital and Medical Services or Indemnity [REVOKED]
 - 365:10-5-190. Purpose. [REVOKED]
 - 365:10-5-191. Applicability and scope [REVOKED]
 - 365:10-5-192. Definitions [REVOKED]
 - 365:10-5-193. Periods for which coverage is extended [REVOKED]
 - 365:10-5-194. When extension period begins [REVOKED]
 - 365:10-5-195. Required notification to employee whose insurance is terminated [REVOKED]
 - Subchapter 27. Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values Regulation [NEW]
 - 365:10-27-1. Authority [NEW]
 - 365:10-27-2. Scope [NEW]
 - 365:10-27-3. Purpose [NEW]
 - 365:10-27-4. Definitions [NEW]
 - 365:10-27-5. Minimum Valuation Mortality Standards [NEW]
 - 365:10-27-6. Transition Rules [NEW]
 - Appendix EE. Triggers For A Substantial Premium Increase [REVOKED]
 - Appendix EE. Triggers For A Substantial Premium Increase [NEW]
 - Appendix LL. Notice To Applicant Regarding Replacement Of Individual Accident And Sickness or Long-Term Care Insurance For Solicitations Other Than Direct Response [NEW]
 - Appendix MM. Notice To Applicant Regarding Replacement Of Accident And Sickness or Long-Term Care Insurance For Direct Response Solicitations [NEW]

AUTHORITY:
Insurance Commissioner, 36 O.S. §§ 307.1, 1510(A)(4)(iii), 4029(H)(4)(h)(vi), 4427 and 4509

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

Subchapter 27. Preneed Life Insurance Minimum Standards for Determining Reserve Liabilities and Nonforfeiture Values Regulation [NEW]

365:10-27-1. Authority [NEW]

365:10-27-2. Scope [NEW]

365:10-27-3. Purpose [NEW]

365:10-27-4. Definitions [NEW]

365:10-27-5. Minimum Valuation Mortality Standards [NEW]

365:10-27-6. Transition Rules [NEW]

365:10-27-7. Effective Date [NEW]

Gubernatorial approval:

September 11, 2008

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08-1266

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed amendments to Section 365:10-1-13, Notification Required Upon Rejection, updates the toll free number of the Oklahoma Health Insurance High Risk Pool and adds the web address to this rule which requires notification of contact information for the High Risk Pool when an insurer rejects an application for health insurance.

The proposed amendments to Part 5 of Subchapter 5, Long-term Care Insurance, 365:10-5-42 through 56, Appendix EE and new Appendices LL and MM, update the regulation to the most recent National Association of Insurance Commissioners' model regulation and implement federal mandates.

The proposed revocation of Part 21 of Subchapter 5, Extension and Termination of Coverage Under Group Accident and Health Policy Contracts of Hospital and Medical Services or Indemnity, Sections 365:10-5-190 through 195, is to allow the Insurance Department to seek legislative amendments that address the issues in a cleaner way. New rules will be adopted if statutory amendments are enacted or not, allowing more input/comment from the individuals and entities affected by the rules.

The purpose of the proposed new Subchapter 27, Preneed Life Insurance Minimum Standards For Determining Reserve Liabilities And Nonforfeiture Values Regulation, 365:10-27-1 through 6, is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products. Research completed by the Deloitte University of Connecticut Actuarial Center and commissioned by the Society of Actuaries as a part of a study of preneed mortality determined that the 2001 CSO Mortality Table, currently recognized as the prevailing table for the purposes of calculating reserves and nonforfeiture values both on a statutory basis and on a tax basis, produced inadequate reserves for insurance policies issued in support of a prearrangement agreement which provides goods and services at the time of an insured's death. This regulation became effective as emergency rules on September 11, 2008, with compliance required for policies issued on or after January 1, 2009.

CONTACT PERSON:

Karl F. Kramer, Deputy Insurance Commissioner, (405) 521-2668

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

PART 1. GENERAL PROVISIONS

365:10-1-13. Notification required upon rejection

In the event an insurer rejects an applicant seeking health insurance coverage, such rejection shall be in writing and shall state with specificity the reason(s) for the denial. The rejection notification shall further advise the applicant of the availability of the Oklahoma Health Insurance High Risk Pool and its toll free telephone number in the following format: You may be qualified for health insurance coverage under the Oklahoma Health Insurance High Risk Pool. For more information regarding this alternative please call ~~1-800-933-7624~~ 1-877-793-6477. You may also want to visit the web-site of the Oklahoma Health Insurance High Risk Pool at www.okhrp.org.

SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES

PART 5. LONG-TERM CARE INSURANCE

365:10-5-42. Policy definitions

(a) No long-term care insurance policy delivered or issued for delivery in the State of Oklahoma shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(1) **"Activities of daily living"** means at least bathing, continence, dressing, eating, toileting and transferring.

(2) **"Acute condition"** means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) **"Adult day care"** means a program for four (4) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

(4) **"Bathing"** means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

(5) **"Cognitive impairment"** means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(6) **"Contenance"** means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(7) **"Dressing"** means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(8) **"Eating"** means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(9) **"Exceptional increase"** means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified:

(A) Due to changes in laws or regulations applicable to long-term care coverage in this state; or

(B) Due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in O.A.C. 365:10-5-47, exceptional increases are subject to the same requirements as other premium rate schedule increases. The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The Commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(10) **"Hands-on assistance"** means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

(11) **"Home health care services"** means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance and activities of daily living and respite care services.

(12) **"Incidental,"** as used in O.A.C. ~~365:10-5-47(j)~~ 365:10-5-47.1(j), means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

(13) **"Medicare"** shall be 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 Laws 89-97, As Enacted by the Eighty-Ninth Congress of the United States of American 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.

(14) **"Mental or Nervous Disorder"** shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(15) **"Personal care"** means the provision of hands-on services to assist an individual with activities of daily living.

(16) **"Qualified Actuary"** means a member in good standing of the American Academy of Actuaries.

(17) **"Similar policy forms"** means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in 36 O.S. § 4424(4)(a)- and are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(18) **"Skilled nursing care", "intermediate care", "personal care", "home care",** and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(19) **"Toileting"** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(20) **"Transferring"** means moving into or out of a bed, chair or wheelchair.

(b) All providers of services, including but not limited to "skilled nursing facility", "extended care facility", "~~intermediate care facility~~", "convalescent nursing home", "personal care facility", "specialized care providers," "assisted living facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. ~~The definition may require~~ When the definition requires that the provider be appropriately licensed or certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

365:10-5-43. Policy practices and provisions

(a) **Renewability.** The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of O.A.C. 365:10-5-44.

(1) No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable".

(2) The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any

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change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(3) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(4) The term "level premium" may only be used when the insurer does not have the right to change the premium.

(5) In addition to the other requirements of this subsection, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

(b) **Limitations and exclusions.**

(1) No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

- (A) Pre-existing conditions or diseases;
- (B) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;
- (C) Alcoholism and drug addiction;
- (D) Illness, treatment or medical condition arising out of:

- (i) war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to a military unit, or working in an area of war whether voluntarily or as required by an employer;
- (ii) participation in a felony, riot or insurrection;
- (iii) service in the armed forces or units auxiliary thereto;
- (iv) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
- (v) aviation (this exclusion applies only to non-fare-paying passengers);

(E) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental programs (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

(F) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(G) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title

XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(H) This subsection is not intended to prohibit exclusions and limitations by type of provider. However, no long-term care issuer may deny a claim because services are provided in a state other than the state of policy issue under the following conditions:

(i) When the state other than the state of policy issue does not have the provider licensing, certification or registration required in the policy, but where the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or

(ii) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.

(iii) For purposes of this paragraph 365:10-5-43(b)(1)(H), "state of policy issue" means the state in which the individual policy or certificate was originally issued.

(2) Subsection (b) of this section is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(c) **Extension of benefits.** Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(d) **Continuation or conversion.**

(1) Group long-term care insurance issued in this state on or after the effective date of this subsection shall provide covered individuals with a basis for continuation or conversion of coverage.

(2) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(3) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would

otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(4) For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(5) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(6) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(A) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(B) The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of paragraph (6) of this subsection.

(8) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care

insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(9) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(10) Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(11) For the purposes of this section a "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(e) **Discontinuance and replacement.** If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

(1) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

(2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(f) **Premium increase prohibitions.**

(1) The premiums charged to an insured for long-term care insurance shall not increase due to either:

(A) The increasing age of the insured at ages beyond sixty-five (65); or

(B) The duration the insured has been covered under the policy.

(2) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under O.A.C. 365:10-5-48.6, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(3) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under O.A.C. 365:10-5-48.6, the initial annual premium shall be based on the reduced benefits.

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(g) **Electronic Enrollment for Group Policies.**

(1) In the case of a group defined in Section 4424(4)(a) of Title 36 of this states statutes any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if:

(A) The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

(B) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

(C) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and "privileged information." is maintained. "For purposes of this subparagraph 365:10-5-43(g)(1)(C), "privileged information" means any individually identifiable information that relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual and is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual.

(2) The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

365:10-5-43.1. Unintentional lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(1) **Notice requirements.**

(A) **Notice before lapse or termination.** No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either: a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's FULL NAME AND HOME ADDRESS. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of

premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(B) **Payroll or pension deduction plan notice requirements.** When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in (A) of this paragraph need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(C) **Lapse or termination for nonpayment of premium.** No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to this Section, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

(2) **Reinstatement.** In addition to the requirement in paragraph (1) of this section, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a ~~of cognitive impairment or the~~ loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

365:10-5-44. Required disclosure provisions

(a) **Renewability.** Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to non-renew is reserved solely to the policyholder.

(b) **Premium rate change.** A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change. Such provision shall be appropriately captioned, and shall appear on the first page of the policy.

(c) **Riders and endorsements.** Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

(d) **Payment of benefits.** A long-term insurance policy which provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary" or words of similar import shall include definitions of such terms and an explanation of such terms in its accompanying outline of coverage.

(e) **Limitations.** If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Pre-existing Condition Limitations."

(f) **Other limitations or conditions on eligibility for benefits.** A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those listed in paragraphs (1) and (2) of this subsection shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

(1) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(2) A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

(g) **Disclosure of tax consequences.** With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement

shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection shall not apply to qualified long-term care insurance contracts.

(h) **Benefit triggers.** Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanations of the trigger shall accompany each benefit description. If an attending physical or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(i) **Qualified long-term care insurance contract.** A qualified long-term care insurance contract must include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. [Policies that are not intended to be a qualified long-term care insurance contract must include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract. The disclosure shall be prominently displayed, and shall read as follows: **This long-term care insurance policy (certificate) is not intended to be a qualified long-term care insurance contract. You need to be aware that benefits received under this policy may create unintended, adverse income tax consequences to you. You may want to consult with a knowledgeable individual about these potential income tax consequences.**]

365:10-5-45. Requirements for application forms and for replacement coverage

(a) **Application form requirements.** 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 long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by 36 O.S. §4424(4)(a), the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

(1) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(2) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

(A) If so, with which company?

(B) If that policy lapsed, when did it lapse?

(3) Are you covered by Medicaid?

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- (4) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?
- (b) **Other policies required to be listed on the application form.** 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) **Solicitations other than direct response.** Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner as set out in Appendix LL of this chapter:
-

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE 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 lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]: (Use additional sheets, as necessary.)

~~I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:~~

- ~~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 in payment of 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 or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.~~
- ~~3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.~~
- ~~4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.~~

~~(Signature of Agent, Broker or Other Representative)
[Typed Name and Address of Agent or Broker]~~

~~The above "Notice to Applicant" was delivered to me on:~~

~~(Date)~~

~~(Applicant's Signature)~~

- (d) **Direct response solicitations.** Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner as set out in Appendix MM:

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF ACCIDENT AND
SICKNESS OR LONG TERM CARE
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 lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with the long term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

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 in payment of 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 or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. ~~[To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.~~

(Company Name)

(e) **Notification of replacement intent.** Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(f) Life insurance policies that accelerate benefits. Life Insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of the Life Insurance and Annuity Policyholders Protection Act, 36 O.S. § 4031 et seq. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

365:10-5-45.1. Reporting requirements

- (a) Every insurer shall maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.
- (b) Each insurer shall report annually by June 30 the ten percent (10%) of its agents with the greatest percentages of lapses and replacements as measured by (a) of this section.
- (c) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance.
- (d) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.
- (e) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual

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sales and as a percent of its total number of policies in force as of the preceding calendar year.

(f) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. An insurer shall use the form in Appendix CC to comply with this provision.

(g) For purposes of this section, "policy" shall mean only long-term care insurance and "report" means on a statewide basis.

(h) Reports required under this section shall be filed with the commissioner.

365:10-5-45.2. Licensing

No agent is authorized to market, sell, solicit or otherwise contact any person for the purpose of marketing long-term care insurance ~~unless the agent has demonstrated his or her knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses except as authorized by the Oklahoma Producer Licensing Act, 36 O.S. § 1435.1, et seq.~~

365:10-5-48.6. Nonforfeiture benefit requirement

(a) No insurer may offer a long-term care insurance policy unless the insurer also offers to the applicant the option to purchase a policy that provides for nonforfeiture benefits. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(1) For purposes of this section, attained age rating is defined as a schedule of premiums starting from the issue date which increases with increasing age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this section, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3) of this subsection.

(3) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of paragraph (b) of this subsection.

(4) No policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(b) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the "paid up status" will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

(c) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(d) The requirements set forth in this section shall become effective July 1, 1996, and shall apply as follows:

(1) Except as provided in paragraph (2) of this subsection, the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 36 O.S. §4424(4), which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

(e) Premiums charged for a policy or certificate containing nonforfeiture benefits shall be subject to the loss ratio requirements of O.A.C. 365:10-5-47 treating the policy as a whole.

~~(f) To comply with the requirement to offer a nonforfeiture benefit pursuant to Section § 4426.2 of Title title 36 of the Oklahoma Code - Nonforfeiture benefits:~~

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits.

(2) The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

(g) If the offer required to be made under Section 4426.2 of Title 36 of Oklahoma Code - Nonforfeiture benefits is rejected, the insurer shall provide the contingent benefit upon lapse described in this section.

(1) After rejection of the offer required under Section 4426.2 of Title 36, for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level

which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in O.A.C. 365:10 Appendix Table 1 of Appendix EE of this chapter based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least sixty (60) days prior to the due date of the premium reflecting the rate increase.

(4) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Table 2 of Appendix EE of this chapter based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) of this section is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase. This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured. On or before the effective date of a substantial premium increase as defined in (3) above, the insurer shall:

~~(A) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; (The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.)~~

~~(B) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection (A). This option may be elected at any time during the 120 day period referenced in Subsection (g)(3).~~

~~(C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120 day period referenced in Subsection (g)(3) shall be deemed to be the election of the offer to convert in Subparagraph (B) above.~~

(5) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:

(A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; (The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.)

(B) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with

the terms of Subsection (A) of this section. This option may be elected at any time during the 120-day period referenced in Paragraph (3) of this subsection. (C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection (g)(3) of this section shall be deemed to be the election of the offer to convert in Subparagraph (B) of this paragraph above.

(6) On or before the effective date of a substantial premium increase as defined in Paragraph (4) of this subsection above, the insurer shall:

(A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Paragraph (4); and

(C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in paragraph (4) shall be deemed to be the election of the offer to convert in Subparagraph (B) of this subsection above if the ratio is forty percent (40%) or more.

(h) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subsection:

(1) For purposes of this subsection, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(2) For purposes of this subsection, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (3).

(3) The standard nonforfeiture credit will be equal to 100% of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection (i).

(4) Benefit date.

(A) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or

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certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

(B) Notwithstanding Subparagraph (A), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

- (i) The end of the tenth year following the policy or certificate issue date; or
- (ii) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(5) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(i) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(j) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(k) The requirements set forth in this section shall become effective twelve (12) months after adoption of this provision and shall apply as follows:

(1) Except as provided in Paragraph (2), the provisions of this section apply to any long-term care policy issued in this state on or after the effective date of this amended regulation.

(2) For certificates issued on or after the effective date of this section, under a group long-term care insurance policy as defined in 36 O.S. § 4424(4)(a), which policy was in force at the time this amended regulation became effective, the provisions of this section shall not apply.

(l) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of O.A.C. 365:10-5-47 treating the policy as a whole.

(m) To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection (g) of this section, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(n) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

- (1) The nonforfeiture provision shall be appropriately captioned;
- (2) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in the changes in rates for premium

payment contracts approved by the commissioner for the same contract form; and

(3) The nonforfeiture provision shall provide at least one of the following:

- (A) Reduced paid-up insurance;
- (B) Extended term insurance;
- (C) Shortened benefit period; or
- (D) Other similar offerings approved by the commissioner.

365:10-5-53. Contingent benefit upon lapse

(a) Notwithstanding any other rule, the Commissioner may require the administration by an insurer of the contingent benefit upon lapse, as described in Section ~~26(A), (D) (3), (E), (F), (G), and (J) of the Long Term Care Insurance Model Regulation promulgated by the National Association of Insurance Commissioners, as adopted in October 2000~~ 365:10-5-48.6(g), as a condition of approval or acknowledgment of a rate adjustment for a block of business for which the contingent benefit upon lapse is not otherwise available.

(b) The insurer shall notify policyholders and certificate holders of the contingent benefit upon lapse when required by the commissioner in conjunction with the implementation of a rate adjustment. The commissioner may require an insurer who files for such a rate adjustment to allow policyholders and certificate holders to reduce coverage to avoid an increase in the policy's premium amount.

(c) The Insurance Commissioner may also approve any other alternative mechanism filed by the insurer in lieu of the contingent benefit upon lapse.

365:10-5-54. State long-term care insurance partnership program

(a) **Purpose.** In accordance with Section 6021 of the Deficit Reduction Act of 2005 (Pub.L. 109-171) and in addition to the applicable provisions of this chapter, the provisions of this section shall apply to any qualified state long-term care insurance partnership policy.

(b) **Requirements for partnership policies.** "Qualified state long-term care insurance partnership policy" or "partnership policy" means an insurance policy that meets the following requirements:

- (1) The policy covers an insured who was a resident of Oklahoma (or a Partnership State) when coverage first became effective under the policy.
- (2) The policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than July 1, 2008.
- (3) The policy meets all the applicable requirements of this Part and the requirements of the National Association of Insurance Commissioners long-term care insurance model act and model regulation as those requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 USC Section 1396p(b)(5)(A)).
- (4) The policy provides the following inflation protections:

(A) For a person who is less than sixty-one years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three percent (3%) per year compounded annually or a rate, compounded annually, that is based upon changes in the consumer price index.

(B) For a person who is at least sixty-one years of age but less than seventy-six years of age as of the date of purchase of the policy, the policy provides annual inflation protection of at least three percent (3%) simple or a rate that is based on the annual consumer price index.

(C) For a person who is at least seventy-six years of age as of the date of purchase of the policy, the policy may provide inflation protection.

(c) **Meaning of consumer price index.** As used in this section, "consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the bureau of labor statistics of the United States department of labor. The Commissioner may approve an alternative index to be used in place of the consumer price index or alternative inflation protection programs developed by the insurer if the Commissioner deems that such programs would meet the intent of this section.

(d) **Notice from insurer or agent.**

(1) An insurer or its agent, soliciting, negotiating or offering to sell a policy that is intended to qualify as a partnership policy, shall provide to each prospective applicant a Partnership Program Notice (Appendix HH), outlining the requirements and benefits of a partnership policy. A similar notice may be used for this purpose if filed and approved by the Commissioner. The Partnership Program Notice shall be provided with the required Outline of Coverage.

(2) A partnership policy issued or issued for delivery in Oklahoma shall be accompanied by a Partnership Disclosure Notice (Appendix II) explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified state long-term care insurance partnership policy. A similar notice may be used if filed and approved by the Commissioner. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid.

(e) **Partnership policy filings.**

(1) A partnership policy shall not be issued or issued for delivery in Oklahoma unless filed with and approved by the Commissioner. Any policy submitted for certification as a partnership policy shall be accompanied by a Partnership Certification Form (Appendix JJ), or a similar form filed and approved by the commissioner.

(2) Insurers requesting to make use of a previously approved policy form as a qualified state long-term care partnership policy shall submit to the commissioner a Partnership Certification Form signed by an officer of the company. Upon request of the Commissioner, the Partnership Certification Form shall be accompanied by a copy of the policy or certificate form listed, the approval

date, and a bookmark for each of the requirements listed in sections II and III of the form. A Partnership Certification Form shall be required for each policy form submitted for partnership qualification.

(f) **Offers of exchange.**

(1) Once an insurer begins to advertise, market, offer, or sell policies that qualify under the state long-term care partnership program, the insurer shall offer to policyholders and certificate holders the opportunity to exchange their existing long-term coverage for coverage that is intended to qualify under the state's long-term care partnership program provided that:

(A) The insurer is required to make the offer only for existing long-term care coverage that was issued on or after February 8, 2006;

(B) The insurer is required to make the offer only for existing long-term care coverage that is the type certified by the insurer for purposes of the state long-term care partnership program;

(C) The insurer is required to made the offer on at least a one time basis, in writing, to the existing policyholder or certificate holder at the time of the policy's first renewal following the date that the insurer begins to advertise, market, offer, or sell policies that qualify under the state's long-term care partnership program; and

(D) All of an insurer's existing long-term care policyholders or certificate holders possessing coverage of the type certified by the insurer shall be given the opportunity to exchange their existing coverage within one year of the date that the insurer began to advertise, market, offer, or sell policies that qualify under the state long-term care partnership program.

(2) An exchange occurs when an insurer offers a policyholder or certificate holder (hereinafter "insured") the option to replace an existing long-term care insurance policy with a policy that qualifies as a partnership plan, and the insured accepts the offer to terminate the existing policy and accepts the new policy. In making an offer to exchange, an insurer shall comply with all of the following requirements:

(A) The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured;

(B) The offer shall remain open for a minimum of ninety (90) days from the date of mailing by the insurer.

(3) Notwithstanding subsections (f)(1) and (2) of this section,

(A) An offer to exchange may be deferred for any insured who is currently eligible for benefits under an existing policy or who is subject to an elimination period on a claim, but such deferral shall continue only as long as such eligibility or elimination period exists; and

(B) An offer to exchange does not have to be made if the insured would be required to purchase additional benefits to qualify for the state long-term care

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partnership program and the insured is not eligible to purchase the additional benefits under the insurer's new business, long-term care and underwriting guidelines.

- (4) If the new policy has an actuarial value of benefits equal to or lesser than the actuarial value of benefits of the existing policy, then all of the following apply:
- (A) The new policy shall not be underwritten; and
 - (B) The rate charged for the new policy shall be determined using the original issue age and risk class of the insured that was used to determine the rate of the existing policy.
- (5) If the new policy has an actuarial value of benefits exceeding the actuarial value of the benefits of the existing policy, then all of the following apply:
- (A) The insurer shall apply its new business, long-term care, underwriting guidelines to the increased benefits only; and
 - (B) The rate charged for the new policy shall be determined using the method set forth in paragraph (4)(B) of this subsection for the existing benefits, increased by the rate for the increased benefits using the then current attained age and risk class of the insured for the increased benefits only.
- (6) The new policy offered in an exchange shall be on a form that is currently offered for sale by the insurer in the general market and the effective date of the partnership plan policy shall be the same as the new policy.
- (7) In the event of an exchange, the insured shall not lose any rights, benefits or built-up value that has accrued under the original policy with respect to the benefits provided under the original policy, including, but not limited to, rights established because of the lapse of time related to pre-existing condition exclusions, elimination periods, or incontestability clauses.
- (8) Insurers may complete an exchange by either issuing a new policy or by amending an existing policy with an endorsement or rider.
- (9) For those insureds with long-term care policies issued before February 8, 2006, any insurer may offer any insured an option to exchange an existing policy for a policy that qualifies as a state long-term partnership plan. The requirements set forth in subsections (f)(2) through (8) of this section shall apply to any such exchange.
- (g) **Report to HHS.** All insurers shall report to the Health and Human Services Secretary such information as required by Centers for Medicare & Medicaid Services (CMS), including but not limited to:
- (1) Notification regarding when insurance benefits provided under partnership plans have been paid and the amount of such benefits paid, and
 - (2) Notification regarding when such policies otherwise terminate.
- (h) **Requests for information by insured.** All insurers shall provide to any insured requesting such information a copy of the Approved Long-Term Care Partnership Program Policy Summary, which is hereby adopted and incorporated into this rule by reference. An insurer may use its own form

as long as the information and content is consistent with the information contained in Appendix KK to this chapter.

(i) **Closed blocks.** The Insurance Commissioner may prohibit an insurer from offering a partnership policy, through an order issued after opportunity for hearing, when an insurer has previously closed or intends to close a block of long-term care insurance coverage or long-term care partnership insurance coverage.

365:10-5-55. Availability of New Services or Providers

(a) An insurer shall notify policyholders of the availability of a new long-term policy series that provides coverage for new long-term care services or providers material in nature and not previously available through the insurer to the general public. The notice shall be provided within twelve (12) months of the date of the new policy series is made available for sale in this state.

(b) Notwithstanding Subsection (a) of this section, notification is not required for any policy issued prior to the effective date of this Section or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on a claim, or who previously had been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(c) The insurer shall make the new coverage available in one of the following ways:

(1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;

(2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;

(3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

(4) By an alternative program developed by the insurer that meets the intent of this Section if the program is filed with and approved by the commissioner.

(d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this Subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a new proprietary policy shall be notified when a new long-term care

policy series that provides coverage for new long-term care services or providers material in nature is made available to that limited distribution channel.

(e) Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to O.A.C. 365:10-5-45 and 365:10-5-48.5, and the reporting requirements of O.A.C. 365:10-5-45.1(a)-(e).

(f) Where the policy is offered through an employer, labor organization, professional, trade or occupational association, the required notification in Subsection (a) of this section shall be made to the offering entity. However, if the policy is issued to a group defined at Section 4424(4)(a) of Title 36, the notification shall be made to each certificateholder.

(g) Nothing in this section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add such new services or providers.

(h) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(i) This section shall become effective on or after July 14, 2008.

365:10-5-56. Right to Reduce Coverage and Lower Premiums

(a) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:

- (1) Reducing the maximum benefit; or
- (2) Reducing the daily, weekly or monthly benefit amount.
- (3) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.

(b) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.

(c) The age to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force.

(d) The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable.

(e) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by O.A.C. 365:10-5-43.1(1).

(f) This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(g) The requirements of this Section shall apply to any long-term care policy issued in this state on or after July 14, 2010.

PART 21. EXTENSION AND TERMINATION OF COVERAGE UNDER GROUP ACCIDENT AND HEALTH POLICY AND CONTRACTS OF HOSPITAL AND MEDICAL SERVICES OR INDEMNITY [REVOKED]

365:10-5-190. Purpose [REVOKED]

~~The purpose of this Part is to implement Section 4509 of Title 36 of the Oklahoma Statutes, to promote the public interest, to promote the availability of extension of benefits, to protect individuals during a continuing course of medical treatment, to prevent unfair practices, and to facilitate public understanding in the availability of extension of benefits upon termination of coverage.~~

365:10-5-191. Applicability and scope [REVOKED]

~~Except as otherwise specifically provided, this Part applies to all group accident and health insurance policies, contracts, or certificates issued or issued for delivery in this state on or after the effective date hereof, by the following insurance carriers:~~

- ~~(1) insurers;~~
- ~~(2) fraternal benefit societies;~~
- ~~(3) nonprofit health, hospital and medical service corporations;~~
- ~~(4) prepaid health plans;~~
- ~~(5) multiple employer welfare arrangements;~~
- ~~(6) health maintenance organizations; or~~
- ~~(7) similar organizations.~~

365:10-5-192. Definitions [REVOKED]

~~For the purpose of this Part, the term "terminated" or "termination" as used in 36 O.S. § 4509 shall mean an employee's loss of coverage, regardless of cause, including termination of the entire group.~~

365:10-5-193. Periods for which coverage is extended [REVOKED]

~~(a) In the case of any employee whose group accident and health insurance policy, contract, or certificate is terminated, the coverage provided prior to the termination shall remain in effect for a period of at least thirty (30) days for the terminated employee and his or her dependents who were covered at the time coverage was terminated.~~

- ~~(1) A period of 30 days will be granted for payment of premium due for the extension of coverage period, during which period the coverage shall remain in force.~~
- ~~(2) Premiums for the extension of coverage may be withheld from any claim payment for covered expenses payable under the policy, certificate, or contract where the expenses are incurred during the thirty (30) day period after the policy, certificate, or contract has terminated.~~
- ~~(3) All terminated employees are eligible for the thirty (30) day extension period provided for under 36 O.S. § 4509(A), regardless of whether they qualify for the additional extension period provided for by 36 O.S. § 4509(B).~~

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(4) A conversion policy is not "similar insurance" as contemplated by 36 O.S. § 4509(A) unless the coverage available under the conversion policy is substantially similar to the group accident and health insurance policy, certificate, or contract that terminated. A policy containing a pre-existing condition limitation shall not be considered similar insurance.

(b) In the case of an employee who had coverage under a policy, certificate, or contract for at least six (6) months and whose insurance has terminated, the coverage provided prior to the termination shall remain in effect for any continuous loss that began while the insurance was in force for a period of not less than three (3) months in the case of basic coverage or six (6) months in the case of major medical coverage. This extension may be predicated upon the continuous total disability of the person insured or his or her dependents or the expenses incurred in connection with a plan of surgical treatment, which shall include maternity care and delivery expenses that commenced prior to the termination.

(1) Premiums may be charged for the extension of benefits provided in this subsection.

(2) Premium charged shall be the premium which would have been charged for the coverage provided under the group policy, certificate, or contract had termination not occurred.

(3) Billing of premiums charged shall be mailed directly to the insured at the last known address of the insured or an address provided by the insured.

(4) Premium billing shall be made based on the premium billing schedule that the group policy, certificate, or contract had in place prior to the termination of coverage.

(5) Extension of insurance benefits shall not be conditioned upon the payment or receipt of premiums before coverage is provided.

(6) Premiums for the extension of benefits may be withheld from any claim payment for covered expenses incurred and due during the extension of benefits period. Normal collection methods provided by law may be used for premiums due but not remitted by the terminated employee.

365:10-5-194. When extension period begins [REVOKED]

In the case of an employee electing an extension of coverage of a group policy, certificate, or contract pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub.L. 99 272, Apr. 7, 1986, 100 Stat. 82, the extension of coverage provided under 36 O.S. § 4509 begins upon termination or exhaustion of the COBRA coverage period, which ever comes first.

(1) Extension of coverage shall be available to an employee who does not elect extension of coverage under the provisions of COBRA.

(2) The extension of coverage begins at the termination or exhaustion of coverage provided by COBRA and is subject to the same extension of coverage requirement had COBRA not been chosen.

(3) Extension of coverage shall be available to an employee who elected the COBRA extension of coverage option at the time such COBRA coverage is terminated, even if termination occurs prior to the exhaustion of the coverage that could be provided by COBRA.

365:10-5-195. Required notification to employee whose insurance is terminated [REVOKED]

(a) Upon termination of coverage, an employee shall be notified in writing of the extension of coverage option provided for under Section 4509 of Title 36 of the Oklahoma Statutes. The insurance carrier shall mail the notice to the employee at the employee's last known address within ten (10) days after termination is first known to the insurance carrier writing the group accident and health insurance policies, contracts, or certificate.

(b) The notice required by this section shall provide:

(1) The dates of extension of coverage;

(2) The provisions for payment of premium, if any;

(3) The fact that premium is not required to be paid prior to coverage being provided but that premium can be withheld from claims incurred during the extension of coverage period; and

(4) Notice to the insured that coverage may be extended for up to six (6) months in the case of continuous total disability, or in connection with a plan of surgical treatment, maternity care and delivery expenses, which commenced prior to the termination of coverage.

SUBCHAPTER 27. PRENEED LIFE INSURANCE MINIMUM STANDARDS FOR DETERMINING RESERVE LIABILITIES AND NONFORFEITURE VALUES REGULATION

365:10-27-1. Authority

This regulation is promulgated by the Insurance Commissioner pursuant to Sections 1510(A)(4)(iii) and 4029(H)(4)(h)(vi) of Title 36 of the laws of this state.

365:10-27-2. Scope

This regulation applies to preneed insurance, as defined in Section 365:10-27-4 of this regulation, and to similar policies and certificates. The Insurance Commissioner shall have the authority to determine what constitutes similar policies and certificates.

365:10-27-3. Purpose

The purpose of this regulation is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products. Research completed by the Deloitte University of Connecticut Actuarial Center and commissioned

by the Society of Actuaries as a part of a study of preneed mortality determined that the 2001 CSO Mortality Table, currently recognized as the prevailing table for the purposes of calculating reserves and nonforfeiture values both on a statutory basis and on a tax basis, produced inadequate reserves for insurance policies issued in support of a prearrangement agreement which provides goods and services at the time of an insured's death.

365:10-27-4. Definitions

The following words and terms when used in this Subchapter shall have the following meaning unless the context clearly indicates otherwise:

"2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the *Proceedings of the NAIC (2nd Quarter 2002)*. Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and non-smoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

"Ultimate 1980 CSO" means the Commissioners' 1980 Standard Ordinary Mortality Tables (1980 CSO) without ten-year (10-year) selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

"Preneed insurance" means for purposes of this regulation any insurance policy or certificate that is issued for the purpose of funding contracts for prepaid funeral benefits pursuant to Section 6125.2 of Title 36 of the laws of this state and the Prepaid Funeral Benefits Act, 36 O.S. § 6121, et seq.

365:10-27-5. Minimum valuation mortality standards

For preneed insurance and similar insurance policies and certificates, the minimum mortality standard for determining reserve liabilities and nonforfeiture values for both male and female insureds shall be the Ultimate 1980 CSO.

365:10-27-6. Transition rules

(a) For preneed insurance policies issued on or after the effective date of this regulation and before January 1, 2012, the 2001 CSO Mortality Table may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both male and female insureds.

(b) If an insurer elects to use the 2001 CSO Mortality Table as a minimum standard for any policy issued on or after the effective date of this regulation and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy testing, an annual written notification to the domiciliary commissioner. The notification shall include:

(1) A complete list of all preneed insurance policy forms that use the 2001 CSO Mortality Table as a minimum standard;

(2) A certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed insurance policies issued after the effective date and using the 2001 CSO Mortality Table as a minimum standard, develops adequate reserves. For the purposes of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies; and

(3) Supporting information regarding the adequacy of reserves for preneed insurance policies issued after the effective date of this regulation and using the 2001 CSO Mortality Table as a minimum standard for reserves.

(c) Preneed insurance policies issued on or after January 1, 2012, must use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

APPENDIX EE. TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE [REVOKED]

APPENDIX EE. TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE [NEW]

TABLE 1. TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE
PURSUANT TO O.A.C. 365:10-5-48.6(g)(3)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

**TABLE 2. TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE
PURSUANT TO O.A.C. 365:10-5-48.6(g)(4)**

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

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APPENDIX LL. NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE FOR SOLICITATIONS OTHER THAN DIRECT RESPONSE [NEW]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE 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 lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:

(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

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 in payment of 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 or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right,

- but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature of Agent, Broker or Other Representative)
[Typed Name and Address of Agent or Broker]

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

APPENDIX MM. NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE FOR DIRECT RESPONSE SOLICITATIONS [NEW]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

[Insurance company's name and address]

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

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 in payment of 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 or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

[OAR Docket #09-831; filed 5-5-09]

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND
HEALTH**

[OAR Docket #09-832]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Minimum Standards; Contract Guidelines
Part 13. Medicare Supplement Insurance Minimum Standards
365:10-5-123. Definitions [AMENDED]
365:10-5-127. Benefit standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued or delivered on or after July 1, 1992 and Prior to June 1, 2010 [AMENDED]
365:10-5-127.1. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010 [NEW]
365:10-5-128. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After [insert effective date adopted by state] and Prior to June 1, 2010 [AMENDED]
365:10-5-128.1. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED TO 365:10-5-128.3]
365:10-5-128.2. Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010 [NEW]
365:10-5-128.3. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED FROM 365:10-5-128.1]
365:10-5-129. Open enrollment [AMENDED]
365:10-5-129.1. Guaranteed Issue for Eligible Persons [AMENDED]
365:10-5-134. Required disclosure provisions
365:10-5-143. Prohibition Against Use of Genetic Information and Requests for Genetic Testing [NEW]
Appendix S. Outline of Coverage [REVOKED]
Appendix S. Outline of Coverage [NEW]

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307.1, 3610, 3611 and 3611.1

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n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed amendments to Part 13 of Subchapter 5, Medicare Supplement Insurance Minimum Standards, 365:10-5-123 through 143 and Appendix S, update the regulation to the most recent National Association of Insurance Commissioners' model regulation and implement federal mandates.

CONTACT PERSON:

Karl F. Kramer, Deputy Insurance Commissioner, (405) 521-2668

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

**SUBCHAPTER 5. MINIMUM STANDARDS;
CONTRACT GUIDELINES**

**PART 13. MEDICARE SUPPLEMENT
INSURANCE MINIMUM STANDARDS**

365:10-5-123. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Applicant" means:

- (A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and
- (B) In the case of a group Medicare supplement policy, the proposed certificateholder.

"Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

"Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

"Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"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.

"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; ~~A state health benefits risk pool;~~
- (G) A state health benefits risk pool;
- (GH) A state health benefits program;

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(~~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)).

"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;

"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.

"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.

"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 1822(g)(1) of the Social Security Act;

(B) Coverage supplemental to the coverage provided under Chapter 55 of the Title 10, United States Code; and

(C) Similar supplemental coverage provided to coverage under a group health plan.

"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).

"Insolvency" means an issuer is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"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.

"Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Advantage " means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), and includes:

(A) 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;

(B) Medicare medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

(C) Medicare Advantage private fee-for-service plans.

"Medicare Supplement Policy" means a group or individual policy of accident and health insurance or a subscriber contract of a non-profit hospital service and medical indemnity corporation or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare Supplement Policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

"Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to July 1, 1992.

"1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

"2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

"Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Secretary" means the Secretary of the United States Department of Health and Human Services.

365:10-5-127. Benefit standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued or delivered on or after July 1, 1992 and prior to June 1, 2010

(a) **Benefit standards.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992 and prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(b) **General standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

(1) **Preexisting conditions.** 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) **Sickness and accidents.** A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) **Benefits designed to cover cost sharing amounts under Medicare.** 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.

(4) **Termination of coverage of a spouse.** 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) **Guaranteed renewable.** Each Medicare supplement policy shall be guaranteed renewable and

(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 (b)(5)(E) of this section, 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 such benefits as otherwise meets 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 (b)(5)(C) of this section, 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 succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(6) **Continuous loss.** Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

~~(7) **Suspension.** 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 such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.~~

(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 such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

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(B) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period.

(B-C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

(C-D) Reinstitution of such coverages:

- (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
- (ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
- (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan as described in O.A.C. 365:10-5-127 to a 2010 Standardized plan as described in O.A.C. 365:10-5-127.1, the offer and subsequent exchange shall comply with the following requirements:

(A) An issuer need not provide justification to the Commissioner if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy

shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner according to the state's rate filing procedure.

(B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(C) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

(D) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

(c) **Standards for basic ("Core") benefits common to Benefit Plans A-J.** Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balances;

(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 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.

(d) **Standards for additional benefits.** The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by O.A.C. 365:10-5-128.

(1) Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

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

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(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. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a 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. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of 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 not covered by Medicare:

(A) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (B) of this paragraph and patient education to address preventive health care measures.

(B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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 one hundred twenty dollars (\$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/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 4 hours in a 24-hour period of services provided by a care provider is one visit.

(B) Coverage requirements and limitations are as follows:

(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

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recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;

(III) One thousand six hundred dollars (\$1,600) per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(C) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(e) **Standards for Plans K and L**

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(A) Coverage of One Hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Coverage of One Hundred percent (100%) of the Part a Hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expense for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit an an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A Deductible: Coverage for Fifty percent (50%) of the Medicare Part A inpatient

hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (J);

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

(F) Hospice Care: Coverage for Fifty percent (50%) of the cost sharing for all part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (J);

(G) Coverage for Fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (J);

(H) Except for coverage provided in Subparagraph (I) below, coverage for Fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph (J) below;

(I) Coverage of One Hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(J) Coverage of One Hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance fo the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of Four Thousand dollars (\$4,000.00) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

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

(A) The benefits described in Paragraphs (1) (A), (B), (C) and (I);

(B) The benefits described in Paragraphs (1) (D), (E), (F), (G) and (H), but substituting Seventy Five percent (75%) for Fifty percent (50%); and

(C) The benefit described in Paragraph (1) (J), but substituting Two Thousand dollars (\$2,000.00) for Four Thousand dollars (\$4,000.00).

365:10-5-127.1. Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after June 1, 2010

(a) **Benefit Standards.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010.

No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of O.A.C. 365:10-5-126 and 365:10-5-127.

(b) **General Standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) **Preexisting conditions.** 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) **Sickness and accidents.** A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) **Benefits designed to cover cost sharing amounts under Medicare.** 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 factors. Premiums may be modified to correspond with such changes.

(4) **Termination of coverage of a spouse.** 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) **Guaranteed renewable.** Each Medicare supplement policy shall be guaranteed renewable.

(A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under O.A.C. 365:10-5-127.1(b)(5)(E) of this regulation, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this Subsection.

(D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificateholder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or

(ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) **Continuous loss.** Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) **Suspension.**

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(B) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (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 reinstated (effective as

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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 resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(c) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(d) Standards for additional benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by O.A.C. 365:10-5-128.2.

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

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

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

365:10-5-128. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for delivery on or after July 1, 1992, and prior to June 1, 2010

(a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in O.A.C. 365:10-5-127(c).

(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 Sections 365:10-5-128(g) and ~~365:10-5-128.1~~ 365:10-5-128.3 of this regulation.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in O.A.C. 365:10-5-123. Each benefit shall be

structured in accordance with the format provided in O.A.C. 365:10-5-127(c) and (d) or O.A.C. Section—365:10-5-127(e) 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 (c) of this section, other designations to the extent permitted by law.

(e) Make-up of benefit plans are as follows:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in 365:10-5-127(c).

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible as defined in 365:10-5-127(d)(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), 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 365:10-5-127(d)(1), (2), (3) & (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an Foreign Country and the At-Home Recovery Benefit as defined in 365:10-5-127(d)(1), (2), (8) & (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), 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 365:10-5-127(d)(1), (2), (8) & (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in 365:10-5-127(c), 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 365:10-5-127(d)(1), (2), (3), (5) & (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 365:10-5-127(c) 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 Section 365:10-5-127(d)(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 365:10-5-127(c), 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 365:10-5-127(d)(1), (2), (4), (8) & (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), 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 365:10-5-127(d)(1), (2), (6) & (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), 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 365:10-5-127(d)(1), (2), (5), (6), (8) & (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in 365:10-5-127(c), 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 365:10-5-127(d)(1), (2), (3), (5), (7), (8), (9) & (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 365:10-5-127(c) of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the

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Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign county, preventive medical care benefit and at-home recovery benefit as defined in Sections 365:10-5-127(d)(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(ef) Make up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 365:10-5-127(e)(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 365:10-5-127(e)(2).

(g) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefits.

365:10-5-128.1. Medicare Select Policies and Certificates [AMENDED AND RENUMBERED TO 365:10-5-128.3]

(a) **Application.** This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) **Definitions.** For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(e) **Authorization.** The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(d) **Plan of operation approval.** A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.

(e) **Plan of operation requirements.** A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(A) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after hour care. The hours of operation and availability of after hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available 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 Commissioner.
- (f) **Plan of operation amendments.** A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.
- (g) **Non-network providers.** 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) **Unavailable services.** 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) **Full disclosure.** A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
- (1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
 - (A) Other Medicare supplement policies or certificates offered by the issuer; and
 - (B) Other Medicare Select policies or certificates.
 - (2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.
 - (3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out of network providers do not count toward the out of pocket annual limit contained in plans K and L.
 - (4) A description of coverage for emergency and urgently needed care and other out of service area coverage.
 - (5) A description of limitations on referrals to restricted network providers and to other providers.
 - (6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.
 - (7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.
- (j) **Proof of full disclosure.** 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 Section 365:10-5-128.1 and that the applicant understands the restrictions of the Medicare Select policy or certificate.
- (k) **Grievance procedures.** A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement.
- (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 Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.
- (l) **Opportunity to purchase Medicare supplement.**
- (1) 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.
 - (2) 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.

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(3) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.

(m) ~~Coverage upon termination of program.~~ Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) ~~Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.~~

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at home recovery services or coverage for Part B excess charges.

(n) ~~Cooperation with state and federal agencies.~~ 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.

365:10-5-128.2. Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after June 1, 2010

(a) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of O.A.C. 365:10-5-126 and 365:10-5-127.

(b) 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 O.A.C. 365:10-5-127.1. If an issuer makes available any of the additional benefits described in O.A.C. 365:10-5-127.1(d), or offers standardized benefit Plans K or L (as described in O.A.C.

365:10-5-128.3(f)(8) and (9)), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described above, a policy form or certificate form containing either standardized benefit Plan C (as described in O.A.C. 365:10-5-128.2(f)(3)) or standardized benefit Plan F (as described in O.A.C. 365:10-5-128.2(f)(5)).

(c) 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 O.A.C. 365:10-5-128.2(g) and in O.A.C. 365:10-5-128.3.

(d) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in O.A.C. 365:10-5-123. Each benefit shall be structured in accordance with the format provided in O.A.C. 365:10-5-127.1(c) and (d); or, in the case of plans K or L, in O.A.C. 365:10-5-128.2(f)(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.

(e) In addition to the benefit plan designations required in Subsection (d) of this section, an issuer may use other designations to the extent permitted by law.

(f) Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in O.A.C. 365:10-5-127.1(c).

(2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in 365:10-5-127.1(d)(1).

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in O.A.C. 365:10-5-127.1(d)(1), (3), (4), and (6), respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in O.A.C. 365:10-5-127.1(d) (1), (3), and (6), respectively.

(5) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in O.A.C. 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in O.A.C. 365:10-5-127.1(d) (1), (3), (4), (5), and (6).

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

(A) The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d) (1), (3), (4), (5), and (6).

(B) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d) (1), (3), (5), and (6), respectively.

(8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(A) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (x);

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

(F) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (x);

(G) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (x);

(H) Part B Cost Sharing: Except for coverage provided in Subparagraph (ix), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (x);

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

(J) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(A) The benefits described in 365:10-5-128.2(f)(8)(A), (B), (C) and (I);

(B) The benefit described in 365:10-5-128.2(f)(8)(D), (E), (F), (G) and (H), but substituting seventy-five percent (75%) for fifty percent (50%); and

(C) The benefit described in 365:10-5-128.2(f)(8)(J), but substituting \$2000 for \$4000.

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(10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(d)(2), (3) and (6).

(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in 365:10-5-127.1(c), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in 365:10-5-127.1(cd)(1), (3) and (6), with copayments in the following amounts:

(A) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(B) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(g) New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

365:10-5-128.3. Medicare select policies and certificates

(a) **Application.** This section shall apply to Medicare Select policies and certificates, as defined in this section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(b) **Definitions.** For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(c) **Authorization.** The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.

(d) **Plan of operation approval.** A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.

(e) **Plan of operation requirements.** A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(A) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(C) There are written agreements with network providers describing specific responsibilities.

(D) Emergency care is available 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 Commissioner.
- (f) **Plan of operation amendments.** A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved. An updated list of network providers shall be filed with the Commissioner at least quarterly.
- (g) **Non-network providers.** 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) **Unavailable services.** 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) **Full disclosure.** A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
 - (1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
 - (A) Other Medicare supplement policies or certificates offered by the issuer; and
 - (B) Other Medicare Select policies or certificates.
 - (2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.
 - (3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.
 - (4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
 - (5) A description of limitations on referrals to restricted network providers and to other providers.
 - (6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.
 - (7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.
- (j) **Proof of full disclosure.** 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) **Grievance procedures.** A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement.
 - (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 Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.
- (l) **Opportunity to purchase Medicare supplement.**
 - (1) 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.
 - (2) 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.
 - (3) 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

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more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(m) Coverage upon termination of program. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(n) Cooperation with state and federal agencies. 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.

365:10-5-129. 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 such 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 issuer shall be made available to all applicants who qualify under this subsection without regard to age.

(b) If an applicant qualifies under subsection (a) or subsection (d) of this Section and submits an application during the time period referenced in said subsection (a) or subsection (d)), and

(1) 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; or

(2) as of the date of application, has had a continuous period of creditable coverage that is less than six (6)

months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

(c) Except as provided in Subsection (b) and Section 365:10-5-140, subsection (a) and subsection (d) of this Section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

(d) At least one of the ten standardized Medicare supplement plans currently available from an issuer shall be made available to all applicants who qualify under this subsection by reason of disability. The issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual first enrolled for benefits under Medicare Part B.

(e) In the event Social Security backdates the Medicare enrollment date, the six-month enrollment period shall be calculated from the date the individual first receives notification of approval of Medicare coverage.

365:10-5-129.1. Guaranteed Issue for Eligible Persons

(a) **Guaranteed Issue.**

(1) Eligible persons are those individuals described in subsection (b) who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) 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) **Employee welfare benefit plan.** 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 or substantially all supplemental health benefits to the individual.

(2) **Medicare Advantage.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any

of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The ~~certification of the organization's organization or plan's plan certification [under this part]~~ has been terminated;

(B) ~~or the~~The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(~~B~~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;

(~~C~~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

(~~D~~E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) **Organizations.**

(A) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 (Medicare risk or 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) (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 365:10-5-129.1(b)(2).

(4) **Medicare supplement.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or because 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) **Termination of enrollment and subsequent enrollment.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or 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 an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment under this subparagraph 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) **Medicare Advantage disenrollment.**

(A) The individual, upon first becoming ~~both enrolled in eligible for benefit under Medicare~~ Part A of Medicare and at age 65 years of age or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

(B) ~~The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).~~

(~~C~~) An individual, under age 65, who first becomes eligible for Medicare Part B and enrolls in a Medicare Advantage plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

(7) **Part D Benefit Enrollment.** The individual enrolls in a Medicare Part D plan during the initial enrollment

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period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).

(c) **Guaranteed issue time periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(1), the guaranteed issue period begins on the later of 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); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Section 365:10-5-129.1(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 Section 365:10-5-129.1(b)(4)(A), the guaranteed issue period begins on the earlier of 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 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 Section 365:10-5-129.1(b)(2), (b)(4)(B), (b)(4)(C), (b)(5) or (b)(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection 365:10-5-129.1(b)(6), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Section 365:10-5-129.1(b) but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

(d) **Extended Medigap access for interrupted trial periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Section 365:10-5-129.1(b)(5)(A) is involuntarily terminated within the first twelve (12) months or 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 365:10-5-129.1(b)(5);

(2) In the case of an individual described in Section 365:10-5-129.1(b)(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Section 365:10-5-129.1(b)(6) is involuntarily terminated with 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 365:10-5-129.1(b)(6); and

(3) For purposes of Sections 365:10-5-129.1(b)(5) and (b)(6), no enrollment of an individual with an organization or provider described in Section 365:10-5-129.1(b)(5)(a), or with a plan or in a program described in Section 365:10-5-129.1(b)(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) **Products to which eligible persons are entitled.** The Medicare supplement policy to which eligible persons are entitled under:

(1) **Section 365:10-5-129. 1(b)(1), (2), (3) and (4).** Section 365:10-5-129.1(b)(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2) **Section 365:10-5-129. 1(b)(5).**

(A) Subject to subparagraph (B), Section 365:10-5-129.1(b)(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Section 365:10-5-129.1(c)(1).

(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is: The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or at the election of the policyholder, an A, B, C, F (including F with a high deductible, K or L policy that is offered by any issuer;

(3) **Section 365:10-5-129. 1(b)(6)(A).** Section 365:10-5-129.1(b)(6)(A) shall include any Medicare supplement policy offered by any issuer.

(4) **Section 365:10-5-129. 1(b)(6)(B).** Section 365:10-5-129.1(b)(6)(B) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible, K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage .

(f) **Notification provisions.**

(1) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual loses

coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

365:10-5-134. Required disclosure provisions

(a) General rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision shall be consistent with the type of contract issued. Such 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, such 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) If the issuer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the issuer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage points which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the policy shall be deemed to have been cancelled on the date the policy was placed in the United States mails in a properly addressed, postage paid envelope; or, if not so posted, on the date of delivery of such policy to the issuer.

(7) Issuers of accident and health policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person(s) 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 CMS and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Part. 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. For 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 Commissioner. Such 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.

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- (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) Such notices shall not contain or be accompanied by any solicitation.
- (c) **MMA notice requirements.** Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.
- (d) **Outline of coverage requirements for Medicare supplement policies.**
- (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant.
- (2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:
- "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."**
- (3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in Appendix S of this Chapter in no less than twelve (12) point type. All plans ~~A-L~~ 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 outline of coverage shall include the items described in Appendix S of this Chapter, in the order prescribed by Appendix S. The appropriate version of the outline of coverage as set out in Appendix S shall be used.
- (e) **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. ' 1395 et seq.), disability income policy, or other policy identified in 365:10-5-122(b), 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) of this Section shall disclose, using the applicable statement in Appendix V, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

365:10-5-143. Prohibition against use of genetic information and requests for genetic testing

- (a) This Section applies to all policies with policy years beginning on or after May 21, 2009.
- (b) An issuer of a Medicare supplement policy or certificate:
- (1) Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and
- (2) Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.
- (c) Nothing in Subsection (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from
- (1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
- (2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).
- (d) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.
- (e) Subsection (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection (a).

(f) For purposes of carrying out Subsection (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(g) Notwithstanding Subsection (c), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(A) compliance with the request is voluntary; and

(B) non-compliance will have no effect on enrollment status or premium or contribution amounts.

(3) No genetic information collected or acquired under this Subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Subsection.

(h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(i) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

(j) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection (h) if such request, requirement, or purchase is not in violation of Subsection (g).

(k) For the purposes of this Section only:

(1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means,

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

(B) the computation of premium or contribution amounts under the policy;

(C) the application of any pre-existing condition exclusion under the policy; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

APPENDIX S. OUTLINE OF COVERAGE [REVOKED]

APPENDIX S. OUTLINE OF COVERAGE [NEW]

TABLE 1. OUTLINE OF COVERAGE - COVER PAGE

[COMPANY NAME]
 Outline of Medicare Supplement Coverage-Cover Page: 1 of 2
 Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

BASIC BENEFITS for plans A – J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services.

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	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	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 A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)		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	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery		At-Home Recovery
				Preventive Care NOT covered by Medicare							Preventive Care NOT covered by Medicare

*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 benefits as Plans F and J after one has paid a calendar year [\$1730] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are [\$1730]. 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 the plan's separate foreign travel emergency deductible.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4000] Out of Pocket Annual Limit***	[\$2000] Out of Pocket Annual Limit***

**** Plans K and L provide for different cost-sharing for items and services than Plans A – J.**

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

*****The out-of-pocket annual limit will increase each year for inflation.**

See Outlines of Coverage for details and exception.

OUTLINE OF COVERAGE TABLE 2. REQUIRED ITEMS

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

[for direct response:]
[insert company's name] is not connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to 365:10-5-128(d).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.]

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**OUTLINE OF COVERAGE
TABLE 3. PLAN A
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

***A benefit period begins on the first day you receive services 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 \$[912]	\$[0]	\$[912] (Part A Deductible)
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$[456] 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 days	All but \$[114] a day	\$[0]	Up to \$ [114] 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 co-insurance for outpatient 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- 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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]

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**OUTLINE OF COVERAGE
TABLE 4. PLAN B
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th days 101st day and after	All approved amounts All but \$[100] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [100] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[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 co-insurance for outpatient 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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 \$[110] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

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**OUTLINE OF COVERAGE
TABLE 5. PLAN C
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [114] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[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 co-insurance for outpatient 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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]	\$[100] Part B Deductible)	\$[0]
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

(continued)

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**Plan C
(continued)**

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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% of amounts over the \$[50,000] lifetime maximum

**OUTLINE OF COVERAGE
TABLE 6. PLAN D
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] Up to \$[114] a day \$[0]	\$[0] \$ [0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[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 co-insurance for outpatient 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.**

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**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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

**Plan D
(continued)
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 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 visits)	\$[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 of \$[50,000]	20% of amounts over the \$[50,000] lifetime maximum

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**OUTLINE OF COVERAGE
TABLE 7. PLAN E
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

***A benefit period begins on the first day you receive services 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 \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$[456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114] a day	\$[0]	Up to \$ [114] 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 co-insurance for outpatient 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 CALENDAR YEAR**

***Once you have been billed \$[110] 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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)

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**Plan E
(continued)**

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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 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 administered or ordered by your doctor when not covered by Medicare First \$[120] each calendar year Additional charges	\$[0] \$[0]	\$[120] \$[0]	\$[0] All costs

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

**OUTLINE OF COVERAGE
TABLE 8. 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 services 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 [\$1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1730]. 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$ [456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114]a day	Up to [114]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 co-insurance for outpatient 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.**

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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 \$[1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1730]. 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES -- IN OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] 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]

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] 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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] life-time maximum

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OUTLINE OF COVERAGE TABLE 9. PLAN G

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

*A benefit period begins on the first day you receive services 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 \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$ [456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114]a day	Up to [114]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 co-insurance for outpatient 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

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Plan G
(continued)
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 Home Care Treatment Plan			
--Benefit for each visit	\$[0]	Actual charges up 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 of \$[50,000]	20% and amounts over the \$[50,000] lifetime maximum

OUTLINE OF COVERAGE
TABLE 10. PLAN H
 MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive services 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 \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$ [456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114]a day	Up to \$[114]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 co-insurance for outpatient 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.**

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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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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 \$[110] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

(continued)

Plan H
(continued)

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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum

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OUTLINE OF COVERAGE TABLE 11. PLAN I

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

*A benefit period begins on the first day you receive services 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 \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$ [456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114]a day	Up to \$[114]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 co-insurance for outpatient 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

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Plan I
(continued)

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 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]	

(continued)

Plan I
(continued)

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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] lifetime maximum

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OUTLINE OF COVERAGE
TABLE 12. 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 services 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 [\$1730] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$1730]. 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 outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$ [456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114]a day	Up to \$[114]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 co-insurance for outpatient 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 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 [\\$1730] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\\$1730]. 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 foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES -- IN OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

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Plan J or HIGH DEDUCTIBLE PLAN J
(continued)

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] 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]
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 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]	

(continued)

Plan J or HIGH DEDUCTIBLE PLAN J
(continued)

PARTS A & B (continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] 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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 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 administered or ordered by your doctor when not covered by Medicare First \$[120] each calendar year Additional charges	\$[0] \$[0]	\$[120] \$[0]	\$[0] All Costs

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

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**OUTLINE OF COVERAGE
TABLE 13. PLAN K**

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[912]	\$[456](50% of Part A deductible)	\$[456](50% of Part A deductible)♦
61 st thru 90th day	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days	All but \$[456] a day \$[0]	\$[456] a day 100% of Medicare eligible expenses	\$[0] \$[0]***
—Beyond the additional 365 days	\$[0]	\$[0]	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$[0]	\$[0]
21 st thru 100th day	All but \$[100] a day	Up to \$[57] a day	Up to \$[57] a day ♦
101st day and after	\$[0]	\$[0]	All costs
BLOOD			
First 3 pints	\$[0]	50%	50%♦
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	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

(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 K

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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$[0] Generally 75% or more of Medicare approved amounts Generally 80%	\$[0] Remainder of Medicare approved amounts Generally 10%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$4000])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$[0] \$[0] Generally 80%	50% \$[0] Generally 10%	50%♦ \$[100] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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PLAN K

PARTS A & B

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

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

OUTLINE OF COVERAGE
TABLE 14. PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[684] (75% of Part A deductible) \$[228] a day \$[456] a day 100% of Medicare eligible expenses \$[0]	\$[228] (25% of Part A deductible)♦ \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[100] a day \$[0]	\$[0] Up to \$[85.50] a day \$[0]	\$[0] Up to \$[28.50] a day♦ All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	75% \$[0]	25%♦ \$[0]
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

(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.

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PLAN L

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)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$2000])*
BLOOD First 3 pints Next \$[110] of Medicare Approved Amounts****	\$[0] \$[0]	75% \$[0]	25%♦ \$[100] (Part B deductible)♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L

PARTS A & B

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

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

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APPENDIX S. OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
OUTLINE OF COVERAGE - COVER PAGE

[COMPANY NAME]

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, J, I and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

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

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

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

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
REQUIRED ITEMS**

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [This paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

[for direct response:]
[insert company's name] is not connected with Medicare.

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

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COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to 365:10-5-128(d).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.]

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN A
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

***A benefit period begins on the first day you receive services 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 \$[912]	\$[0]	\$[912] (Part A Deductible)
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$[456] 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 days	All but \$[114] a day	\$[0]	Up to \$ [114] 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$[0]

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

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

***Once you have been billed \$[100] of Medicare- 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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 --Durable medical equipment First \$[100] of Medicare Approved Amounts*	100%	\$[0]	\$[0]
Remainder of Medicare Approved Amounts	\$[0]	\$[0]	\$[100] (Part B Deductible)
	80%	20%	\$[0]

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN B
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve days are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th days 101st day and after	All approved amounts All but \$[100] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [100] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$[0]

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

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**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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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 \$[110] of Medicare Approved Amounts*	\$[0]	\$[0]	\$[110] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN C
MEDICARE (PART A)--HOSPITAL SERVICES--PER BENEFIT PERIOD**

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] \$[0] \$[0]	\$[0] Up to \$ [114] a day All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$[0]

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

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**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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- 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]	\$[100] Part B Deductible)	\$[0]
Remainder of Medicare Approved Amounts	80%	20%	\$[0]

(continued)

**Plan C
(continued)**

OTHER BENEFITS--NOT COVERED BY MEDICARE

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

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**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN D**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$[456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th days 101st day and after	All approved amounts All but \$[114] a day \$[0]	\$[0] Up to \$[114] a day \$[0]	\$[0] \$ [0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$[0]

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

**PLAN 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

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**Plan D
(continued)
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]

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 of \$[50,000]	20% of amounts over the \$[50,000] lifetime maximum

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
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 services 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 [\$1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1730]. 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th days 91st day and after: --While using 60 lifetime reserve days --Once lifetime reserve dates are used --Additional 365 days --Beyond the Additional 365 days	All but \$[912] All but \$[228] a day All but \$[456] a day \$[0] \$[0]	\$[912] (Part A Deductible) \$[228] a day \$ [456] a day 100% of Medicare Eligible Expenses \$[0]	\$[0] \$[0] \$[0] \$[0]*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th days 101st day and after	All approved amounts All but \$[114]a day \$[0]	\$[0] Up to [114]a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$[0]

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

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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 \$[1730] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1730]. 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 \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES -- IN OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] 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]

OTHER BENEFITS--NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1730] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1730] 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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maximum of \$[50,000]	\$[250] 20% and amounts over the \$[50,000] life-time maximum

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OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010 PLAN G

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

*A benefit period begins on the first day you receive services 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 \$[912]	\$[912] (Part A Deductible)	\$[0]
61st thru 90th days	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: --While using 60 lifetime reserve days	All but \$[456] a day	\$ [456] a day	\$[0]
--Once lifetime reserve dates 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 days	All but \$[114]a day	Up to [114]a day	\$[0]
101st day and after	\$[0]	\$[0]	All costs
BLOOD First 3 pints	\$[0]	3 pints	\$[0]
Additional amounts	100%	\$[0]	\$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/co- insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$[0]

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

PLAN 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 OUR 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	80% (Generally)	20% (Generally)	\$[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-- TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

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Plan G
(continued)
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 Home Care Treatment Plan			
--Benefit for each visit	\$[0]	Actual charges up 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 of \$[50,000]	20% and amounts over the \$[50,000] lifetime maximum

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN K**

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[912]	\$[456](50% of Part A deductible)	\$[456](50% of Part A deductible)♦
61 st thru 90th day	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used:	All but \$[456] a day	\$[456] a day	\$[0]
—Additional 365 days	\$[0]	100% of Medicare eligible expenses	\$[0]***
—Beyond the additional 365 days	\$[0]	\$[0]	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$[0]	\$[0]
21 st thru 100th day	All but \$[100] a day	Up to \$[57] a day	Up to \$[57] a day ♦
101st day and after	\$[0]	\$[0]	All costs
BLOOD			
First 3 pints	\$[0]	50%	50%♦
Additional amounts	100%	\$[0]	\$[0]
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayments/coinsurance	50% of Medicare copayments/coinsurance♦

(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.

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PLAN K

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**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$[0] Generally 75% or more of Medicare approved amounts Generally 80%	\$[0] Remainder of Medicare approved amounts Generally 10%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$4000])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$[0] \$[0] Generally 80%	50% \$[0] Generally 10%	50%♦ \$[100] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

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

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

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OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010 PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[912]	\$[684] (75% of Part A deductible)	\$[228] (25% of Part A deductible)♦
61st thru 90th day	All but \$[228] a day	\$[228] a day	\$[0]
91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days	All but \$[456] a day	\$[456] a day	\$[0]
—Beyond the additional 365 days	\$[0]	100% of Medicare eligible expenses	\$[0]***
	\$[0]	\$[0]	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day	All approved amounts All but \$[100] a day	\$[0] Up to \$[85.50] a day	\$[0] Up to \$[28.50] a day♦
101st day and after	\$[0]	\$[0]	All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	75% \$[0]	25%♦ \$[0]
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayments/coinsurance	50% of Medicare copayments/coinsurance♦

(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 L

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)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs (and they do not count toward annual out-of-pocket limit of [\$2000])*
BLOOD First 3 pints Next \$[110] of Medicare Approved Amounts****	\$[0] \$[0]	75% \$[0]	25%♦ \$[100] (Part B deductible)♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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PLAN L

PARTS A & B

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

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

**OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010
PLAN M**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[1068] All but \$[267] a day All but \$[534] a day \$[0] \$[0]	\$[534](50% of Part A deductible) \$[267] a day \$[534] a day 100% of Medicare eligible expenses \$[0]	\$[534](50% of Part A deductible) \$[0] \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[133.50] a day \$[0]	\$[0] Up to \$[133.50] a day \$[0]	\$[0] \$0 All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$[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.

Permanent Final Adoptions

PLAN M

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

* Once you have been billed \$[135] 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] Generally 80%	\$[0] Generally 20%	\$[135] (Part B deductible) \$[0]
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
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(continued)

PLAN M

OTHER BENEFITS—NOT COVERED BY MEDICARE

<p>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 Remainder of Charges</p>	<p>\$[0] \$[0]</p>	<p>\$[0] 80% to a lifetime maxi- mum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
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OUTLINE OF COVERAGE OF MEDICARE SUPPLEMENT PLANS SOLD AFTER JUNE 1, 2010 PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[1068] All but \$[267] a day All but \$[534] a day \$[0] \$[0]	\$[1068](Part A deductible) \$[267] a day \$[534] a day 100% of Medicare eligible expenses \$[0]	\$[0] \$0 \$[0] \$[0]** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[133.50] a day \$[0]	\$[0] Up to \$[133.50] a day \$[0]	\$[0] \$[0] All costs
BLOOD First 3 pints Additional amounts	\$[0] 100%	3 pints \$[0]	\$[0] \$[0]
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$[0]

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

PLAN N

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

* Once you have been billed \$[135] 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] Generally 80%	\$[0] Balance, other than up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$[135] (Part B deductible) up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	\$[0]	\$[0]	All costs
BLOOD First 3 pints Next \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$[0] \$[0] 80%	All costs \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$[0]	\$[0]

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$[0] 80%	\$[0] \$[0] 20%	\$[0] \$[135] (Part B deductible) \$[0]
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PLAN N

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 Remainder of Charges	\$[0] \$[0]	\$[0] 80% to a lifetime maxi- mum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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[OAR Docket #09-832; filed 5-5-09]

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 15. PROPERTY AND CASUALTY**

[OAR Docket #09-834]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 7. Property and Casualty Competitive Loss Cost Rating Regulation
- 365:15-7-32. Use of "a" rates [NEW]
- Appendix D. Format for Notification to Policyholders of Application for Rate Change [REVOKED]
- Appendix D. Format for Notification to Policyholders of Application for Rate Change [NEW]

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307.1, 997 and 6821

DATES:

Comment period:

January 15, 2009 to February 16, 2009

Public hearing:

February 18, 2009

Adoption:

March 3, 2009

Submitted to Governor:

March 3, 2009

Submitted to House:

March 3, 2009

Submitted to Senate:

March 3, 2009

Gubernatorial approval:

March 24, 2009

Legislative approval:

Failure of the Legislature to disapprove the rules resulted in approval on April 28, 2009

Final adoption:

April 28, 2009

Effective:

July 14, 2009

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed new rule 365:15-7-32 defines the term "a" rates as used in the Property and Casualty Competitive Loss Cost Rating Act and requires an insurer claiming an "a" rate exemption from the Act to make a filing that justifies the claim of exemption.

Appendix D is revised. The proposed amendments require notification to policyholders of either a rate increase or decrease. The terminology of Section 6821 of Title 36 discusses rate changes, not rate increases.

CONTACT PERSON:

Karl F. Kramer, Deputy Insurance Commissioner, (405) 521-2668

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2009

**SUBCHAPTER 7. PROPERTY AND CASUALTY
COMPETITIVE LOSS COST RATING
REGULATION**

365:15-7-32. Use of "a" rates

(a) As used in Section 997 of Title 36 of the laws of this state, an "a" rate is a rating rule or rate expressed as the symbol "a" or the words "refer to company" listed opposite a classification code on the manual rule and rate pages.

(1) An "a" rate may be used only when neither an advisory organization nor any other insurer has yet established a manual rate based upon experience.

(2) Once an advisory organization or an insurer acquires sufficient experience to establish a manual rate for such coverage, then the coverage is no longer considered to be eligible for "a" rating.

(b) An insurer claiming an "a" rate exemption pursuant to Section 997 of Title 36 of the laws of this state shall file with the Commissioner a statement justifying the use of the exemption. The statement shall include the policies and procedures for underwriting and developing "a" rates and any formal guidelines established by the insurer for these situations. The filing shall include an acknowledgment that the coverage is no longer eligible for "a" rating once an advisory organization or an insurer acquires sufficient experience to establish a manual rate for such coverage.

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APPENDIX D. FORMAT FOR NOTIFICATION TO POLICYHOLDERS OF APPLICATION FOR RATE CHANGE [REVOKED]

APPENDIX D. FORMAT FOR NOTIFICATION TO POLICYHOLDERS OF APPLICATION FOR RATE CHANGE [NEW]

NOTICE OF RATE CHANGE APPLICATION

TO ALL INSUREDS OF [medical professional liability insurer name]

On [rate change application filing date], [medical professional liability insurer name] filed a Rate Change Application with the Oklahoma Insurance Department, seeking approval of a any rate change in its medical professional liability rates. The proposed effective date of this rate change will be [effective date]. Policyholders are entitled to notice of the Rate Change Application pursuant to Section 6821(C) of Title 36 of the Oklahoma Insurance Code.

[Medical professional liability insurer name] has the burden of proving that the requested change is justified and meets the requirements of Section 6821. You or your representative may request a hearing by the Oklahoma Insurance Department on the Application. The hearing request must be in writing and must be received by the Insurance Department within forty-five (45) days of the date of this notice. Requests for a hearing must be addressed to the Oklahoma Insurance Department, Attn: Property and Casualty Division, P. O. Box 53408, Oklahoma City, OK 73152-3408. The scope of the hearing will be limited to the items mentioned by Section 6821. Written requests for a hearing and written comments about the proposed change become public record and are subject to the Oklahoma Open Records Act.

No professional medical liability insurer shall cancel or refuse to renew coverage of a policyholder on the basis of a policyholder's exercise of any right pursuant to Section 6821.

Specific questions about the circumstances that produced the Rate Change Application should be directed to [medical professional liability insurer contact person, contact information]. Questions about the details of the Application should be directed to the Oklahoma Insurance Department's Property and Casualty Rates Division.

Sincerely,

[medical professional liability insurer contact information].

[OAR Docket #09-834; filed 5-5-09]

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 25. LICENSURE OF
PRODUCERS, ADJUSTERS, BAIL
BONDSMEN, COMPANIES, PREPAID
FUNERAL BENEFITS, AND VIATICAL AND
~~LIFE SETTLEMENTS PROVIDERS AND~~
BROKERS**

[OAR Docket #09-835]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Producers, Brokers, ~~and~~ Limited Lines Producers and
Vehicle Protection Product Warrantors

- 365:25-3-1. Insurance producers continuing education [AMENDED]
- 365:25-3-14. Insurance adjusters continuing education [AMENDED]
- 365:25-3-18. Compensation and education for sale of Medicare Advantage or Medicare private fee for service products and plans [AMENDED]
- 365:25-3-19. Medicare Part D volunteer counselors [NEW]
- 365:25-3-20. Vehicle protection product warrantor; fee; forms [NEW]

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307.1, 6653(C), 1435.19, 1435.29(C) and (H), 1435.5(B)(8), 6217(F), 6650, et seq. and 6653(C)

DATES:

Comment period:

January 15, 2009 to February 16, 2009

Public hearing:

February 18, 2009

Adoption:

March 3, 2009

Submitted to Governor:

March 3, 2009

Submitted to House:

March 3, 2009

Submitted to Senate:

March 3, 2009

Gubernatorial approval:

March 24, 2009

Legislative approval:

Failure of the Legislature to disapprove the rules resulted in approval on April 28, 2009

Final adoption:

April 28, 2009

Effective:

July 14, 2009

SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

365:25-3-19. Medicare Part D volunteer counselors [NEW]

Gubernatorial approval:

August 8, 2008

Register publication:

26 Ok Reg 16

Docket number:

08-1229

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed amendments to 365:25-3-1(d)(4) deletes health coverage and welfare coverage from elective credit topics. There is no elective credit for life and health producers. The proposed amendments to 365:25-3-1(f)(1) adds a non-refundable course review fee to be paid by producer continuing education providers.

The amendments to 365:25-3-1(f)(11) delete the requirement that producers complete a course evaluation form to be submitted by the provider to the Department and, if approved, the provision will state that a provider shall provide written notification to each producer of the opportunity to offer comments on any Continuing Education Class via the Oklahoma Insurance Department website. The proposed new paragraph 365:25-3-1(f)(12) requires a non-refundable course review fee of thirty dollars (\$30.00) per course pursuant to Section 1435.29(C) of Title 36.

The proposed amendments to 365:25-3-14(c) provide that non-resident adjusters are not required to take continuing education in Oklahoma if they have met the continuing education requirement of another state that licenses non-resident adjusters.

The proposed new paragraph 365:25-3-14(f)(11) requires a non-refundable course review fee of thirty dollars (\$30.00) per course pursuant to Section 6217(F) of Title 36.

The proposed amendments to 365:25-3-18 provide clarity to continuing education requirements for sellers of Medicare Advantage products.

The proposed new rule 365:25-3-19 sets forth supporting documentation to be submitted to the Insurance Commissioner by volunteer counselors prior to conducting enrollment assistance to Medicare beneficiaries enrolling in Medicare Part D plans. Section 9 of House Bill 2122 (36 O.S. § 1435.5(B)(8)) provides that the supporting documents must be set out by rule. This rule was effective as an emergency rule on August 8, 2008.

The proposed new rule 365:25-3-20 requires the payment of a two hundred dollar (\$200.00) fee for initial and annual registrations to cover the cost of processing the registration and maintaining records pursuant to the new Vehicle Protection Product Act, 36 O.S. § 6650, et seq., and in particular, Section 6653(C) of Title 36.

CONTACT PERSON:

Karl F. Kramer, Deputy Insurance Commissioner, (405) 521-2668

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2009:

SUBCHAPTER 3. PRODUCERS, BROKERS, AND LIMITED LINES PRODUCERS AND VEHICLE PROTECTION PRODUCT WARRANTORS

365:25-3-1. Insurance producers continuing education

(a) **Purpose.** The purpose of this section is to set forth the requirements for continuing education, which an insurance producer must meet and to set forth the requirements for approval by the Insurance Commissioner of a proposed continuing education course.

(b) **Definitions.** The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

- (1) **"CEC"** means continuing education credit.
- (2) **"Certificate of course completion"** means a document acceptable to the Commissioner which signifies satisfactory completion of the course and reflects hours of credit earned.
- (3) **"Continuing Education Advisory Committee"** means the committee established by the Commissioner for the purpose of reviewing and recommending approval or disapproval of continuing education courses.
- (4) **"Credit hour"** means at least fifty (50) minutes classroom instruction unless a correspondence or self-study course.
- (5) **"Instructor"** means a person who presents course materials approved for continuing education credit hours, and who has experience, training, and/or education in the course subject matter and has been approved by the Commissioner.

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- (6) **"Instructor Qualification Form"** means a form acceptable to the Commissioner and completed by the instructor which documents qualifications of the instructor.
- (7) **"Licensee"** means a natural person who is licensed by the Commissioner as an insurance producer.
- (8) **"Provider"** means a person, corporation, professional association or its local affiliates, an insurance company or any other entity which is approved by the Commissioner and provides approved continuing education to insurance producers.
- (9) **"Provider Course Completion Form"** means a form acceptable to the Commissioner and completed by the provider which documents completion of an approved course by a producer or producers.
- (c) **Exceptions.** The requirements for continuing education in this section shall not apply to:
- (1) limited lines producers.
 - (2) a non-resident producer who resides and is licensed in a state or district having continuing education requirements and the producer meets all the requirements of that state or district to practice therein. The non-resident producer shall be responsible for completing any reporting requirements necessary to verify completion.
 - (3) a non-resident producer of a state that does not require continuing education hours may fulfill the requirements of any other state's continuing education requirements and shall be deemed to have complied with this rule upon proof of completion of said hours.
- (d) **Continuing education requirements.**
- (1) **CEC during twenty-four month period.** All licensees shall complete the required hours of continuing education as set forth in 36 O.S. § 1435.29 during each twenty-four month period. The twenty-four month period begins the first day of the month following the month in which the license is granted. The credit hours completed must be in those lines in which the producer is licensed. Ethics shall include, but not be limited to, the study of fiduciary responsibility, commingling of funds, payment and acceptance of commissions, unfair claims practices, policy replacement consideration, and conflicts of interest.
 - (2) **Certificates of course completion required for license renewal.** If requested by the Insurance Department, each producer shall submit upon each licensing renewal certificate(s) of course completion as approved by the Insurance Department, which verify courses completed during the previous twenty-four month period.
 - (3) **Credits carried over.** Six (6) credit hours in excess of the minimum twenty-four month period requirement shall carry forward to the next twenty-four month period. Excess hours may be applied to bring a lapsed license into compliance.
 - (4) **Elective Credit Legislative updates.**
 - (A) At least two (2) of the continuing education credit hours of instruction completed by licensees each twenty-four month period shall be taken in the following topics:
 - (A) state legislative updates
 - (B) federal legislative updates
 - (iii) health coverage
 - (iv) welfare coverage
 - (B) ~~Electives in health and welfare coverage shall not apply to property and casualty and title producers.~~
- (5) **Credits for instructors.** An instructor who is a licensee shall receive the same continuing education credit for presenting approved course materials as a licensee who attends an approved classroom instructional session.
- (6) **Prerequisite for renewal or reinstatement.** As a prerequisite for licensure renewal or upon reinstatement following a lapse of license, a producer must submit, on his or her renewal/reinstatement date, the appropriate forms as specified in this section which establish that the education requirements have been met for the previous year(s).
- (e) **Approval of continuing education providers.**
- (1) **Information required, fee.** Each provider shall apply for approval from the Commissioner. Each provider, with the exception of public funded educational institutions, federal agencies or Oklahoma state agencies shall submit after its approval a provider fee of Two Hundred Dollars (\$200.00), and all providers, including public funded educational institutions, federal agencies and Oklahoma agencies shall provide:
 - (A) Name and address of the provider;
 - (B) Contact person and his or her address and telephone number;
 - (C) The location of the courses or programs, if known, unless it is an individual self-study course;
 - (D) The number of CEC hours requested for each course;
 - (E) Topic outlines which list the summarized topics covered in each course and a copy of any course materials. If a prior approved course has substantially changed, a summarization of those changes;
 - (F) The names and qualification of instructors. An instructor shall have one of the following qualifications:
 - (i) Three (3) years of recent experience in the subject area being taught; or
 - (ii) A degree related to the subject area being taught; or
 - (iii) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.
 - (G) If a prior approved course has materially changed, a summarization of those changes;
 - (2) **Renewal fee.** An annual renewal fee of Two Hundred Dollars (\$200.00) shall be payable on or before the approval anniversary date of each year by each provider to renew the approval of the provider. A fee of double the annual renewal fee shall be paid if the application for renewal is late or incomplete on the approval anniversary date.
 - (3) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval of any provider

for violation of or non-compliance with any provision of this section.

(f) **Courses; approval; records; fee.**

(1) **Timeline for approval.** At least thirty (30) days prior to the use of any course and not less than ten (10) days prior to the Continuing Education Advisory Committee meeting immediately preceding the course date, the provider shall apply for and submit the appropriate course review fee to the Commissioner for course approval. The Commissioner shall grant or deny approval based upon information submitted in this section regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of CEC hours awarded for an approved course and the line or lines of insurance for which the course qualifies.

(2) **Written approval required.** All courses shall require written approval by the Commissioner.

(3) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval for any course approval. This withdrawal will not affect any CEC hours attained under the course previous to the withdrawal.

(4) **Minimum of one credit hour.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.

(5) **Continuing education course must be separate from meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.

(6) **Content of courses.** Courses must be of a meaningful nature and shall not include items such as prospecting, motivation, sales techniques, psychology, recruiting, and subjects not relating to the insurance license. However, agency management courses designed to assist producers in becoming more efficient, profitable, and assuring their perpetuation, will be deemed to be in the best interest of the insuring public and thereby subject to approval. Each such agency management course must include the description, the effects the course is designed to accomplish toward the purposes of efficiency, profitability, and/or perpetuation and each course will be reviewed for approval on its own merits.

(7) **Certificate of Course Completion.** At the completion of each course, the provider shall provide the insurance producer a "Certificate of Course Completion" Form.

(8) **List of producers completing course to Commissioner; producer license numbers.** Within ten (10) business days after completion of each course, the provider shall provide the Commissioner a list of all insurance producers who completed the course on the Course Completion Form. This list shall contain the course number, date of completion and license numbers of all insurance producers completing the course. If the list is not reported within ten (10) business days, a late report fee of \$50.00 shall be paid to the Insurance Department. Failure to pay the late report fee may result in revocation of provider approval. Continued late filing may also result in loss of approval.

(9) **Course records maintained four years.** Providers shall maintain course records for at least four (4) years. The Commissioner may order an examination of a provider, at the provider's expense, for good cause shown.

(10) **Repeated approved course.** At least fourteen (14) days prior to the repetition of an approved course, the Commissioner shall be notified in writing of the repetition, providing course number, name, date and instructor's name.

(11) **Course evaluation.** The continuing education provider shall provide written notification to each producer of the opportunity to offer comments on any continuing education class via the Insurance Department website require each producer listed on the Course Completion Form to complete a course evaluation form to be submitted to the Department within ten (10) business days after completion of each course.

(12) A non-refundable course review fee of thirty dollars (\$30.00) per course shall be submitted by all continuing education providers at the time the course submission is first submitted for review and upon submission for renewal at expiration with the exception of publicly funded educational institutions, federal agencies, Oklahoma state agencies, non-profit organizations, and not-for-profit organizations.

(g) **Approved Professional Designation Programs**

(1) **Definitions.**

(A) **Participation.** As used in 36 O.S. § 1435.29(B)(3), participates means successfully completing any part of a course curriculum totaling twenty (20) classroom or equivalent classroom hours of an approved professional designation program.

(B) **Approved Professional Designation Program.** As used in 36 O.S. § 1435.29(B)(3), an approved professional designation program means an educational insurance program approved by the Commissioner with a sponsoring organization that administers curriculum requirements and testing standards for candidates.

(2) **Requirements.** A professional designation program shall satisfy the following criteria to receive initial and ongoing approval for the program:

(A) The program shall have a sponsoring organization;

(B) The program's sponsoring organization shall maintain and govern a code of conduct;

(C) The program shall be relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma;

(D) Each course of the professional designation course curriculum shall be a minimum of twenty (20) hours of classroom instruction or equivalent classroom instruction; and

(E) The program shall include an examination requirement that students shall pass before earning the designation.

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- (3) **Submissions.** The sponsoring organization shall submit the following to the Commissioner for its professional designation program to be considered for initial and ongoing approval for the program:
- (A) The sponsoring organization's code of conduct;
 - (B) The sponsoring organization's membership requirements;
 - (C) The professional designation program's course requirements; and
 - (D) The professional designation program's examination requirements.
- (4) **Submission exemptions.** Professional designation programs recognized by the National Association of Insurance Commissioners (NAIC) for waiver/exemption of pre-licensing education training shall receive initial and continuing approval without submission by the sponsoring organization.
- (h) **Presumptive Continuing Education Credit Approval.**
- (1) **Requirements.** A professional association may receive presumptive approval of the association's continuing education courses by satisfying the following requirements:
- (A) The association shall have a mission statement that includes a commitment to enhance the professional, educational, or ethical skills of its members;
 - (B) The association shall maintain and govern a code of member conduct;
 - (C) The association shall offer educational programs relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma; and
 - (D) The association shall perpetuate its continuity through the election of officers.
- (2) **Submissions.** Each professional association shall submit the following to be considered for initial and ongoing presumptive course approval:
- (A) The association's mission statement;
 - (B) The association's code of member conduct;
 - (C) The chapter officers, the responsibilities for each officer, and the term of office for each officer;
 - (D) The mailing address and primary contact for the association; and
 - (E) The list of continuing education courses approved in Oklahoma and offered by the professional association in the past twenty-four (24) months.
- (3) **Notification of approval or disapproval.**
- (A) The Commissioner shall notify the association within ninety (90) days from the receipt of submission whether presumptive approval for continuing education courses was granted. The notification shall indicate the reasons for disapproval.
 - (B) Submissions to the Commissioner by an association seeking presumptive approval of continuing education courses shall include the course summary, instructor name, course date and location and shall be submitted to the Commissioner at least fifteen (15) business days prior to the presentation of the course.
 - (C) If the Commissioner receives a report or reports that the content of a continuing education course may violate 365:25-3-1(f)(6) of this section, the Commissioner may review the content and determine if the course should be disapproved for noncompliance. The Commissioner shall notify the association if the course has been disapproved due to non-compliance, and the association shall immediately cease offering the course upon receipt of the notification. The association may then make corrections to a disapproved course to bring the course into compliance with 365:25-3-1(f)(6) of this section and submit the course for approval by the Commissioner in the manner of an original submission for presumptive continuing education course approval.
 - (D) Should an association receive notification of three (3) disapproved courses within a twenty-four (24) month period, the association's presumptive approval for continuing education courses shall be rescinded for twenty-four (24) months after which time the association may re-apply for presumptive approval.
- (4) **Assignment of course number.** The Commissioner shall assign a course number once the presumptive approval for continuing education courses has been granted and shall notify the association of the assigned course number. All future correspondence relating to that course shall reference the assigned course number.
- (5) **Instructor approval.** Instructors shall be approved by the Commissioner at least fourteen (14) calendar days prior to a presentation of a course. The Commissioner may disapprove any course if instructor approval has not been granted.
- (6) **Review.** Course approval shall be reviewed every three (3) years. The association shall re-submit the items required in subparagraph (3)(B) of this section during the fourth quarter of the last approval year.
- (7) **Agency Management Courses.** Agency management courses shall not be considered for presumptive continuing education approval.
- (i) **Self study and Distance Learning Courses.** The Insurance Commissioner shall determine appropriate guidelines and standards for self-study and distance learning CEC offerings. The guidelines and standards shall include authentication of the registered licensee, technology requirements for course delivery and testing protocols. Guidelines and standards shall be reviewed, updated as appropriate, and published annually. Failure to follow the guidelines and standards established by the Commissioner may result in denial of continuing education credit for the producer and revocation of the course approval and or provider status for the provider.
- (j) **Repeating courses.** An insurance producer may repeat a course within the twenty-four month period if the maximum credits designated for the course were not attained in the first attempt. By repeating the course, the producer may not during the twenty-four month period earn more than the maximum credits designated for the course. A producer may repeat a course after two years have elapsed and receive the maximum credits designated for the course. This section shall not apply to ethics courses.

(k) **Extension of time.** For good cause shown, the Commissioner may grant an extension of time during which the requirements imposed by the act may be completed. The extension shall not exceed twelve (12) months. The extension will not alter the requirements or due date of the succeeding twenty-four-month period. "Good cause" includes disability, natural disaster, or other extenuating circumstances. Each request for extension of time shall be in writing from the licensee and shall include details and any documentation to support the request. Each request must be received by the Commissioner no less than thirty (30) days before the expiration of the twenty-four month period.

(l) **Course approval.** Prior to the Commissioner's approval or disapproval of a course in 365:25-3-1(f), a continuing education advisory committee will review the course submitted and make its nonbinding recommendation to the Commissioner on granting or denying approval based upon information submitted in 365:25-3-1(e) regarding the course or additional information regarding the course, if necessary, the number of CEC hours awarded for an approved course and the line or lines of insurance for which the course qualifies. Each course approval shall be valid for a period of not more than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course approval following the review of material changes shall reset the validity period. At the expiration of the validity period, providers shall submit the course for approval by the Commissioner if the provider wants to continue to offer the course for continuing education credit.

(m) **Severability provision.** If any provision of this section, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the section, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

365:25-3-14. Insurance adjusters continuing education

(a) **Purpose.** The purpose of this section is to set forth the requirements for continuing education which an insurance adjuster must meet, and to set forth the requirements for approval by the Insurance Commissioner of a proposed continuing education course.

(b) **Definitions.** The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

- (1) **"CEC"** means continuing education credit.
- (2) **"Certificate of course completion"** means a document acceptable to the Commissioner which signifies satisfactory completion of the course and reflects hours of credit earned.
- (3) **"Continuing Education Advisory Committee"** means the committee established by the Commissioner for the purpose of reviewing and recommending approval or disapproval of continuing education courses.
- (4) **"Credit hour"** means at least fifty (50) minutes of classroom instruction, unless a correspondence or self-study course.

(5) **"Instructor"** means a person who presents course materials approved for continuing education credit hours, and who has experience, training, and/or education in the course subject matter and has been approved by the Commissioner.

(6) **"Instructor Qualification Form"** means a form acceptable to the Commissioner and completed by the instructor which documents qualifications of the instructor.

(7) **"Licensee"** means a natural person who is licensed by the Commissioner as an insurance adjuster.

(8) **"Provider"** means a person, corporation, professional association or its local affiliates, an insurance company or any other entity which is approved by the Commissioner and provides approved continuing education to insurance adjusters.

(9) **"Provider Course Completion Form"** means a form acceptable to the Commissioner and completed by the provider ~~which~~ that documents completion of an approved course by an adjuster or adjusters.

(c) **Exceptions.** Continuing education requirements shall not apply to ~~a non-resident adjuster~~ adjuster licensed in a this state that has a continuing education requirement for adjusters ~~if the adjuster:~~

(1) Holds an active license as an adjuster in his or her resident (home) state, and the state has a credit hour based continuing education requirement; or

(2) Has designated a state that licenses adjuster as his or her "home state," and the state has a credit hour based continuing education requirement for non-resident adjusters.

(d) **Continuing education requirements.**

(1) **Twelve hours of CEC during twenty-four month period.** All licensees shall complete twelve (12) credit hours of continuing education during each twenty-four month period. The twenty-four month period begins the first day of the month following the month in which the license is granted. The credit hours completed must be in those lines in which the adjuster is licensed. Courses taken in excess of twelve (12) hours will not carry forward. However, courses taken in excess of twelve (12) hours may be applied retroactively in order to bring a lapsed license into compliance.

(2) **Certificates of course completion required for license renewal.** If course completion is not reflected on the license renewal form issued by the Insurance Department, each adjuster shall attach, if requested by the Commissioner, an approved course completion certificate to the license renewal form returned to the Department for verification of course completion. The Commissioner shall maintain a cumulative total of continuing education credit hours to insure compliance within the twenty-four (24) month period.

(3) **Credits for instructors.** An instructor who is a licensee shall receive the same continuing education credit for presenting approved course materials as a licensee who attends an approved classroom instructional session by including his/her name and license number on roster.

(4) **Prerequisite for renewal or reinstatement.** As a prerequisite for license renewal or prior to reinstatement

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following a lapse of license, an adjuster must submit the appropriate forms as specified in this section that establish the educational requirements have been met if not currently recorded by the Oklahoma Insurance Department.

- (e) **Approval of continuing education providers.**
- (1) **Information required.** Each provider shall apply for approval by the Commissioner. All providers, including publicly funded educational institutions, federal agencies, or Oklahoma state agencies, shall provide:
- (A) Name and address of the provider.
 - (B) Contact person and his or her address and telephone number(s).
 - (C) The location of the courses or programs, if known, unless it is an individual self-study course.
 - (D) The number of CEC hours requested for each course.
 - (E) Topic outlines which list the summarized topics covered in each course and a copy of any course materials.
 - (F) The names and qualification of instructors. An instructor shall have one of the following qualifications:
 - (i) Three (3) years of recent experience in the subject area being taught; or
 - (ii) A degree related to the subject area being taught; or
 - (iii) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.
 - (G) If a prior approved course has materially changed, a summarization of those changes.
- (2) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval of any provider for violation of or non-compliance with any provision of this section.
- (f) **Courses; approval; records.**
- (1) **Course approval timeline.** A provider shall apply to the Commissioner for course approval by submitting forms and materials to the Commissioner the first day of the month one full month prior to the date of the first course offering. The Commissioner shall grant or deny approval based upon information submitted in this section regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of CEC hours awarded for an approved course and the line or lines of insurance for which the course qualifies.
- (2) **Repeated approved course.** At least fourteen (14) days prior to the repetition of an approved course, the Commissioner shall be notified in writing of the repetition, providing course number, name, date, location and instructor's name.
- (3) **Written approval required.** All courses shall require written approval by the Commissioner.
- (4) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval for any course.

This withdrawal will not affect any CEC hours attained under the course previous to the withdrawal.

- (5) **Minimum of one credit hour.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.
- (6) **Continuing education course must be separate from meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.
- (7) **Content of courses.** Courses must be of a meaningful nature and shall not include items such as prospecting, motivation, sales techniques, psychology, recruiting, time management, phone etiquette, basic pre-licensing principles of adjusting, and subjects not relating to the adjuster's license.
- (8) **Certificate of Course Completion.** At the completion of each course, the provider shall provide the insurance adjuster a "Certificate of Course Completion" Form.
- (9) **List of adjusters completing course to Commissioner.** Within ten (10) business days after completion of each course, the provider shall provide the Commissioner a list of all insurance adjusters who completed the course on the Course Completion Form. This list shall contain the course number, date of completion and license numbers of all insurance adjusters completing the course. If the list is not reported within ten (10) business days, a late report fee of \$50.00 shall be paid to the Insurance Department. Failure to pay the late report fee may result in revocation of provider approval. Continued late filing may also result in loss of approval.
- (10) **Course records maintained four (4) years.** Providers shall maintain course records for at least four (4) years. The Commissioner may order an examination of a provider, at the provider's expense, for good cause shown.
- (11) A non-refundable course review fee of thirty dollars (\$30.00) per course shall be submitted by all continuing education providers at the time the course submission is first submitted for review and upon submission for renewal at expiration with the exception of publicly funded educational institutions, federal agencies, Oklahoma state agencies, non-profit organizations, and not-for-profit organizations.
- (g) **Approved professional designation programs**
- (1) **Definitions.**
- (A) **Participation.** As used in 36 O.S. § 1435.29(B)(3), participates means successfully completing any part of a course curriculum totaling twenty (20) classroom or equivalent classroom hours of an approved professional designation program.
- (B) **Approved professional designation program.** As used in 36 O.S. § 1435.29(B)(3), an approved professional designation program means an educational insurance program approved by the Commissioner with a sponsoring organization that administers curriculum requirements and testing standards for candidates.

- (2) **Requirements.** A professional designation program shall satisfy the following criteria to receive initial and ongoing approval for the program:
- (A) The program shall have a sponsoring organization;
 - (B) The program's sponsoring organization shall maintain and govern a code of conduct;
 - (C) The program shall be relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma;
 - (D) Each course of the professional designation course curriculum shall be a minimum of twenty (20) hours of classroom instruction or equivalent classroom instruction; and
 - (E) The program shall include an examination requirement that students shall pass before earning the designation.
- (3) **Submissions.** The sponsoring organization shall submit the following to the Commissioner for its professional designation program to be considered for initial and ongoing approval for the program:
- (A) The sponsoring organization's code of conduct;
 - (B) The sponsoring organization's membership requirements;
 - (C) The professional designation program's course requirements; and
 - (D) The professional designation program's examination requirements.
- (4) **Submission exemptions.** Professional designation programs recognized by the National Association of Insurance Commissioners (NAIC) for waiver/exemption of pre-licensing education training shall receive initial and continuing approval without submission by the sponsoring organization.
- (h) **Presumptive continuing education credit approval.**
- (1) **Requirements.** A professional association may receive presumptive approval of the association's continuing education courses by satisfying the following requirements:
- (A) The association shall have a mission statement that includes a commitment to enhance the professional, educational, or ethical skills of its members;
 - (B) The association shall maintain and govern a code of member conduct;
 - (C) The association shall offer educational programs relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma; and
 - (D) The association shall perpetuate its continuity through the election of officers.
- (2) **Submissions.** Each professional association shall submit the following to be considered for initial and ongoing presumptive course approval:
- (A) The association's mission statement;
 - (B) The association's code of member conduct;
 - (C) The chapter officers, the responsibilities for each officer, and the term of office for each officer;
 - (D) The mailing address and primary contact for the association; and
 - (E) The list of continuing education courses approved in Oklahoma and offered by the professional association in the past twenty-four (24) months.
- (3) **Notification of approval or disapproval.**
- (A) The Commissioner shall notify the association within ninety (90) days from the receipt of submission whether presumptive approval for continuing education courses was granted. The notification shall indicate the reasons for disapproval.
- (B) Submissions to the Commissioner by an association seeking presumptive approval of continuing education courses shall include the course summary, instructor name, course date and location and shall be submitted to the Commissioner at least fifteen (15) business days prior to the presentation of the course.
- (C) If the Commissioner receives a report or reports that the content of a continuing education course may violate 365:25-3-1(f)(7) of this section, the Commissioner may review the content and determine if the course should be disapproved for noncompliance. The Commissioner shall notify the association if the course has been disapproved due to non-compliance, and the association shall immediately cease offering the course upon receipt of the notification. The association may then make corrections to a disapproved course to bring the course into compliance with 365:25-3-1(f)(7) of this section and submit the course for approval by the Commissioner in the manner of an original submission for presumptive continuing education course approval.
- (D) Should an association receive notification of three (3) disapproved courses within a twenty-four (24) month period, the association's presumptive approval for continuing education courses shall be rescinded for twenty-four (24) months after which time the association may re-apply for presumptive approval.
- (4) **Assignment of course number.** The Commissioner shall assign a course number once the presumptive approval for continuing education courses has been granted and shall notify the association of the assigned course number. All future correspondence relating to that course shall reference the assigned course number.
- (5) **Instructor approval.** Instructors shall be approved by the Commissioner at least fourteen (14) calendar days prior to a presentation of a course. The Commissioner may disapprove any course if instructor approval has not been granted.
- (6) **Review.** Course approval shall be reviewed every three (3) years. The association shall re-submit the items required in subparagraph (3)(B) of this section during the fourth quarter of the last approval year.
- (7) **Agency management courses.** Agency management courses shall not be considered for presumptive continuing education approval.
- (i) **Self study and distance learning courses.** The Insurance Commissioner shall determine appropriate guidelines and standards for self-study and distance learning CEC offerings.

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The guidelines and standards shall include authentication of the registered licensee, technology requirements for course delivery and testing protocols. Guidelines and standards shall be reviewed and updated as appropriate and published on the Commissioner's website annually. Failure to follow the guidelines and standards established by the Commissioner may result in denial of continuing education credit for the adjuster and revocation of the course approval and or provider status for the Provider.

(j) **Repeating courses.** An insurance adjuster may repeat a course within the twenty-four month period if the maximum credits designated for the course were not attained in the first attempt. By repeating the course, the adjuster may not during the twelve month period earn more than the maximum credits designated for the course. An adjuster may repeat a course after two (2) license renewal dates have elapsed and receive the maximum credits designated for the course.

(k) **Extension of time.** For good cause shown, the Commissioner may grant an extension of time during which the requirements imposed by the act may be completed. The extension shall not exceed twelve (12) months. The extension will not alter the requirements or due date of the succeeding twelve-month period. "Good cause" includes disability, natural disaster, or other extenuating circumstances. Each request for extension of time shall be in writing from the licensee and shall include details and any documentation to support the request. Each request must be received by the Commissioner no less than thirty (30) days before the expiration of the twenty-four month period.

(l) **Continuing education advisory committee.**

(1) There shall hereby be established the Continuing Education Advisory Committee. This committee shall consist of representatives from the Agents Licensing Division, and representatives from the industry (not to exceed three (3) individuals) as designated by the Commissioner. Members of the Advisory Board established by 36 O.S. § 6221 may also serve on the Continuing Education Advisory Committee. The committee shall meet at least quarterly and additionally as required. Members of the committee shall serve without pay and shall not be reimbursed for any expenses associated therewith.

(2) Prior to the Commissioner's approval or disapproval of a course in 365:25-3-14(e), the Continuing Education Advisory Committee will review the course submitted and make its nonbinding recommendation to the Commissioner on granting or denying approval based upon information submitted pursuant to 365:25-3-14(e) and additional information regarding the course, if necessary. Each course approval shall be valid for a period of no longer than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course materials may be resubmitted as requested for review at the time of expiration. All existing courses previously approved and current with the Commissioner shall be submitted in accordance with the expiration date as granted by the Commissioner unless the course has a material change, as previously detailed.

(m) **Severability provision.** If any provision of this section, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the section, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

365:25-3-18. Compensation and education for sale of Medicare Advantage (including private fee for service plans) or Medicare prescription drug private fee for service products and plans

(a) **Compensation; selling, soliciting or negotiating Medicare Advantage products and plans.** ~~The provisions of this section shall apply only to insurance companies and producers who solicit, negotiate or sell Medicare Advantage or Medicare private fee for service (PFFS) products and plans.~~

~~(b) An insurance company shall not pay or offer to pay compensation to producers based on the number of sales of Medicare Advantage or Medicare private fee for service products and plans. An insurance company may pay a commission for each sale, but compensation shall not be tiered or based on a sales threshold.~~

~~(c) A producer shall not accept compensation based on the number of sales of Medicare Advantage or Medicare private fee for service products and plans. A producer may receive a commission for each sale, but compensation shall not be tiered or based on a sales threshold.~~

~~(d) Producers who intend to solicit, negotiate or sell Medicare Advantage or Medicare private fee for service products and plans shall complete not less than eight (8) hours of pre-licensing education relating to Medicare Advantage or Medicare private fee for service plans or products in addition to the pre-licensing education requirements of the Insurance Code and Insurance Department rules.~~

~~(e) Producers who sell, solicit, negotiate or sell Medicare Advantage or Medicare private fee for service products and plans shall biennially complete not less than eight (8) hours of continuing education relating to Medicare Advantage or Medicare private fee for service plans or products in addition to other continuing education required pursuant to the Oklahoma Insurance Code and Insurance Department rules.~~

(1) **Applicability.** The provisions of this section shall apply only to insurance companies and producers who solicit, negotiate or sell Medicare Advantage (including private fee for service plans) or Medicare Prescription Drug products and plans.

(2) **Insurance companies.** An insurance company shall not pay or offer to pay compensation to producers based on the number of sales of Medicare Advantage products and plans. An insurance company may pay a commission for each sale, but compensation shall not be tiered or based on a sales threshold.

(3) **Producers.** A producer shall not accept compensation based on the number of sales of Medicare Advantage products and plans. A producer may receive a commission for each sale, but compensation shall not be tiered or based on a sales threshold.

(4) **One-time training requirement.** An individual may not sell, solicit or negotiate Medicare Advantage (including private fee for service plans) or Medicare Prescription Drug products and plans unless the individual is licensed as an insurance producer for accident and health and has completed a one-time training course. The training shall meet the requirements set forth in subsection (b) of this section.

(5) **Producers licensed prior to July 14, 2008.** An individual already licensed for accident and health who sells, solicits or negotiates Medicare Advantage products and plans may not continue to sell, solicit or negotiate Medicare Advantage products and plans unless the individual has completed a one-time training course as set forth in subsection (b) of this section prior to the individual's first biennial license renewal period occurring after July 14 of the year 2008.

(b) **Training Requirements.**

(1) **One-time training.** The one-time training required by this section shall be no less than eight (8) hours and shall not be applied as continuing education course credit.

(2) **All subsequent biennial renewal periods.** Producers who sell solicit, or negotiate Medicare Advantage (including private fee for service plans) or Medicare Prescription Drug products and plans shall complete four (4) hours of continuing education during each biennial renewal period. The continuing education required by this section may be applied as a continuing education course credit under Section 1435.29 of Title 36 of the Oklahoma Statutes.

(3) **Company products; sales and marketing information.** The training required by this section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

365:25-3-19. Medicare Part D volunteer counselors

(a) To qualify for an exemption from the licensure requirements of the Oklahoma Producer Licensing Act of the Oklahoma Insurance Code pursuant to Section 1435.5(B)(8) of Title 36 of the Oklahoma statutes, partner organizations using volunteer counselors to assist Medicare beneficiaries with enrollment in Medicare Part D plans pursuant to the Federal Medicare Prescription Drug, Improvement and Modernization Act of 2008 shall file with the Insurance Commissioner the following supporting documentation prior to conducting enrollment assistance activity:

(1) The name, address and other pertinent contact information for the partner organization along with a list of persons acting as volunteer counselors who intend to assist in the enrollment of Medicare beneficiaries in Medicare Part D;

(2) A description of the training received by each volunteer counselor named in the list required by paragraph (1) of this subsection;

(3) A statement signed by each volunteer counselor named in the list required by paragraph (1) of this subsection stating:

(A) My name is [insert name of volunteer counselor] and my personal address is [insert personal address];

(B) I have received and read the Medicare Part D Prescription Drug Plan training materials provided by [insert partner organization name];

(C) I have not received and will not accept commissions or other valuable consideration from any person or plan for the enrollment assistance provided by me to Medicare beneficiaries;

(D) I will not disclose or use confidential information obtained as a result of my association with, or access to, any person with Medicare for any other purpose not directly required by CMS and the Oklahoma Insurance Department;

(E) I understand and acknowledge that the exemption from the licensure requirements of the Oklahoma Producer Licensing Act of the Oklahoma Insurance Code is strictly limited to my service as a volunteer counselor assisting in the enrollment of Medicare beneficiaries in Medicare Part D Prescription Drug Plans; and

(4) Any other information the Insurance Commissioner may request from a partner organization or volunteer counselor to assist in the verification of compliance with the requirements of Section 1435.5(B)(8) of Title 36 of the Oklahoma statutes.

(b) The Insurance Commissioner may order a volunteer counselor, after notice and opportunity for hearing, to cease the assistance of Medicare beneficiaries with enrollment in Medicare Part D plans for failure to comply with the requirements of Section 1435.5(B)(8) of Title 36 and this section. Issuance of this order shall not limit the Insurance Commissioner from taking other administrative action as authorized by the Oklahoma Insurance Code and the laws of this state.

365:25-3-20. Vehicle protection product warrantor; fee; forms

Registrants making filings pursuant to the Vehicle Protection Product Act, 36 O.S. § 6650, et seq., shall register and pay a fee of Two Hundred Dollars (\$200.00) upon initial registration. Said registrants shall register and pay a fee of Two Hundred Dollars (\$200.00) for annual registrations on or before July 15. The first annual registration shall be filed and the fee paid on or before July 15 of the year 2009. Registrants filing late shall pay a late fee in an amount equal to the initial and annual registration fee in addition to the initial and annual registration fees required herein.

[OAR Docket #09-835; filed 5-5-09]

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TITLE 365. INSURANCE DEPARTMENT CHAPTER 25. LICENSURE OF PRODUCERS, ADJUSTERS, BAIL BONDSMEN, COMPANIES, PREPAID FUNERAL BENEFITS, AND VIATICAL AND ~~LIFE SETTLEMENTS PROVIDERS AND~~ BROKERS

[OAR Docket #09-836]

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RULES:

Subchapter 7. Companies
Part 7. Companies In Hazardous Financial Condition
365:25-7-40. Authority
365:25-7-41. Purpose
365:25-7-42. Standards for determining hazardous financial condition
365:25-7-43. Commissioner's authority
Subchapter 9. Prepaid Funeral Benefits
365:25-9-3. Forms
365:25-9-8. Conversion from trust to insurance funded contracts
Subchapter 11. Viatical Settlements Regulation
365:25-11-1. Approval of viatical settlement contracts by Commissioner pursuant to 36 O.S. § ~~4045~~ 4055.5 [AMENDED]
365:25-11-2. License requirements for viatical settlement providers [REVOKED]
365:25-11-2.1. Definitions [NEW]
365:25-11-3. License requirements for ~~viatical settlement brokers~~ [AMENDED]
365:25-11-4. Other requirements for brokers [REVOKED]
365:25-11-4.1. Standards for evaluation of reasonable payments for terminally ill insureds [NEW]
365:25-11-5. Reporting requirement [AMENDED]
365:25-11-6. General rules [AMENDED]
365:25-11-7. Requirement to file advertising [NEW]
365:25-11-8. Prohibited practices [NEW]
365:25-11-9. Insurance company practices [NEW]
365:25-11-10. Transition period for existing licenses [NEW]
Subchapter 13. Life Settlements Regulation [REVOKED]
365:25-13-1. Approval of life settlement contracts by commissioner pursuant to 36 O.S. § 4089 [REVOKED]
365:25-13-2. License requirements for life settlement providers [REVOKED]
365:25-13-3. License requirements for life settlement brokers [REVOKED]
365:25-13-4. Other requirements for brokers [REVOKED]
365:25-13-5. Reporting requirement [REVOKED]
365:25-13-6. General rules [REVOKED]
365:25-13-7. Advertising [REVOKED]
Subchapter 21. Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities [NEW]
365:25-21-1. Purpose [NEW]
365:25-21-2. Scope [NEW]
365:25-21-3. Authority [NEW]
365:25-21-4. Definition [NEW]
365:25-21-5. Prohibited Uses of Senior-Specific Certifications and Professional Designations [NEW]
365:25-21-6. Effective Date [NEW]
Appendix U. Informational Brochure To Be Provided To A Prospective Viator at First Contact Pursuant To O.A.C. 365:25-11-6(a) [NEW]
Appendix V. Verification of Coverage For Life Insurance Policies [NEW]
Appendix W. Payouts For Insureds Who Are Terminally Ill [NEW]

AUTHORITY:

Insurance Commissioner, 36 O.S. §§ 307.1, 1201, et seq., 1435.19, 1435.29(H), 1435.5(B)(8), 1801, et seq., 1901, et seq., 4055.16 and 6123

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Subchapter 11. Viatical Settlements Regulation
365:25-11-1. Approval of viatical settlement contracts by Commissioner pursuant to 36 O.S. § ~~4045~~ 4055.5 [AMENDED]
365:25-11-2. License requirements for viatical settlement providers [REVOKED]
365:25-11-2.1. Definitions [NEW]
365:25-11-3. License requirements for ~~viatical settlement brokers~~ [AMENDED]
365:25-11-4. ~~Other requirements for brokers~~ [REVOKED]
365:25-11-4.1. Standards for evaluation of reasonable payments for terminally ill insureds [NEW]
365:25-11-5. Reporting requirement [AMENDED]
365:25-11-6. General rules [AMENDED]
365:25-11-7. Requirement to file advertising [NEW]
365:25-11-8. Prohibited practices [NEW]
365:25-11-9. Insurance company practices [NEW]
365:25-11-10. Transition period for existing licenses [NEW]
365:25-11-11. Effective date [NEW]
Subchapter 13. Life Settlements Regulation [REVOKED]
365:25-13-1. Approval of life settlement contracts by commissioner pursuant to 36 O.S. § 4089 [REVOKED]
365:25-13-2. License requirements for life settlement providers [REVOKED]
365:25-13-3. License requirements for life settlement brokers [REVOKED]
365:25-13-4. Other requirements for brokers [REVOKED]
365:25-13-5. Reporting requirement [REVOKED]
365:25-13-6. General rules [REVOKED]
365:25-13-7. Advertising [REVOKED]
Appendix U. Informational Brochure To Be Provided To A Prospective Viator at First Contact Pursuant To O.A.C. 365:25-11-6(a) [NEW]
Appendix V. Verification of Coverage For Life Insurance Policies [NEW]
Appendix W. Payouts For Insureds Who Are Terminally Ill [NEW]

Gubernatorial approval:

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INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The proposed amendments to Part 7 of Subchapter 7, the Companies In Hazardous Condition Regulation, 365:25-7-40 through 43, update the regulation to the latest National Association of Insurance Commissioners' model regulation and is an NAIC accreditation requirement. The regulation sets forth the standards the Insurance Commissioner may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to the policyholders, creditors or the general public.

The proposed amendments to 365:25-9-3 remove text to remedy duplication in the rules and provide for the date of filing of itemization of charges that must be submitted by prepaid funeral benefit licensees. The proposed amendments to 365:25-9-8 clarify issues relating to conversions from trust funded prepaid funeral benefits contracts to insurance funding.

The proposed amendments to the Viatical Settlement Regulation, 365:25-11-1, et seq., including new Appendices U, V, and W, and the proposed revocation of the Life Settlement Regulation, 365:25-13-1, et seq., implement the Viatical Settlement Act of 2008 passed during the 2008 session of the Oklahoma Legislature.

The proposed new Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities, 365:25-21-1 through 6, sets forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product.

CONTACT PERSON:

Karl F. Kramer, Deputy Insurance Commissioner, (405) 521-2668

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2009:

SUBCHAPTER 7. COMPANIES

PART 7. COMPANIES IN HAZARDOUS FINANCIAL CONDITION

365:25-7-40. Authority

This part is adopted and promulgated by the Oklahoma Insurance Commissioner pursuant to Section 307.1, 1801, et seq. and Section 1901, et seq., of Title 36 of the Oklahoma Statutes.

365:25-7-41. Purpose

(a) The purpose of this part is to set forth the ~~criteria standards~~ which the Commissioner may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to the policyholders, creditors or the general public or to holders of their policies or certificates of insurance.

(b) This part shall not be interpreted to limit the powers granted the Commissioner by any laws or parts of laws of this state, nor shall this part be interpreted to supersede any laws or parts of laws of this state.

365:25-7-42. Standards for determining hazardous financial condition

The following, standards, either singly or a combination of two or more, may be considered by the Commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors or the general public. The Commissioner may consider:

- (1) Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries;
- (2) The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and related reports;

~~(3) The ratios of commission expense, general insurance expense, policy benefits and reserve increases as to annual premium and net investment income that could lead to an impairment of capital and surplus. Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts;~~

~~(4) The insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;~~

~~(5) The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;~~

~~(6) Whether the insurer's operating loss for the last twelve month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than fifty percent (50%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;~~

~~(7) Whether any affiliate, subsidiary or reinsurer is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations. Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;~~

~~(7) Whether a reinsurer, obligor or any entity within the insurer's insurance holding company system, is insolvent, threatened with insolvency or delinquent in payment of its monetary or other obligations, and which in the opinion of the commissioner may affect the solvency of the insurer;~~

~~(8) Contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the Commissioner may affect the solvency of the insurer;~~

~~(9) Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer;~~

~~(10) The age and collectibility of receivables;~~

~~(11) Whether the management of the insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;~~

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(12) Whether management of an insurer has failed to respond to ~~the Commissioner's~~ inquiries relative to the condition of the insurer or has furnished false and misleading information ~~in response concerning an inquiry to such inquiries or concerning such inquiries;~~

(13) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the Commissioner;

(14) Whether management of an insurer either has filed any false or misleading sworn financial statement ~~or statements~~, or has released a false or misleading financial statement ~~or statements~~ to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

(15) Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

~~(15)~~ (16) Whether the insurer has experienced or will experience in the foreseeable future cash flow and/or liquidity problems.

(17) Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles and standards of practice;

(18) Whether management persistently engages in material under reserving that results in adverse development;

(19) Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;

(20) Any other finding determined by the commissioner to be hazardous to the insurer's policyholders, creditors or general public.

(b) If the Commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to ~~the~~ its policyholders, creditors or the general public, then the Commissioner may, upon ~~his~~ a determination, issue an order requiring an insurer to making such finding and including a list of requirements necessary to abate such finding. Such list may include among, other things:

(1) Reduce the total amount of present and potential liability for policy benefits by reinsurance;

(2) Reduce, suspend or limit the volume of business being accepted or renewed;

(3) Reduce general insurance and commission expenses by specified methods;

(4) Increase the insurer's capital and surplus;

(5) Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders;

(6) File reports in a form acceptable to the Commissioner concerning the market value of an insurer's assets;

(7) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Commissioner deems necessary;

(8) Document the adequacy of premium rates in relation to the risks insured;

(9) File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or on such format as promulgated by the Commissioner;

(10) Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the commissioner;

(11) Provide a business plan to the commissioner in order to continue to transact business in the state;

(12) Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any non-life insurance product written by the insurer that the commissioner considers necessary to improve the financial condition of the insurer.

(c) If the insurer is a foreign insurer, the Commissioner's order may be limited to the extent provided by statute.

(d) An insurer subject to an order under Subsection (b) may request a hearing to review that order. The notice of hearing shall be served upon the insurer pursuant to Oklahoma Administrative Procedures Act. The notice of hearing shall state the time and place of hearing, and the conduct, condition or ground upon which the Commissioner based the order. Unless mutually agreed between the commissioner and the insurer, the hearing shall occur not less than ten (10) days nor more than thirty (30) days after notice is served and shall be held at the Office of the Insurance Commissioner in Oklahoma City, Oklahoma.

365:25-7-43. Commissioner's authority

(a) For the purposes of making a determination of an insurer's financial condition under this part, the Commissioner may:

(1) Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceedings;

(2) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates consistent with the NAIC Accounting Policies and Procedures Manual, state laws and regulations;

(3) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor;

(4) Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next 12-month period.

SUBCHAPTER 9. PREPAID FUNERAL BENEFITS

365:25-9-3. Forms

(a) **General requirements.** ~~Bond forms, Applications for Original Permit, Contracts and Applications for Conversion from trust funded prepaid funeral benefits to insurance funded prepaid funeral benefits shall be submitted to the Insurance Commissioner for approval by submitting an original and two copies.~~

(1) **Application for original-prepaid funeral benefits permit form.** ~~An Application for Original Prepaid Funeral Benefits Permit, Form PFB-1, must be filed with and approved by the Insurance Commissioner before any contracts covered by this act may be marketed. The statutory fee must accompany this application.~~

(2) **Bond form requirements.** Appendix D of this chapter, is a sample bond to be used in connection with "The Act". Any variance from this form must have the prior written approval of the Insurance Commissioner. If any bond required by "The Act" is canceled for any reason, a thirty (30) day written notice must be given by the insurer to the Insurance Commissioner.

(3) **Conversion Forms.** Applications for Conversion from a trust funded prepaid funeral benefit to an insurance-funded prepaid funeral benefit shall be filed with and approved by the Insurance Commissioner before any contracts covered by "The Act" may be converted. Applications for Conversion shall be filed using the Application for Conversion form as set forth in Appendix R of this chapter. Any variance from this form must have prior written approval by the Insurance Commissioner.

(b) **Additional general requirements.** Withdrawal forms, individual refunds, ~~annual reports,~~ renewal applications, and the annual statement of financial condition shall be submitted to the Insurance Commissioner for review by submitting one copy of the withdrawal form and individual refund. Submit the original ~~annual report,~~ renewal application and annual statement of financial condition.

(1) **Withdrawal forms.** Appendix E of this chapter is the application which must be submitted to the Insurance Commissioner in order to withdraw funds after a contract has been fulfilled.

(2) **Individual refunds.** Appendix F of this chapter, must be submitted to the Insurance Commissioner when a person desires to withdraw any funds deposited for prepaid funeral expenses prior to fulfillment of the contract.

(3) **Annual reports.**

(A) Annual reports must be filed in accordance with Section 6128 of "The Act". Such reports should be submitted in columnar form in alphabetical order according to the last name of the contract holder. Appendix G of this chapter is included for the sole purpose of establishing guidelines for this report. A complete annual report shall be composed of the following items arranged in the order shown below:

- (i) PF-1-a
- (ii) PF-1-b
- (iii) PF-1-c
- (iv) PF-1-d
- (v) PF-2-a

(vi) PF-2-b

(vii) PF-2-c

(B) Computer print-outs may be submitted in lieu of the reports listed above so long as each legibly provides no less information than shown in the Insurance Commissioner's sample forms. Not less than one page of each annual report form shown above, other than the PF-2-b, shall be submitted. However, where a particular form is not relevant to the operations of a given permitholder, it may be submitted clearly marked, "Not Applicable".

(C) All itemized statements of charges must be submitted with the annual report in accordance with Section 6123 of Title 36 of the Oklahoma statutes.

(4) **Annual statement of financial condition.** An Annual Statement of Financial Condition (Reconciliation of Trust Accounts) must be filed in accordance with Section 6129 of "The Act". Appendix H of this chapter (Form PF-3) is included for the sole purpose of establishing guidelines for this statement.

(5) **Renewal application.** A renewal application (PFB-2) must be filed with the Commissioner no later than December 31 of each year in order to renew the permit for the succeeding calendar year. The statutory fee must accompany this renewal application.

365:25-9-8. Conversion from trust to insurance funded contracts

(a) **Conversion permitted only on forms approved by Oklahoma Insurance Department.** Pursuant to Title 36 Okla. Stat. § 6136.18 existing prepaid funeral contracts that utilize trust funded benefits may be converted to insurance funded prepaid funeral benefits provided the application for such conversion is made on forms approved by the Oklahoma Insurance Department which meet the requirements of the Oklahoma Insurance Code and this subchapter.

(b) **Definitions.** The words and terms used in this section shall be defined according to this title, unless otherwise defined herein or unless the context clearly indicates otherwise.

(1) **"Applicant"** means a permit holder who files an application with the Oklahoma Insurance Department to convert its trust-funded prepaid funeral benefit contract(s) under existing contracts to insurance funded prepaid funeral benefit contract(s).

(2) **"Cash Surrender Value"** means the net amount due the policy owner from the insurer upon surrender of an insurance policy, which will never be less than the amount of the trust funds transferred from the trust to the insurance policy as of transfer date.

(3) **"Death Benefit"** means the total of all contract principal payments collected and accumulated earnings that are transferred at conversion, together with all future gross premiums paid and all accumulated interest earned annually on accumulated interest thereon. Interest must be compounded annually and calculated on gross premiums paid. The post-conversion death benefit can never be less than the pre-conversion death benefit.

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- (4) **"Insurance policy"** means either: ~~an individual or group fixed annuity contract relating to an insurance conversion application.~~
- (A) A standard life or accident insurance policy; or
- (B) An individual or group fixed annuity contract relating to an insurance conversion application.
- (5) **"Load"** means any commission, allowance, surrender charge or other compensation, expense load, premium expense, administrative charge or expense, policy fees, or other fee or expense paid to an Oklahoma Insurance Department licensed agent associated with or occurring by reason of sale, issuance, lapse, surrender, or redemption of an insurance policy in connection with the conversion of any trust-funded prepaid funeral contract to insurance funded prepaid funeral contract.
- (6) **"Post-conversion Administrator"** means the administrator, who shall be the funeral home requesting conversion or an administrator selected by the funeral home requesting conversion, of the prepaid funeral benefits contracts who holds and administers the prepaid funeral contracts after conversion and assumes responsibility for receiving the proceeds of the insurance policy upon maturity of a contract and processing payment to the funeral provider after verifying that the funeral service and merchandise under the prepaid funeral contract have been delivered.
- (7) **"Required reserves"** means the reserve liabilities for all outstanding insurance contracts valued or calculated pursuant to actuarial standards and statutory accounting standards not inconsistent with the Oklahoma Insurance Code.
- (c) **Applications.** When applying for permission to convert trust funded benefits under existing prepaid funeral contracts to insurance funded benefits, an applicant ~~must~~ shall:
- (1) ~~hold~~ Hold a valid permit issued by the Oklahoma Insurance Department;
- (2) ~~be~~ Be in good standing with the Oklahoma Insurance Department;
- (3) ~~submit~~ Submit a completed conversion application to the Oklahoma Insurance Department; and
- (4) ~~not~~ Not have been found to be in violation of any applicable laws or regulations relating to the Oklahoma Insurance Code or not have any other deficiencies of any significance that have not been remedied or corrected to the satisfaction of the Oklahoma Insurance Department.
- (d) **Included in application.** Each application for conversion must include:
- (1) ~~a~~ A copy of a letter to the applicant from an insurer authorized to do business in Oklahoma evidencing the policy form number and setting out the insurer's agreement to issue insurance policies to convert the prepaid funeral contracts from trust-funded benefits to insurance funded benefits; and
- (2) ~~a~~ A copy of the written commitment to the Commissioner containing the agreement between or among the insurer, the applicant, and the post-conversion administrator regarding the transfer, receipt, and the application of the trust funds upon conversion, which commitment

must require that a copy of each insurance policy issued be furnished to the owner of the insurance policy and that a copy be made available to the respective prepaid funeral contract purchasers upon request, in the event they are not the owners of the policies;

(3) ~~a~~ A pre-conversion summary of the individual prepaid funeral contracts, which must include, at a minimum, the following information (as of a date within thirty (30) days of the date of the application), as well as aggregated totals for each category of information, if appropriate:

(A) ~~individual~~ Individual prepaid funeral benefits contract purchaser's name; ~~and/or the owner~~

(B) Individual prepaid funeral benefits contract owner's name if other than the purchaser;

(C) ~~date~~ Date of execution of pre-converted prepaid funeral contract;

(D) ~~face~~ Face amount of the contract;

(E) ~~amount~~ Amount paid in and the unpaid balance;

(F) ~~accumulated~~ Accumulated earnings;

(G) ~~amount~~ Amount due the prepaid funeral contract purchaser upon cancellation and the amount due the applicant upon death of the prepaid funeral contract owner, assuming death or cancellation were to occur on or about the date of the application;

(H) ~~amount~~ Amount retained by the applicant under the Okla. Stat. tit. 36, § 6125; and

(I) ~~whether~~ Whether the pre-converted contract is or was a contract pursuant to Okla. Stat. tit. 36, § 6125(B)(1) or § 6125 (B)(2).

(4) ~~a~~ A post-conversion summary of the individual prepaid funeral contracts, which must include, at a minimum, the following information (as of the same date as the pre-conversion summary), as well as aggregated totals for each category of information, if appropriate:

(A) ~~annuitant's name~~ Name of insured or annuitant;

(B) Owner of insurance policy or annuity if other than the insured or annuitant;

(C) ~~original~~ Original prepaid funeral contract amount;

(D) ~~amount~~ Amount paid in and the unpaid balance;

(E) ~~amount~~ Amount applied to the purchase of the insurance policy;

(F) ~~initial~~ Initial cash surrender value and initial death benefit under the insurance policy; and

(G) ~~amount~~ Amount retained by the applicant under the Okla. Stat. tit. 36, § 6125

(5) ~~a~~ A copy of the proposed negative response notification letter, as required in Okla. Stat. tit. 36, § 6136.18(C)(2), to the prepaid funeral contract purchasers from the applicant containing a statement explaining the purchaser has sixty (60) days to file a written request with the Department to have the contract converted back to trust fund benefits;

(6) ~~an~~ An actuarial certification certifying that the reserves to be held by the insurance company with respect to the conversion will be adequate to pay claims as they

become due (dated no more than six (6) months prior to the date of the application);

(7) ~~a~~ A copy of the form of assignment, if any, to be used in assigning insurance policy rights or proceeds to the post-conversion administrator.

(e) **Standards for approval of application.** An application for conversion will be approved by the Commissioner if, in the Commissioner's opinion, the rights and interests of the prepaid funeral contract purchasers under the insurance funded contract arrangement will be safeguarded to at least the same degree as provided under the trust-funded benefits contract. An application may be approved without the necessity of a hearing.

(1) In order for insurance funded contracts under an application for conversion to be considered to safeguard the rights and interests of the prepaid funeral contract purchasers to at least the same degree as the trust-funded benefits, insurance benefits must comply with this subsection.

(A) The transfer of the trust funds to the insurance company must be at least equal to the full sum required to be deposited as trust principal by the applicant pursuant to the Insurance Code under the trust-funded prepaid funeral contract proposed for conversion, plus all net earnings accumulated with respect thereto, as of the transfer date. No load may be deducted from the trust funds transferred pursuant to the conversion application.

(B) No provision in the insurance policy may allow for contesting coverage, limit death benefits in the case of suicide, refer to physical examination, or otherwise operate as an exclusion, limitation or condition other than requiring submission of proof of death or surrender of the policy at the time the prepaid funeral contract is funded, matures, or cancels, as the case may be.

(C) The insurance company must demonstrate that, in the previous seven years, the average death benefit growth under the same or substantially similar insurance policies issued by the insurance company to fund prepaid funeral contract has been at least 3.0% of accumulated premiums based on gross premiums paid. If the insurance company cannot so demonstrate, then the insurance policy must provide for guaranteed growth of the death benefit of no less than 2.0% annum compounded annually on gross premiums paid beginning in the first year of the policy.

(D) The post-conversion administrator is responsible for payment of all death and cancellation claims pursuant to the terms of the prepaid funeral benefits contract and in accordance with Okla. Stat. tit. 36, § 6125.

(E) Any insurance policy issued on any individual must be for an amount not less than the amount of principal and interest transferred for that individual to the insurance company, and any supplemental insurance policy issued to cover the unfunded portion of the contract must have a face amount that is at least as

great as the unfunded principal balance. No credit or reduction may be made for interest earned or accrued on the paid-in principal balance.

(F) The insurance policy must provide each prepaid funeral contract purchaser with a cash surrender value or cancellation benefit that is at least the same the amount of the trust funds transferred from the trust to the insurance policy as of transfer date and for the duration of the prepaid funeral contract less any amount due to the purchaser from the funeral home, if any, as set forth in Okla. Stat. tit. 36, § 6125. If a prepaid funeral contract is canceled at the initiative of the purchaser after the 60-day initial conversion cancellation period or the purchaser requests withdrawal of monies prior to death and in accordance with Okla. Stat. tit. 36, § 6125, the Funeral Home/Applicant or post conversion administrator must remit at least the applicable cancellation benefit directly to the purchaser in accordance with the provision of the prepaid funeral contract and in accordance with Okla. Stat. tit. 36, § 6125(B)(1).

(G) The post-conversion administrator must submit to the department, within 90 days of the date of transfer of the trust funds as authorized by the Commissioner's order, a post-conversion summary of the individual prepaid funeral contracts as of the conversion date, which must include, at a minimum, the following information, as well as aggregated totals for each category of information, if appropriate:

- (i) ~~insured's~~ Insured's name;
- (ii) ~~insured's~~ Insured's policy number;
- (iii) ~~the~~ The original prepaid funeral contract amount;
- (iv) ~~amount~~ Amount paid in;
- (v) ~~unpaid~~ Unpaid balance of the prepaid funeral contract;
- (vi) ~~amount~~ Amount retained by the applicant under Okla. Stat. tit. 36, § 6125;
- (vii) ~~amount~~ Amount applied to the purchase of the insurance policy; and
- (viii) ~~initial~~ Initial cash surrender value and initial death benefit under the insurance policy.

(H) The applicant shall relinquish to the post-conversion administrator the individual prepaid funeral contract ledgers reflecting the amount paid and the amount left owing on the prepaid funeral contract, if any. The post-conversion administrator shall be responsible for maintaining such ledgers to reflect the principal balance of the converted contract as well as any outstanding balances.

(I) Within 90 days of the execution of the conversion order, the post-conversion administrator must submit a notarized statement to the department attesting that the insurance policies have been issued and funded on behalf of the contract purchasers listed in the original post-conversion summary included in the conversion application and that all notices required under subsection (c)(3)(I) of this section have

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been given. Within 120 days of the execution of the conversion order, all requirements under this section for completion of a conversion must be met, if they are not, the conversion order is void without further action of the department.

(J) If for any reason the Commissioner deems it necessary before final approval of the conversion order, the Commissioner may order a financial examination of the trust. The cost of said financial examination shall be paid by the applicant and conducted in accordance with Section 6129.1 of Title 36 of the Oklahoma Statutes, as the Commissioner deems warranted. The applicant shall demonstrate compliance with the Oklahoma Insurance Code, and if the applicant fails to do so, the Commissioner may request an examination of the trust as set forth in Section 6129.1 of Title 36 of the Oklahoma Statutes.

(K) The Commissioner may hold a hearing on an application. Hearings shall be conducted pursuant to the Oklahoma Insurance Code, Insurance Department rules and regulations, and the laws of the State of Oklahoma. The applicant shall have the burden to demonstrate by a preponderance of the evidence the existence of all factors necessary to entitle the applicant to convert to insurance funded benefits from trust-funded benefits.

SUBCHAPTER 11. VIATICAL SETTLEMENTS REGULATION

365:25-11-1. Approval of viatical settlement contracts by Commissioner pursuant to 36 O.S. §4045 4055.5

Viatical settlement contracts filings pursuant to 36 O.S. § 4045 4055.5 shall be filed with the Rate and Form Compliance Life and Health Division of the Insurance Department.

365:25-11-2. License requirements for viatical settlement providers [REVOKED]

~~A viatical settlement provider, as defined in 36 O.S. § 4042 of the Oklahoma Viatical Settlement Act, shall not enter into or solicit a viatical settlement contract without first obtaining a license from the Commissioner.~~

~~(1) The Commissioner may ask for such additional information as is necessary to determine whether the applicant complies with the requirements of Section 4043 of Title 36 of the Oklahoma Viatical Settlement Act.~~

~~(2) Viatical settlement providers shall acquire and maintain a surety in the amount of \$50,000.00. A copy of the executed bond shall be filed with the Commissioner at the time of application for a license.~~

365:25-11-2.1. Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Act" means the Viatical Settlements Act of 2008.

"Insured" means the person covered under the policy being considered for viatication.

"Life expectancy" means the mean of the number of months the individual insured under the life insurance policy to be viaticated can be expected to live as determined by the viatical settlement provider considering medical records and appropriate experiential data.

"Net death benefit" means the amount of the life insurance policy or certificate to be viaticated less any outstanding debts or liens.

"Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

365:25-11-3. License requirements for ~~viatical settlement brokers~~

~~A viatical settlement broker shall not solicit a viatical settlement contract without first obtaining a license from the Commissioner.~~

~~(1) A viatical settlement broker shall make application on a form required by the Commissioner.~~

~~(2) The application shall be accompanied by a fee of \$500.00. The license may be renewed yearly by payment of a fee of \$500.00. Failure to pay the renewal fee within the time prescribed shall result in automatic revocation of the license.~~

~~(3) The Commissioner shall have the right to suspend, revoke or refuse to renew the license of any viatical settlement broker if the Commissioner finds that:~~

~~(A) There was any misrepresentation in the application for a license;~~

~~(B) The broker has been found guilty of fraudulent or dishonest practices, has been found guilty of a felony or any misdemeanor of which criminal fraud is an element, or is otherwise shown to be untrustworthy or incompetent;~~

~~(C) The licensee has placed or attempted to place a viatical settlement with a viatical settlement provider not licensed in this state; or~~

~~(D) The licensee has violated any of the provisions of the Viatical Settlement Act, 36 O.S. § 4041, et seq., or this regulation.~~

~~(4) A person shall be deemed to meet the licensing requirements of this section and of the Viatical Settlement Act, 36 O.S. § 4041, et seq., and shall be permitted to operate as a viatical settlement broker, as defined in Section 4042(2) of the Viatical Settlement Act, if that person is licensed as a resident or nonresident insurance producer with a life insurance line of authority pursuant to the Oklahoma Producer Licensing Act, 36 O.S. § 1435.1, et seq., for at least one year. Not later than thirty (30) days from the first day of operating as a viatical settlement broker, the producer shall notify the Insurance Department that he or she is acting as a viatical settlement broker on a form or~~

in a manner that may be prescribed by the Insurance Department, and shall pay the fee as set out in this section. The notification shall include an acknowledgment by the producer that he or she will operate as a viatical settlement broker in accordance with the Viatical Settlement Act and this regulation.

(a) In addition to the information required in Section 4055.3 of Title 36 of this state's statutes, the Commissioner may ask for other information necessary to determine whether the applicant for a license as a viatical settlement provider or viatical settlement broker complies with the requirements of that section.

(b) Applicants must complete an application form specified by the Commissioner for the license they seek.

(c) The application shall be accompanied by the applicable fee. The license may be renewed yearly by payment of the applicable fee and a current copy of a letter of good standing obtained from the filing officer of the applicant's state of domicile. If a viatical settlement provider or viatical settlement broker fails to pay the renewal fee within the time prescribed, or a viatical settlement provider fails to submit the reports required in O.A.C. 365:25-11-5, the nonpayment or failure to submit the required reports shall, after notice and opportunity for hearing, result in lapse of the license. If a viatical settlement provider has, at the time of renewal, viatical settlements where the insured has not died, it shall do one of the following:

(1) Renew or maintain its current license status until the earlier of the following events:

(A) The date the viatical settlement provider properly assigns, sells or otherwise transfers the viatical settlements where the insured has not died; or

(B) The date that the last insured covered by viatical settlement transaction has died.

(2) Appoint, in writing, either the viatical settlement provider that entered into the viatical settlement, the broker who received commissions from the viatical settlement, if applicable, or any other viatical settlement provider or broker licensed in this state to make all inquiries to the viator, or the viator's designee, regarding health status of the insured or any other matters.

(d) An individual licensed as a viatical settlement broker or authorized to act under a license issued to a licensed entity as a viatical settlement broker shall complete 4 hours of department-approved continuing education during each renewal period.

(1) The required continuing education hours shall include a minimum of:

(A) Three (3) hours in life insurance and viaticals; and

(B) One (1) hours in ethics.

(2) A life insurance producer who is operating as a viatical settlement broker pursuant to Section 4055.3(A)(2) of the Act shall not be subject to the continuing education requirements of this subsection (d).

(3) The license of an individual who fails to comply with this continuing education requirement shall terminate at the end of its current term and may not be renewed until

the continuing education requirement for the prior license term has been satisfied.

(e) A viatical settlement broker or viatical settlement provider shall file with the Commissioner, and thereafter for as long as the license remains in effect shall keep in force, evidence of financial responsibility in the sum of not less than Fifty Thousand Dollars (\$ 50,000.00).

(1) This evidence shall be in the form of an errors and omissions insurance policy issued in accordance with Oklahoma law by an insurer authorized to do business in Oklahoma, a surety executed and issued by an insurer authorized to issue surety bonds in Oklahoma, or a deposit of cash, certificates of deposits, or securities, or any combination of these evidences of financial responsibility. The policy, bond, deposit or combination thereof shall not be terminated without thirty (30) days prior written notice to the licensee and the commissioner.

(2) The Commissioner may also accept as evidence of financial responsibility proof that a financial instrument in accordance with the requirements in Paragraph (1) has been filed with the Commissioner of any other state where the viatical settlement broker or viatical settlement provider is licensed as a viatical settlement broker or viatical settlement provider.

(f) A person shall be deemed to meet the licensing requirements of this section and Section 4055.3 of the Act and shall be permitted to operate as a viatical settlement broker, as defined in Section 4055.2 of Title 36 of the Act, if that person is licensed as a resident or nonresident insurance producer with a life insurance line of authority pursuant to the Oklahoma Producer Licensing Act, 36 O.S. § 1435.1, et seq., for at least one year. Not later than thirty (30) days from the first day of operating as a viatical settlement broker, the producer shall notify the department that he or she is acting as a viatical settlement broker on a form or in a manner that may be prescribed by the department, and shall pay any applicable fees to be determined by the department. The notification shall include an acknowledgment by the producer that he or she will operate as a viatical settlement broker in accordance with the Act and this regulation.

365:25-11-4. Other requirements for brokers [REVOKED]

(a) ~~Viatical settlement brokers shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.~~

(b) ~~Broker shall disclose to the viator any contractual arrangement or agreement for compensation that may exist between the viatical settlement provider and the broker.~~

365:25-11-4.1. Standards for evaluation of reasonable payments for terminally ill insureds

In order to assure that viators receive a reasonable return for viaticating an insurance policy, the return for viaticating a policy shall be no less than the payouts set out in Appendix W of this chapter for insureds who are terminally ill.

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365:25-11-5. Reporting requirement

On or before March 1 of each calendar year, each viatical settlement provider licensed in this state shall ~~make a report containing the following information~~ submit the following information related to the licensee's activities for the previous calendar year:

- (1) ~~For each policy viaticated:~~
 - (A) ~~Date viatical settlement entered into;~~
 - (B) ~~Life expectancy of viator at time of contract;~~
 - (C) ~~Face amount of policy; and~~
 - (D) ~~Amount paid by the viatical settlement provider to viaticate the policy;~~
- (2) ~~For each deceased viator:~~
 - (A) ~~Date viatical settlement entered into;~~
 - (B) ~~Life expectancy of viator at time of contract;~~
 - (C) ~~Face amount of policy;~~
 - (D) ~~Amount paid by the viatical settlement provider to viaticate the policy;~~
 - (E) ~~Date of death of viator; and~~
 - (F) ~~Total insurance premiums paid by viatical settlement provider to maintain the policy in force.~~ A report of the viatical settlement transactions related to Oklahoma viators, which shall be submitted on a form provided by the Insurance Commissioner;
- (3) Breakdown of applications received, accepted and rejected, by disease category; A report of the individual mortality of Oklahoma insureds, which shall be submitted on a form provided by the Insurance Commissioner; and
- (4) Breakdown of policies viaticated by issuer and policy type; A certification of the information contained in the reports, which shall be submitted on a form provided by the Insurance Commissioner and shall be filed with the reports.
- (5) ~~Number of secondary market as compared to primary market transactions;~~
- (6) ~~Portfolio size; and~~
- (7) ~~Amount of outside borrowings.~~

365:25-11-6. General rules

- (a) Viatical settlement brokers, at the time of their first contact with a prospective viator, shall provide an informational brochure. Such brochure shall use the language and format set out in Appendix U.
- (b) With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement agreement, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a designation, to the estate of the viator.
- (c) Payment of the proceeds of a viatical settlement pursuant to ~~36 O.S. § 4049(D)~~ 4055.9(D) of the ~~Oklahoma Viatical Settlement Act~~ shall be by means of wire transfer to ~~the~~ an account of designated by the viator or by certified check or cashier's check.
- (d) Payment of the proceeds pursuant to a viatical settlement shall be made in a lump sum ~~except where the viatical settlement provider has purchased an annuity or similar financial~~

instrument issued by a licensed insurance company or bank, or an affiliate of either. Retention of a portion of the proceeds not disclosed or described in the viatical settlement contract by the viatical settlement provider or escrow agent is not permissible without written consent of the viator.

- (d) ~~Installment payments shall not be made unless the viatical settlement company has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank. The amount used to purchase an annuity shall not be less than the viatical settlement proceeds paid in a lump sum.~~
- (e) A viatical settlement provider or broker shall not discriminate in the making or soliciting of viatical settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation, or discriminate between viators with dependents and without.
- (f) A viatical settlement provider or broker shall not pay or offer to pay any finder's fee, commission or other compensation to any ~~viator's insured's~~ physician, attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator, other than a viatical settlement broker, with respect to the viatical settlement.
- (g) Contacts for the purpose of determining the health status of the viator by the viatical settlement provider or broker after the viatical settlement has occurred shall be limited to once every three (3) months for viators with a life expectancy of more than one year, and to no more than one per month for viators with a life expectancy of one year or less. The provider or broker shall provide a written explanation of the procedure for these contacts at the time the viatical settlement contract is entered into. A viatical settlement provider shall not knowingly solicit purchasers who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.
- (h) Viatical settlement providers and brokers shall not solicit investors who could influence the treatment of the illness of the viators whose coverage would be the subject of the investment. If a viatical settlement provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following provisions:
 - (1) A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. Benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;
 - (2) A provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either:
 - (A) Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or
 - (B) Send a copy of the instrument sent from the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy; and
 - (3) A provision that apportions the premiums to be paid by the viatical settlement provider and the viator, provided

that the contract provides premium payment terms and nonforfeiture options no less favorable, on a proportional basis, than those included in the policy.

(i) Advertising standards:

(1) Advertising should be truthful and not misleading by fact or implication.

(2) If the advertiser mentions the speed with which the viatication will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(3) If the advertising mentions the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the advertiser during the past six (6) months. In all cases where the insured is a minor child, disclosures to and permission of a parent or legal guardian satisfy the requirements of the Act and this regulation.

365:25-11-7. Requirement to file advertising

A viatical settlement licensee shall provide a copy of any advertisement intended for use in this state whether through written, radio, or television medium to the Commissioner for review and approval before the advertisement is disseminated within this state.

365:25-11-8. Prohibited practices

(a) A viatical settlement provider or viatical settlement broker shall obtain from a person that is provided with patient identifying information a signed affirmation that the person or entity will not further divulge the information without procuring the express, written consent of the insured for the disclosure. Notwithstanding the foregoing, if a viatical settlement provider or viatical settlement broker is served with a subpoena and, therefore, compelled to produce records containing patient identifying information, it shall notify the viator and the insured in writing at their last known addresses within five (5) business days after receiving notice of the subpoena.

(b) A viatical settlement provider shall not act also as a viatical settlement broker, whether entitled to collect a fee directly or indirectly, in the same viatical settlement.

(c) A viatical settlement broker shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

365:25-11-9. Insurance company practices

(a) Life insurance companies authorized to do business in this state shall respond to a request for verification of coverage from a viatical settlement provider or a viatical settlement broker within thirty (30) calendar days of the date a request is received, subject to the following conditions:

(1) A current authorization consistent with applicable law, signed by the policy owner or certificate holder, accompanies the request;

(2) In the case of an individual policy or group insurance coverage where details with respect to the certificate holder's coverage are maintained by the insurer, submission of a form substantially similar to Appendix V, which has been completed by the viatical settlement provider or the viatical settlement broker in accordance with the instructions on the form.

(b) Nothing in this section shall prohibit a life insurance company and a viatical settlement provider or a viatical settlement broker from using another verification of coverage form that has been mutually agreed upon in writing in advance of submission of the request.

(c) A life insurance company may not charge a fee for responding to a request for information from a viatical settlement provider or viatical settlement broker in compliance with this section in excess of any usual and customary charges to contract holders, certificate holders or insureds for similar services.

(d) The life insurance company may send an acknowledgment of receipt of the request for verification of coverage to the policy owner or certificate holder and, where the policy owner or certificate owner is other than the insured, to the insured. The acknowledgment may contain a general description of any accelerated death benefit that is available under a provision of or rider to the life insurance contract.

(e) A life insurance company shall not require the viator or insured to sign any request for change in a policy or a group certificate from a viatical settlement provider that is the owner or assignee of the insured's insurance coverage, unless the viator or insured has ownership, assignment or irrevocable beneficiary rights under the policy. In such a situation, the viatical settlement provider shall provide timely notice to the insured that a settlement transaction on the policy has occurred. Timely notice shall be provided within fifteen (15) calendar days of the change in a policy or group certificate.

365:25-11-10. Transition period for existing licenses

(a) A viatical settlement provider, a viatical settlement broker, a life settlement provider, or a life settlement broker lawfully transacting business in this state pursuant to Sections 4045 and/or 4085 of Title 36 of the laws of this state on the effective date of this regulation may continue to transact such business if said provider's or broker's license was active prior to November 1, 2008, and the licensee submits a complete application as specified in O.A.C. 365:25-11-3 for a license pursuant to the Viatical Settlements Act of 2008, 36 O.S. § 1455.1, et seq., on or before December 31, 2008.

(b) If an existing licensee's application pursuant to this subsection is approved, the new license will replace the prior license issued by the Commissioner pursuant to Sections 4045 and/or 4085 and will remain in force for the balance of the term of the prior license.

(c) If an existing licensee's application for licensure pursuant to the Act and this section is denied, the prior license of the licensee issued pursuant to Sections 4045 and/or 4085 of Title 36 is no longer valid and shall be immediately surrendered to the Commissioner.

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SUBCHAPTER 13. LIFE SETTLEMENTS REGULATION [REVOKED]

365:25-13-1. Approval of life settlement contracts by commissioner pursuant to 36 O.S. [REVOKED]

Life settlement contracts filings pursuant to 36 O.S. § 4089 shall be filed with the Life and Health Division of the Insurance Department.

365:25-13-2. License requirements for life settlement providers [REVOKED]

A life settlement provider, as defined in 36 O.S. § 4086 of the Oklahoma Life Settlement Act, shall not enter into or solicit a life settlement contract without first obtaining a license from the Commissioner.

- (1) The Commissioner may ask for such additional information as is necessary to determine whether the applicant complies with the requirements of Section 4087 of Title 36 of the Oklahoma Life Settlement Act.
- (2) Life settlement providers shall acquire and maintain a surety in the amount of \$100,000.00. A copy of the executed bond shall be filed with the Commissioner at the time of application for a license.

365:25-13-3. License requirements for life settlement brokers [REVOKED]

A life settlement broker shall not solicit a life settlement contract without first obtaining a license from the Commissioner.

- (1) A life settlement broker shall make application on a form required by the Commissioner.
- (2) The application shall be accompanied by a fee of \$500.00. The license may be renewed yearly by payment of a fee of \$500.00. Failure to pay the renewal fee within the time prescribed shall result in automatic revocation of the license.
- (3) The Commissioner shall have the right to suspend, revoke or refuse to renew the license of any life settlement broker if the Commissioner finds that:
 - (A) There was any misrepresentation in the application for a license;
 - (B) The broker has been found guilty of fraudulent or dishonest practices, has been found guilty of a felony or any misdemeanor of which criminal fraud is an element, or is otherwise shown to be untrustworthy or incompetent;
 - (C) The licensee has placed or attempted to place a life settlement with a life settlement provider not licensed in this state; or
 - (D) The licensee has violated any of the provisions of the Life Settlement Act, 36 O.S. § 4085, et seq., or this regulation.
- (4) A person shall be deemed to meet the licensing requirements of this section and of the Life Settlement Act, 36 O.S. § 4085, et seq., and shall be permitted to operate

as a life settlement broker, as defined in Section 4086(3) of the Life Settlement Act, if that person is licensed as a resident or nonresident insurance producer with a life insurance line of authority pursuant to the Oklahoma Producer Licensing Act, 36 O.S. § 1435.1, et seq., for at least one year. Not later than thirty (30) days from the first day of operating as a life settlement broker, the producer shall notify the Insurance Department that he or she is acting as a life settlement broker on a form or in a manner that may be prescribed by the Insurance Department, and shall pay the fee as set out in this section. The notification shall include an acknowledgment by the producer that he or she will operate as a life settlement broker in accordance with the Life Settlement Act and this regulation.

365:25-13-4. Other requirements for brokers [REVOKED]

- (a) Life settlement brokers shall not, without the written agreement of the owner of a life insurance policy obtained prior to performing any services in connection with a life settlement, seek or obtain any compensation from the owner of a life insurance policy.
- (b) Broker shall disclose to the owner any contractual arrangement or agreement for compensation that may exist between the life settlement provider and the broker.

365:25-13-5. Reporting requirement [REVOKED]

On March 1 of each calendar year, each life settlement provider licensed in this state shall file with the Life and Health Division of the Oklahoma Insurance Department a report containing the following information for the previous calendar year:

- (1) For each policy purchased:
 - (A) Date life settlement entered into;
 - (B) Life expectancy of insured at time of contract;
 - (C) Face amount of policy; and
 - (D) Amount paid by the life settlement provider to purchase the policy;
- (2) For each deceased insured:
 - (A) Date life settlement entered into;
 - (B) Life expectancy of insured at time of contract;
 - (C) Face amount of policy;
 - (D) Amount paid by the life settlement provider to purchase the policy;
 - (E) Date of death of insured; and
 - (F) Total insurance premiums paid by life settlement provider to maintain the policy in force.
- (3) Breakdown of applications received, accepted and rejected, by age category;
- (4) Breakdown of policies involved in life settlement transactions by issuer and policy type;
- (5) Number of secondary market as compared to primary market transactions;
- (6) Portfolio size; and
- (7) Amount of outside borrowings.

365:25-13-6. General rules [REVOKED]

- (a) With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the owner prior to entering into the life settlement agreement, or to such other beneficiary, other than the life settlement provider, as the owner may thereafter designate, or in the absence of a designation, to the estate of the owner.
- (b) Payment of the proceeds of a life settlement pursuant to 36 O.S. § 4093(D) of the Oklahoma Life Settlement Act shall be by means of wire transfer to the account of the owner or by certified check.
- (c) Payment of the proceeds pursuant to a life settlement shall be made in a lump sum. Retention of a portion of the proceeds by the life settlement provider or escrow agent is not permissible.
- (d) Installment payments shall not be made unless the life settlement provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank. The amount used to purchase an annuity shall not be less than the life settlement proceeds paid in a lump sum.
- (e) A life settlement provider or broker shall not discriminate in the making of life settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation, or discriminate between viators with dependents and without.
- (f) A life settlement provider or broker shall not pay or offer to pay any finder's fee, commission or other compensation to any owner or insured's physician, attorney, accountant or other person providing medical, legal or financial planning services to the owner, or to any other person acting as an agent of the owner with respect to the life settlement.
- (g) Contacts for the purpose of determining the health status of the insured by the life settlement provider or broker after the life settlement has occurred shall be limited to once every three (3) months for insureds with a life expectancy of more than one year, and to no more than one per month for insureds with a life expectancy of one year or less. The provider or broker shall provide a written explanation of the procedure for these contacts at the time the life settlement contract is entered into.
- (h) Life settlement providers and brokers shall not solicit investors who could influence the treatment of the illness of the insured whose coverage would be the subject of the investment.

365:25-13-7. Advertising [REVOKED]

- (a) This section shall apply to any advertising of life settlement contracts, or related products or services intended for dissemination in this state, including Internet advertising viewed by persons located in this state. Where disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation wherever possible.
- (b) Every life settlement licensee shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its contracts, products and services. All advertisements, regardless of by

whom written, created, designed or presented, shall be the responsibility of the life settlement licensee, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the viatical settlement licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisements not furnished by the life settlement licensee.

(c) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a life settlement contract (or life settlement purchase agreement, product or service) shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(d) Certain life settlement advertisements are deemed false and misleading on their face and are prohibited. False and misleading life settlement advertisements include, but are not limited to, the following representations:

- (1) "Guaranteed," "fully secured," "100 percent secured," "fully insured," "secure," "safe," "backed by rated insurance companies," "backed by federal law," "backed by state law," or "state guaranty funds," or similar representations;
- (2) "No risk," "minimal risk," "low risk," "no speculation," "no fluctuation," or similar representations;
- (3) "Qualified or approved for individual retirement accounts (IRAs), Roth IRAs, 401(k) plans, simplified employee pensions (SEP), 403(b), Keogh plans, TSA, other retirement account rollovers," "tax deferred," or similar representations;
- (4) Utilization of the word "guaranteed" to describe the fixed return, annual return, principal, earnings, profits, investment, or similar representations;
- (5) "No sales charges or fees" or similar representations;
- (6) "High yield," "superior return," "excellent return," "high return," "quick profit," or similar representations;
- (7) Purported favorable representations or testimonials about the benefits of life settlement contracts or life settlement purchase agreements as an investment, taken out of context from newspapers, trade papers, journals, radio and television programs, and all other forms of printed and electronic media.

(e) The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

- (1) An advertisement shall not omit material information or use words, phrases, statements, references or illustrations if the omission or use has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any benefit,

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loss covered, premium payable, or state or federal tax consequence. The fact that the life settlement contract or purchase agreement offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the parties to the sale or purchase agreement are not satisfied includes a "free look" period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(2) An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

(3) An advertisement shall not represent that premium payments will not be required to be paid on the life insurance policy that is the subject of a life settlement contract or life settlement purchase agreement in order to maintain that policy, unless that is the fact.

(4) An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable or in any manner an incorrect or improper practice.

(5) The words "free," "no Cost," "without cost," "no additional cost," "at no extra cost," or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(6) Testimonials, appraisals or analysis used in advertisements must be genuine; represent the current opinion of the author; be applicable to the life settlement contract or life settlement purchase agreement, product or service advertised, if any; and be accurately reproduced with sufficient completeness to avoid misleading or deceiving any person or prospective purchasers as to the nature or scope of the testimonials, appraisal, analysis or endorsement. In using testimonials, appraisals or analysis, the life settlement licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(A) If the individual making a testimonial, appraisal, analysis or an endorsement has a financial interest in the life settlement provider or related entity as a stockholder, director, officer, employee or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(B) An advertisement shall not state or imply that a life settlement contract or life settlement purchase agreement, benefit or service has been approved or endorsed by a group of individuals, society, association or other organization unless that is the fact and unless any relationship between an organization and the life settlement licensee is disclosed. If the entity making the endorsement or testimonial is owned, controlled or managed by the life settlement licensee, or receives any payment or other consideration from the life settlement licensee for making an endorsement or testimonial, that fact shall be disclosed in the advertisement.

(C) When an endorsement refers to benefits received under a life settlement contract or life settlement purchase agreement, all pertinent information shall be retained for a period of five (5) years after its use.

(f) An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

(g) An advertisement shall not disparage insurers, life settlement providers, life settlement brokers, life settlement investment agents, insurance producers, policies, services or methods of marketing.

(h) The name of the life settlement licensee shall be clearly identified in all advertisements about the licensee or its life settlement contract or life settlement purchase agreements, products or services, and if any specific life settlement contract or life settlement purchase agreement is advertised, the life settlement contract or life settlement purchase agreement shall be identified by form number. If an application is part of the advertisement, the name of the life settlement provider shall be shown on the application.

(i) An advertisement shall not use a trade name, group designation, name of the parent company of a life settlement licensee, name of a particular division of the life settlement licensee, service mark, slogan, symbol or other device or reference without disclosing the name of the life settlement licensee, if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the life settlement licensee, or to create the impression that a company other than the life settlement licensee would have any responsibility for the financial obligation under a life settlement contract or life settlement purchase agreement.

(j) An advertisement shall not use any combination of words, symbols or physical material that by their content, phraseology, shape, color or other characteristics are so similar to a combination of words, symbols or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective persons or purchasers into believing that the solicitation is in some manner connected with a government program or agency.

(k) An advertisement may state that a life settlement licensee is licensed in the state where the advertisement appears, provided it does not exaggerate that fact or suggest or imply that competing life settlement licensee may not be so licensed. The advertisement may ask the audience to consult the licensee's web site or contact the department of insurance to find out if the state requires licensing and, if so, whether the life settlement provider, life settlement broker or life settlement investment agent is licensed.

(l) An advertisement shall not create the impression that the life settlement provider, its financial condition or status, the payment of its claims or the merits, desirability, or advisability of its life settlement contracts or life settlement purchase agreement forms are recommended or endorsed by any government entity.

(m) The name of the actual licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name,

any group designation, name of any affiliate or controlling entity of the licensee, service mark, slogan, symbol or other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

(n) ~~An advertisement shall not directly or indirectly create the impression that any division or agency of the state or of the U.S. government endorses, approves or favors:~~

- ~~(1) Any life settlement licensee or its business practices or methods of operations;~~
- ~~(2) The merits, desirability or advisability of any life settlement contract or life settlement purchase agreement;~~
- ~~(3) Any life settlement contract or life settlement purchase agreement; or~~
- ~~(4) Any life insurance policy or life insurance company.~~

~~(o) If the advertising emphasizes the dollar amounts available to persons involved in life settlement contracts, the advertising shall disclose the average purchase price as a percent of face value obtained by persons involved in life settlement contracts during the past six (6) months.~~

~~(p) If the advertiser emphasizes the speed with which the life settlement transaction will occur, the advertising must disclose the average time frame from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the person involved in the life settlement transaction.~~

SUBCHAPTER 21. REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

365:25-21-1. Purpose

The purpose of this regulation is to set forth standards to protect consumers from misleading and fraudulent marketing practices with respect to the use of senior-specific certifications and professional designations in the solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product.

365:25-21-2. Scope

This regulation shall apply to any solicitation, sale or purchase of, or advice made in connection with, a life insurance or annuity product by an insurance producer.

365:25-21-3. Authority

(a) This regulation is issued under the authority of Article 12 of Title 36 of the laws of this State.

(b) Nothing in this regulation shall limit the commissioner's authority to enforce existing provisions of law.

365:25-21-4. Definition

For purposes of this regulation, "insurance producer" means a person required to be licensed under the laws of this State to sell, solicit or negotiate insurance, including annuities.

365:25-21-5. Prohibited uses of senior-specific certifications and professional designations

(a) Unfair and deceptive acts or practices.

- (1) It is an unfair and deceptive act or practice in the business of insurance within the meaning of Article 12 of Title 36 of the laws of this State for an insurance producer to use a senior-specific certification or professional designation that indicates or implies in such a way as to mislead a purchaser or prospective purchaser that the insurance producer has special certification or training in advising or servicing seniors in connection with the solicitation, sale or purchase of a life insurance or annuity product or in the provision of advice as to the value of or the advisability of purchasing or selling a life insurance or annuity product, either directly or indirectly through publications or writings, or by issuing or promulgating analyses or reports related to a life insurance or annuity product.
- (2) The prohibited use of senior-specific certifications or professional designations includes, but is not limited to, the following:

(A) Use of a certification or professional designation by an insurance producer who has not actually earned or is otherwise ineligible to use such certification or designation;

(B) Use of a nonexistent or self-conferred certification or professional designation;

(C) Use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training or experience that the insurance producer using the certification or designation does not have; and

(D) Use of a certification or professional designation that was obtained from a certifying or designating organization that:

(i) Is primarily engaged in the business of instruction in sales or marketing;

(ii) Does not have reasonable standards or procedures for assuring the competency of its certificants or designees;

(iii) Does not have reasonable standards or procedures for monitoring and disciplining its certificants or designees for improper or unethical conduct; or

(iv) Does not have reasonable continuing education requirements for its certificants or designees in order to maintain the certificate or designation.

(b) Rebuttable presumption. There is a rebuttable presumption that a certifying or designating organization is not disqualified solely for purposes of subsection (a)(2)(D) when the certification or designation issued from the organization does not primarily apply to sales or marketing and when the

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organization or the certification or designation in question has been accredited by:

- (1) The American National Standards Institute (ANSI);
- (2) The National Commission for Certifying Agencies;
or
- (3) Any organization that is on the U.S. Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes."

(c) **Words or acronyms.** In determining whether a combination of words or an acronym standing for a combination of words constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing seniors, factors to be considered shall include:

- (1) Use of one or more words such as "senior," "retirement," "elder," or like words combined with one or more words such as "certified," "registered," "chartered," "advisor," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and
- (2) The manner in which those words are combined.

(d) **Organizations licensed by or registered by a State of federal services regulatory agency**

(1) For purposes of this regulation, a job title within an organization that is licensed or registered by a State or federal financial services regulatory agency is not a certification or professional designation, unless it is used in a manner that would confuse or mislead a reasonable consumer, when the job title:

- (A) Indicates seniority or standing within the organization; or
- (B) Specifies an individual's area of specialization within the organization.

(2) For purposes of this subsection, financial services regulatory agency includes, but is not limited to, an agency that regulates insurers, insurance producers, broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

365:25-21-6. Effective Date

This regulation shall become effective July 14, 2009.

APPENDIX U. INFORMATIONAL BROCHURE TO BE PROVIDED TO A PROSPECTIVE VIATOR AT FIRST CONTACT PURSUANT TO O.A.C. 365:25-11-6(A) [NEW]



State Insurance
Department

Selling Your Life Insurance Policy

Understanding Viatical Settlements

Always Check with Your State

Contact your state insurance or securities departments to learn about the issues and risks of viatical settlements *if*:

- you're considering selling your life insurance policy;
- you're asked to sell your life insurance policy *and* your health hasn't changed since you bought the policy;
- you're asked to buy a new life insurance policy *and* immediately sell it for cash.

Buying a Life Insurance Policy?

If you're interested in buying a life insurance policy as an investment, contact your state insurance department *before* you make a decision.

OKLAHOMA INSURANCE DEPARTMENT

2401 NW 23rd Street, Suite 28
Toll Free Phone: 800-522-0071
Phone: 405-521-2828 Fax: 405-522-3642
Email: feedback@oid.ok.gov
Website: www.ok.gov/oid

Questions to Ask

- Do I still need life insurance protection?
- If I sell my policy, how do they decide how much cash I get?
- Is this an employer or other group policy? If so, do I need permission to sell it?
- If I sell my policy, who will be the legal owner?
- Do I need the advice of a tax or estate planning advisor before I decide to sell my policy?
- Who will have specific information about me, my family or my health status?
- After I sell my policy, can it be resold by the buyer?

Your state insurance department may have a list of viatical settlement providers and brokers that are licensed to do business in the state. Contact them to make sure yours are on the list.

What is a Viatical Settlement?

A viatical settlement is the sale of a life insurance policy to a third party. The owner (*viator*) of the life insurance policy sells the policy for an immediate cash benefit.

The buyer (the viatical settlement provider) becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies.

At one time, most viatical settlements were from people with a life-threatening illness. Now, individuals who are not facing a health crisis may sell their life insurance policies to get cash.

Your state insurance department and the National Association of Insurance Commissioners want you to have the facts before you sell your life insurance policy. This brochure provides some of that information, but it is only a starting point. Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you.

Consider Your Options

If you're selling your policy to get cash to pay expenses, check all of your options. You may find a way to get more cash from your life insurance policy.

1. Ask your insurance agent or company if you have any cash value in your life insurance policy. You may be able to use some of the cash value to meet your immediate needs and keep your policy in force for your beneficiaries. You may also be able to use the cash value as security for a loan from a financial institution.
2. Find out if your life insurance policy has an *accelerated death benefit*. An accelerated death benefit typically pays some of the policy's death benefit before the insured dies. It may be a way for you to get cash from a policy without selling it to a third party.

Consumer tips

- Comparison shop. Get quotes from several companies to make sure you have a competitive offer.
- Find out the tax implications. Not all proceeds received from the sale of your life insurance policy are tax free.
- It's important to know that any of your creditors could claim your cash settlement.
- Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- The buyer of your policy can periodically ask you about your health status. The buyer is required to give you a privacy notice outlining who will get this personal information. Be sure to read it.
- Check all application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.
- Make sure the viatical settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.
- Find out if you have the right to change your mind about the settlement AFTER you get the money. If so, how many days do you have to reconsider and return the money?

APPENDIX V. VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES [NEW]

VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

SUBMITTED TO: _____ **NAIC #** _____
Name of Insurance Company

POLICY NUMBER: _____

SUBMITTED FROM: _____
Name of Viatical Settlement Broker/Provider

ADDRESS: _____

TELEPHONE NUMBER: _____

CONTACT: _____ **TITLE:** _____

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE VIATICAL SETTLEMENT PROVIDER/BROKER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Owner's name	*	
Address	*	
City, state, ZIP code	*	
Tax ID or social security number	*	
Insured's name	*	
Insured's date of birth	*	
Second insured's name (if applicable)	*	
Second insured's date of birth (if applicable)	*	

I hereby consent by my signature below to release of information requested by this form by the insurance company to the viatical settlement broker/provider.

Signature of policy owner

Date signed

Form VOC

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IS THE POLICY IN FORCE? _____ YES _____ NO
 IF NO, SIGN, AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT
 BROKER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

POLICY TYPE, RIDERS & OPTIONS:

* _____ TERM _____ WHOLE LIFE _____ UNIVERSAL LIFE _____ VARIABLE LIFE

If a question is not applicable to the type of policy, write N/A in the column.

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Original issue date	*	
Maturity date of policy		
State of issue	*	
Does the policy have an irrevocable beneficiary?	*	
Is the policy currently assigned?	*	
Was the policy ever converted or reinstated?		
Is the policy in the contestability period?	*	
Is the policy in the suicide period?	*	
Please list all riders and indicate if any are in the contestable or suicide period.	*	

POLICY VALUES

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Policy values as of (insert date)		
Current face amount of policy	*	
Amount of accumulated dividends		
Current face amount of riders		
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans		
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is policy participating?	*	
If yes, what is the current dividend option?		

PREMIUM INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of (insert date)		
Date of last cost of insurance deduction		

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

Signature

Printed Name

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TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____ (date).

Insurance company: _____ NAIC # _____

Printed name: _____ Title: _____

Telephone number: _____ Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____ Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____ Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- Absolute Assignment/Change of Ownership/Viatical Assignment
- Change of Beneficiary
- Release of Irrevocable Beneficiary (if applicable)
- Waiver of Premium Claim Form
- Disability Waiver of Premium Approval Letter
- Release of Assignment
- Change of Death Benefit Option Form (if UL)
- Allocation Change Form (if Variable)
- Annual Report
- Current In Force Illustration

APPENDIX W. PAYOUTS FOR INSUREDS WHO ARE TERMINALLY ILL [NEW]

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	80%
At least 6 but less than 12 months	70%
At least 12 but less than 18 months	65%
At least 18 but less than 24 months	60%

[OAR Docket #09-836; filed 5-5-09]

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TITLE 375. OKLAHOMA STATE BUREAU OF INVESTIGATION CHAPTER 8. RECORDS RETENTION AND DESTRUCTION

[OAR Docket #09-805]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 3. Administrative Records
375:8-3-34 through 375:8-3-36 [AMENDED]
Subchapter 5. Financial Records
375:8-5-5 through 375:8-5-6 [AMENDED]
Subchapter 7. Personnel Records
375:8-7-25 [AMENDED]
Subchapter 9. Electronic Records
375:8-9-1 [AMENDED]

AUTHORITY:

Oklahoma State Bureau of Investigation, 74 O.S., Section 150.7

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N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The proposed amended sections change the subject rules from a specific time requirement regarding record retention in favor of deferring to and complying with the rule for retaining those records established by the Department of Central Services (subchapter 3, 5, and 9) or the Department of Labor (Subchapter 7) as the case may be. Since those agencies already have established administrative rules regarding the proper treatment of those documents, the OSBI rules are repetitive and cumulative.

CONTACT PERSON:

Jimmy Bunn Jr., Legal Counsel, OSBI, 6600 N. Harvey, Oklahoma City, OK., 73116, 405-879-2605

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 26, 2009:

SUBCHAPTER 3. ADMINISTRATIVE RECORDS

375:8-3-34. Landscape architect, engineer, and architect selection records

Records prepared in compliance with the Department of Central Services requirements for selection of landscape architects, engineers, and architects for public construction projects shall be retained as follows:

(1) Proposals from unsuccessful landscape architects, engineers, and architects shall be ~~shall be~~ retained in hard copy paper form for not less than three (3) years then be retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

(2) Proposals from successful landscape architects, engineers, and architects shall be retained in hard copy paper form for not less than three (3) years then be retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

375:8-3-35. Capital improvement projects records

OSBI capital improvement project records, including but not limited to, information to bidders, bid form proposals, bid affidavits, pertinent Senate and House bills, public construction contracts, and Construction Contract Forms for Use by Public Agencies shall be retained in hard copy paper form for not less than three (3) years then be retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained ~~for~~ until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

375:8-3-36. Court orders

Court orders issued by judges requiring that certain actions be taken by the OSBI shall be retained in office for two (2) years after exhaustion of all legal remedies then retained or destroyed at the discretion of the Director.

SUBCHAPTER 5. FINANCIAL RECORDS

375:8-5-5. Procurement and ~~communication~~ other costs related records

(a) Unless specifically provided otherwise by administrative rule, all procurement and communication costs records shall be retained in hard copy paper form for not less than three (3) years from the date of purchase then stored in house until placed in permanent storage. Such documents shall be held in hard copy form, in house or in permanent storage for not less than ten (10) years total. Once placed in permanent storage, all such documents stored in house may then be retained or destroyed at the discretion of the Director.

(b) The following documents shall be retained in office until no longer needed for administrative purposes then retained or destroyed at the discretion of the Director.

(1) Correspondence and materials from Risk Management Division concerning policies and rules and regulations regarding Risk Management.

(2) Records containing inventory and sales reports (FMD-1) for OSBI owned vehicles, including vehicle number, make, model and year, purchase date, cost, license tag number, location and whether owned, loaned or leased by OSBI.

(3) Monthly summaries turned into Fleet Management Division reporting fuel cost and usage, maintenance done and cost and related information.

(4) Records containing correspondence and reports detailing Fleet Management policies and rules and regulations.

(c) The following records shall be retained in house or in permanent storage until one (1) year after all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies then retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

(1) Postal Service Form 3083-Trust Accounts and Withdrawal Receipts-Postal Service form received daily by agency showing balance for Business Reply Mail (Permit 601).

(2) Record of Registered, Insured, C.O.D., Certified, and Express Mail-U.S. Postal Service PS Form 38877, used in conjunction with special mail services.

~~(d) The following records shall be retained at a minimum hard copy paper form for not less than three (3) years from the date of purchase then stored in house or in permanent storage until one (1) year after all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies then retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.~~

~~(1) Copies of documents submitted to Central Purchasing to acquire products on Scheduled Buys.~~

~~(2) Copies of Central Purchasing "OO" Contacts for goods and services.~~

~~(3) Copies of documents submitted to the Central Purchasing Division of the Department of Central Services to acquire goods and services, including but not limited to, Central Purchasing Form #2, "Purchase Requisition"; Invitation to Bid; correspondences concerning purchase; copy of purchase order; sole source affidavit if applicable; contents for professional services and local funding project awards; and CP Form 001, "Change Order Form".~~

~~(4) Copies of OSF Form 17, "Purchase Order Form," OSF Form 3A, "Contracts," OSF Form 6C, "Advice of~~

~~Change", and OSF Form 49, "Request for 30 Day Requirement Waiver".~~

~~(5) Records for purchases conducted through the bid process but not through the Department of Central Services.~~

(d) Copies of procurement documents including, but not limited to, correspondence, forms, bid documents, and bid responses, completed in-house or by the Department of Central Services for acquisition of products and/or services will be retained in accordance with the Department of Central Services' rules for record retention.

~~(6e) Monthly telephone bills and applicable attachments sent by the Office of State Finance.~~

~~(7) Non-binding contracts for equipment maintenance, services, and supplies, as well as documents relating to service calls.~~

~~(ef) Memos, worksheets, and invitations to bid on surplus property shall be retained in office for five (5) years after sale or transfer then retained or destroyed at the discretion of the Director provided all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies and provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.~~

~~(f) Contracts for leasing of space for office, warehouse, or storage and contracts for the leasing of equipment shall be retained in office until five (5) years after vacating the facility or expiration of the contract whichever is longer and then retained or destroyed at the discretion of the Director provided all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies and provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.~~

(g) Contracts for leasing of space for office, warehouse, or storage and contracts for the leasing of equipment shall be retained in accordance with the Department of Central Services rules for record retention.

~~(gh) Log books supplied by United Parcel Service, Federal Express, or other private courier used for shipping materials shall be retained in office five (5) years one (1) year then retained or destroyed at the discretion of the Director provided all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies and provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.~~

~~(hi) Reports of auctions conducted by the OSBI, including but not limited to letters to the Central Purchasing Division of the Central Purchasing Division of the Department of Central Service requesting permission for auction, lists of items to be auctioned, letter from Department of Central Service authorizing sale, buyer sign-in sheets, sales tickets, amounts recorded by buyer (net sales, tax, gross), report to Department~~

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of Central Services on items sold and price of each, and other miscellaneous supporting documents, and copies of reports to Oklahoma Tax Commission (Schedule 83-13, Series 3-1) on sales tax derived from the auction shall be retained in office for five (5) years then retained or destroyed at the discretion of the Director provided all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies and provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

~~(i) Record copies of contracts other than those relating to space or equipment rental or professional services to which the OSBI is party shall be retained in office until five (5) years after expiration of the contract, then retained or destroyed at the discretion of the Director provided all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies and provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.~~

~~(j) Records containing a copy of the contract; a copy of any evaluations required; and any books, records, documents, accounting procedures, practices or any other items of the service provider relevant to the performance of a professional services contract shall be retained until five (5) years after expiration of the contract, then retained or destroyed at the discretion of the Director provided all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies and provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.~~

(kj) Records of detailed vehicle maintenance for OSBI owned vehicles shall be retained in office until the vehicle is sold or otherwise disposed of, then may be retained or destroyed at the discretion of the Director provided all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies and no legal actions are pending. If legal action involving the records is pending, the records shall be retained in office until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

375:8-5-6. Other financial records

(a) Unless specifically provided otherwise by administrative rule, all other financial records shall be retained in house until placed in permanent storage. Such documents shall be held in house or in permanent storage for not less than three (3) years. Once placed in permanent storage, all such documents stored in house may then retained or destroyed at the discretion of the Director.

(b) Documents relating to annual inventory reviews and documents which support posting the inventory database shall be retained in house until placed in permanent storage. Such

documents shall be held in permanent storage for perpetuity. Once placed in permanent storage, all such documents stored in house may then be retained or destroyed at the discretion of the Director.

(c) Correspondence between the OSBI and the Office of State Finance, Department of Central Services, State Treasurer, State Auditor and Inspector and/or vendors whether in hard copy form or maintained in electronic mail systems shall be retained until one (1) year after all audits have been completed and all applicable audit reports have been accepted and resolved by all applicable federal and state agencies then retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

(d) Copies of signature cards submitted to the State Treasurer, the Office of Personnel Management, Department of Central Services, the Office of State Finance or to other State Agencies containing the names and signatures of persons authorized to deposit proceeds or moneys in agency accounts or sign checks shall be retained in office until the person listed is no longer authorized to handle financial transactions, then retained or destroyed at the discretion of the Director.

(e) Warranties for equipment purchased by an agency for its use shall be retained in office until the warranty is no longer effective, then retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.

SUBCHAPTER 7. PERSONNEL RECORDS

375:8-7-25. Material safety data sheets

Material Safety Data Sheets (MSDS) listing each hazardous substance which has been identified by the Chemical Information List (CIL) shall be retained ~~in office for five (5) years, then placed in permanent storage for a minimum of forty (40) years then retained or destroyed at the discretion of the Director provided no legal action is pending. If legal action involving the records is pending, the records shall be retained until the exhaustion of all legal remedies, then retained or destroyed at the discretion of the Director.~~ accordance with the Department of Labor requirements for these documents.

SUBCHAPTER 9. ELECTRONIC RECORDS

375:8-9-1. Data processing, planning, development, and evaluation records

Records consisting of planning, development, and evaluation records relating to selection, including feasibility studies, planning documents, and justification supporting materials; implementation; upgrading, modification, or conversion of systems and equipment; procedures; and manuals pertaining to

the acquisition and use of data processing equipment shall be retained in office for one (1) year after equipment has been disposed of or program discontinued the accordance with the Department of Central Services' rules for records retention.

[OAR Docket #09-805; filed 4-30-09]

**TITLE 375. OKLAHOMA STATE BUREAU OF INVESTIGATION
CHAPTER 9. OKLAHOMA OPEN RECORDS**

[OAR Docket #09-807]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. Criminal History Information
375:9-1-2 [AMENDED]
375:9-1-3 [AMENDED]

AUTHORITY:

Oklahoma State Bureau of Investigation, 74 O.S., Section 150.7

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Failure of the legislature to disapprove the rules resulted in approval on April 14, 2009

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N/A

ANALYSIS:

The proposed amendments establish the fee for a name search of the Oklahoma Sex Offender Registry and the Mary Rippe Violent Crime Offenders Registry. The fee was authorized by passage of Section 599.1 of Title 57 of the Oklahoma Statutes. The amendments also reflect a change in fingerprint based searches of Oklahoma Criminal History Records from \$35.00 to \$19.00. Finally, the amendments reflect changes to the manner in which the results of a criminal history record request are reported.

CONTACT PERSON:

Jimmy Bunn Jr., Legal Counsel, OSBI, 6600 N. Harvey, Oklahoma City, OK., 73116, 405-879-2605

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 26, 2009:

SUBCHAPTER 1. CRIMINAL HISTORY INFORMATION

375:9-1-2. Request for criminal history records

(a) **Obtaining criminal history records.**

(1) Members of the public may request criminal history records from the OSBI by completing ~~OSBI Form #CHDO1~~ a Record Check Request Form and ~~faxing~~ delivering or mailing the form to the following address: Oklahoma State Bureau of Investigation, Criminal History Reporting Unit, 6600 N. Harvey, Suite 140, Oklahoma City, Oklahoma 73116.

(2) Delivery of the request in person may be made Monday through Friday (except holidays) between the hours of 8:30 a.m. and 4:30 p.m. unless otherwise posted in advance.

(A) If the request is made by an individual for the sole purpose of determining whether or not his or her own criminal history record is accurate, the cashier at the OSBI will have that individual complete an "Individual Request for Criminal History Record Inspection Form."

(B) Upon completion of the form, a records check clerk will conduct a criminal history check based on the information provided. After completion of this check, the original form will be returned to the requestor, along with a copy of the requestor's criminal history record if any such record exists.

(C) The request form and the individual's criminal history record will be stamped, dated, and initialed by the records clerk prior to their issuance to the requestor. A copy of the request form will be retained in the files of the OSBI.

(D) If a fee is applicable, the cashier will accept payment and prepare a receipt. One copy of the receipt shall be given to the requestor. ~~The cashier will then complete the fee information on each sequentially numbered NCR invoice (OSBI Form CHDO1) and give the form(s) to the requestor to complete the remainder of the information blocks.~~ A records clerk will conduct a criminal history check based on the information provided, ~~returning the carbon copy of the NCR form(s) and record(s) found~~ the completed form to the requestor. The form(s) and record(s) will be stamped with the appropriate stamp(s), dated, and initialed by the searcher prior to their return. ~~The original NCR form and the original and one A copy of the completed record check form and receipt will be retained for OSBI files.~~ Criminal Justice Agencies will not be charged for these services.

(3) All requests delivered by mail shall include a stamped, self-addressed envelope. Replies will be made by return mail.

(4) All request forms must be typed or the information legibly printed by the requestor. Handwritten requests which are not easily read will be returned unprocessed.

(b) **Required information.** Persons, businesses, government agencies, and other entities making requests for criminal

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history records shall provide the following information to the OSBI on OSBI form #CHIDO1:

- (1) the full name of the subject of the record;
 - (2) the date of birth or approximate age of the subject of the record;
 - (3) the social security number of the subject, if known;
 - (4) inked fingerprints of the subject, if available; and
 - (5) any other information which tends to establish the identity of the subject such as sex and race.
- (c) **Method of search.** Searches for criminal history records shall be conducted only by personnel of the Oklahoma State Bureau of Investigation.
- (d) **Fees.**
- (1) Requests which clearly would cause excessive disruption of the Oklahoma State Bureau of Investigation's essential functions or any request for criminal history information made by any private entity, state agency, board, department, or commission for licensing, or other non-law enforcement purpose will pay a fee based on the following schedule for the type of record requested:
 - (A) Name Search, Oklahoma records only, the cost is \$15.00.
 - (B) Fingerprint search, Oklahoma records only, the cost is ~~\$35.00~~ 19.00.
 - (C) Fingerprint search, Oklahoma and FBI records, the cost is \$41.00.
 - (D) Oklahoma Department of Corrections Offender Lookup
 - (i) Mary Rippy Violent Offender Check, the cost is \$2.00.
 - (ii) Sex Offender Check, the cost is \$2.00.
 - (2) All requests not for a commercial purpose must be accompanied by a document copying fee of \$.25 per page. Certified copies of any requested documents will be supplied for \$1.00 per page.
 - (3) Persons checking the accuracy of their records will not be charged a fee.
 - (4) Fees may be paid by money order, cashier's check, certified check, or cash when the application is made in person. Cash will not be accepted with applications delivered by mail.
 - (5) Personal checks will not be accepted under any circumstances. Fees submitted for requests numbering two or more shall be paid with one money order, cashier's check, certified check, or business check rather than with a \$15.00 remittance for each name search requested. Checks shall be made payable to OSBI.

375:9-1-3. Results of search for criminal history record

Results of the criminal history record search will be returned bearing one of the following notations:

- (1) "SUBJECT IDENTICAL WITH SUBJECT OF ATTACHED OKLAHOMA STATE BUREAU OF INVESTIGATION NUMBER _____."
- (2) ~~"Based on the information provided, subject of attached Oklahoma State Bureau of Investigation Number _____ may be the same as your subject."~~

(3) ~~"Based on the information provided, you are advised that the subject has no criminal history record in the files of the Oklahoma State Bureau of Investigation."~~

(4) ~~"This request contains a partial name and/or date of birth or approximate age. Multiple candidates exist. No specific individual can be identified with the subject of your request without more specific screening criteria."~~

(2) "THE ATTACHED FINGERPRINT CARD WAS SEARCHED THROUGH THE OSBI AND NO ARREST DATA WAS REVEALED."

(3) "NO RECORD WAS FOUND MATCHING THE SUBJECT NAME AND/OR DESCRIPTION"

(4) "BASED UPON THE INFORMATION PROVIDED, THE SUBJECT MAY BE THE SAME AS OSBI #A COPY OF THE RECORD IS ATTACHED."

(5) "THE SUBJECT IS CURRENTLY REGISTERED WITH THE OKLAHOMA DEPARTMENT OF CORRECTIONS."

(6) "THE SUBJECT HAS COMPLETED THEIR REQUIRED REGISTRATION TERM WITH THE OKLAHOMA DEPARTMENT OF CORRECTIONS."

[OAR Docket #09-807; filed 4-30-09]

TITLE 375. OKLAHOMA STATE BUREAU OF INVESTIGATION CHAPTER 25. OKLAHOMA SELF-DEFENSE ACT

[OAR Docket #09-806]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. Application for Concealed Handgun License
375:25-1-3 [AMENDED]
375:25-1-5 [AMENDED]
375:25-1-7 [AMENDED]

AUTHORITY:

Oklahoma State Bureau of Investigation, 21 O.S., 1290.3

DATES:

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Failure of the legislature to disapprove the rules resulted in approval on April 14, 2009

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June 26, 2009

PERSEUED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The proposed amended sections increase options for requesting a Self Defense Application packet. They also reflect the changes in the options for validity period of a license that were made by alteration in statute.

CONTACT PERSON:

Jimmy Bunn Jr., Legal Counsel, OSBI, 6600 N. Harvey, Oklahoma City, OK., 73116, 405-879-2605

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 26, 2009:

SUBCHAPTER 1. APPLICATION FOR CONCEALED HANDGUN LICENSE

375:25-1-3. Request for an application packet

(a) Any eligible person may request an application packet for a concealed handgun license from the OSBI. To determine eligibility see Title 21 O. S. 1995, Sections 1290.9 through 1290.11.

(b) An application may be requested by phone, in person by e-mailing sda@osbi.state.ok.us or by regular mail, postage prepaid, at the following address: Oklahoma State Bureau of Investigation, Self Defense Act Licensing Unit, 6600 North Harvey, Suite 300, Oklahoma City, Oklahoma 73116. The application and law book are also available for download on the OSBI website at www.ok.gov/osbi.

(1) An application packet may be requested in person between the hours of 8:30 a.m. and 4:30 p.m. Monday through Friday (excluding state holidays). In the event the OSBI is unable to furnish an application packet immediately, the person requesting an application packet shall provide his or her mailing address.

(2) A request for an application packet which is delivered by mail must include the mailing address of the person requesting the packet.

375:25-1-5. Investigation of license applications and issuance or denial of license

(a) Upon receipt of the application and required materials from the sheriff, the OSBI shall confirm that the application form has been filled out properly. If the form has been properly filled out, the OSBI shall conduct its investigation pursuant to Title 21 O.S. 1995, Section 1290.12 (10-11).

(b) Issuance or denial of license shall be pursuant to Title 21 O.S. 1995, Section 1290.12(12).

(1) A license shall be valid in this state for a period of ~~four~~ (4) 5 or 10 years, unless subsequently suspended or revoked as provided by law.

(2) Once issued a license, the licensee shall be required to have possession of his or her valid concealed handgun license and a valid Oklahoma driver license or an Oklahoma State photo identification at all times when in

possession of an authorized pistol. See Title 21 O.S. 1995, Section 1290.8.

375:25-1-7. Application for renewal of handgun license

(a) A license may be renewed in the ~~same~~ manner provided for ~~issuing an original license, except the training requirements shall not apply to a renewal.~~ in Title 21 O.S. 1995, Section 1290.5.

(b) No person shall have any authority to continue to carry a concealed handgun in this state when a license is allowed to expire or when a license has been suspended or revoked for any reason.

[OAR Docket #09-806; filed 4-30-09]

**TITLE 380. DEPARTMENT OF LABOR
CHAPTER 55. AMUSEMENT RIDE SAFETY
RULES**

[OAR Docket #09-857]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

380:55-1-2 [AMENDED]

Subchapter 5. Fees

380:55-5-5 [AMENDED]

Subchapter 13. Miscellaneous

380:55-13-1 [AMENDED]

380:55-13-2 [AMENDED]

AUTHORITY:

Department of Labor; 40 O.S. §§ 460 and 471, Amusement Ride Safety Act

DATES:

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February 26, 2009

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April 13, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on April 23, 2009

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April 23, 2009

Effective:

March 1, 2010

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

Incorporated standards:

American Society for Testing of Materials ("ASTM"), latest edition and most current addenda; The National Association of Amusement Ride Safety Officials ("NAARSO"), latest edition and most current addenda; and Amusement Industry Manufacturers and Suppliers International ("AIMS"), latest edition and most current addenda

Incorporating rules:

380:55-13-1

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Availability:

8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays, at Oklahoma Department of Labor, 3017 N. Stiles, Suite 100, Oklahoma City, OK 73105, (405) 521-6100.

ANALYSIS:

The purpose of the proposed amendment to OAC 380:55-13-1 is to establish initial administrative rules as required by newly enacted legislation, Oklahoma Statutes Title 40, Section 471, effective July 1, 2008. The rules address the certification requirements applicable to the qualification and certification of amusement ride operators; identify national standards applicable to amusement ride operators; provide definitions; establish program administrative procedures; and identify testing requirements. OAC 380:55-13-2 is amended to establish standards for the quality of water used in amusement rides. The proposed rules adopt the standards already in use by the Oklahoma Department of Health. The proposed amendments to 380:55-1-2 and 380:55-5-5 define terms necessary for the administration of the Amusement Ride Safety Act and include some non-substantive changes to correct spelling errors. The amended definitions of "kiddie rides," "major rides," and "other rides" will clarify how the fee structure created in 40 O.S. §463 will be applied to inflatable rides, water park rides, and the water quality of water park rides.

CONTACT PERSON:

Tiffany J. Wythe, Assistant General Counsel, Oklahoma Department of Labor, 3017 N. Stiles, Suite 100, Oklahoma City, OK 73105, (405) 521-6100.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF MARCH 1, 2010:

SUBCHAPTER 1. GENERAL PROVISIONS

380:55-1-2. Definitions

The following words and terms, when used in this Chapter shall have the following meaning, unless the context clearly indicates otherwise.

"Act" means the Amusement Ride Safety Act, 40 O.S. § 460 *et seq.*

"Actual inspection time" means the time the inspector is at the amusement area ~~include~~ including: unloading, erection, relocating, set up, testing, observation, repair maintenance and delays incident hereto.

"Alteration" means any change in either the structural or operational characteristics of the amusement ride which will alter its performance from that specified in the design criteria of the manufacturer. [40 O.S. 460.1]

"Amusement area" means that which is commonly referred to as the midway. An area occupied by an activity, exposition show or amusement ride or rides. It is principally devoted to offering amusement exhibits, or entertainment to the public. All structures that receive electrical power from an independent source, which also serves amusement rides and attractions, are included within the amusement area.

"Certificate" means the document issued to an applicant upon successful examination.

"Certification" means the testimony of qualification.

"Competent" means having the requisite or adequate ability or quality to perform the functions necessary to operate an amusement ride in accordance with the Manufacturer's and ASTM standards.

"Fees" mean those fees provided for in the Amusement Ride Safety Act and further defined in Subchapter 5 of this Chapter.

"General public" means a gathering of two (2) or more persons, regardless of whether an admission fee is charged, but does not include a gathering of two (2) or more persons where every person in attendance is related by blood, marriage, or adoption to every other person in attendance.

"Inflatable amusement device" means an amusement ride or device, consisting of air-filled structures designed for use, as specified by the manufacturer, that may include but not be limited to bounce, climb, slide or interactive play. They are made of flexible fabric, kept inflated by continuous air flow by one or more blowers, and rely upon air pressure to maintain their shape.

"Inspection" means the process by which inspectors determine the safety status of an amusement ride at the scheduled inspection site. It also means attempted inspections of rides registered with the owner that would have been inspected had the show arrived at the site as scheduled.

"Inspector" means an individual determined qualified by the Commissioner of Labor based upon the ~~inspec-~~ ~~tor's~~ inspector's background, training and experience who inspects amusement rides covered by the Act. Inspectors so qualified may be issued an appropriate identification card by the Commissioner of Labor.

"Large inflatable amusement device" means an inflatable amusement device that has a surface that is designed to enable patrons to stand, sit or climb to a height of fifteen (15) feet or higher.

"Operator" means the person who is physically operating the ride during that period of time when it is open to the public.

"Owner" includes the term "operator" as that term is defined in the Act.

"Red tag" means a red colored tag affixed to a ride or a part thereof, by an inspector indicating to the public and the owner that the ride is in violation of the Act and therefore shall not be operated.

"Reassembled" means the fitting together of manufactured parts into a machine, structure or unit of a machine or structure.

"Registration number" means a number permanently assigned to each amusement ride. The number tag is to be permanently affixed for identification ~~purpose~~ purposes to a main structural member of the ride and shall not be removed unless so directed by an inspector.

"Scope of inspection" includes: access and egress ramps, steps, walkways, the mechanical or physical ride itself to include foundation, supports, and blocking. Also included within the scope are power sources and amusement area or midways which may become hazardous to the public.

"Show" means a group of rides, the property of one or more owners.

"Small inflatable amusement device" means an inflatable amusement device that has a surface that is designed to enable patrons to stand, sit or climb to a height of less than fifteen (15) feet.

"Written order for the temporary cessation of operation" means a written order will be provided to the ~~on-site~~ onsite owner, manager, or operator. It shall be signed by the inspector, identify the safety violation and the correction necessary. It shall be countersigned by the onsite owner, manager, or operator.

SUBCHAPTER 5. FEES

380:55-5-5. Criteria for type determination

Criteria for type determination of amusement rides are as follows:

- (1) KIDDIE RIDES: Primarily designed and/or engineered for children although adults may or may not fit into carriers or tubs. Inflatable rides are kiddie rides.
- (2) MAJOR RIDES: Primarily designed and/or engineered for adults and families. Children usually fit into the carriers or tubs. Water park rides are major rides.
- (3) OTHER RIDES:
 - (A) SIZE:
 - (i) When erected are large.
 - (ii) May be transported on several tractor-trailer rigs.
 - (iii) Encompass large amounts of ground space.
 - (iv) Usually are exceptionally tall, wide or deep.
 - (B) COMPLEXITY:
 - (i) May have independent self-propelled carriers.
 - (ii) May require several pre-setup inspections at various stages of erection due to many parts or sub-assemblies.
 - (iii) Requires many temporary or permanent fasteners of different types.
 - (iv) Generally have large or many integrated systems involving electronic, hydraulic, mechanical or pneumatic devices.
 - (v) Drive systems usually involve two or more belt, cable, chain, rod or shaft devices.
 - (C) The water quality of water park rides shall be included in this category.

SUBCHAPTER 13. MISCELLANEOUS

380:55-13-1. Competent operator

(a) All amusement rides or devices must be under the control of a competent operator at all times when the ride or device is in operation. Operators shall be trained in the safe operation of the ride. The minimum requirement for training shall be that contained in the most current edition of the American Society for Testing of Materials (ASTM) standards, entitled "~~Standard Practice for Operation Procedures for Amusement Rides and Devices~~."ASTM Standards for Amusement Rides and Devices".

(b) Owners/operators must be able to communicate meaningfully with an inspector, owner, patron or emergency personnel.

(c) Owners shall, upon request, provide the Department of Labor inspector with the necessary documentation setting forth the qualifications of each operator as required by (a) of this Section.

(d) The following categories of certificates may be issued by the Department:

(1) Supervisors: An applicant with a minimum of five (5) years experience in the amusement ride industry and a National Association of Amusement Ride Safety Officials (NAARSO) Level 1 Certification or Amusement Industry Manufacturers and Suppliers International (AIMS) Level 1 Certification in maintenance or operation of amusement rides may be issued a supervisor certificate which allows the certificate holder to operate all amusement rides for which the operator/applicant provides documentation showing the operator/applicant has been trained thereon.

(2) Certified Trainers:

(A) Upon written request, qualified personnel may be permitted to test and certify operators in lieu of testing performed by the Department of Labor. The request shall be on company letterhead, along with all required documentation and shall be received by the Department of Labor thirty (30) days prior to certification in Oklahoma. All certified trainers shall be required to re-apply for certified trainer status on a yearly basis.

(B) All certified trainers shall train operators to a level complying with the requirements contained in the most current edition of the American Society for Testing of Material (ASTM) standards entitled F-24, Standard Practice for Ownership and Operations of Amusement Rides and Devices F770-06.

(C) All certified trainers shall be subject to a yearly and/or unannounced audits of all training documentation and on-site training. This audit may include testing of operators.

(D) Training material shall include a documented training program outlining the amount and type of training required for each amusement device, to include the following: fact sheets, operator's test, answer sheets and operator documentation. This material shall be provided to the Department of Labor thirty (30) days prior to trainer status being granted. All training shall also be maintained on-site at all times and subject to review by Department of Labor personnel during normal business hours. Failure to provide this material upon request may result in all operators being re-tested by Department of Labor personnel and loss of trainer status.

(E) Minimum requirements for Certified Trainers are as follows:

(i) For certified trainers training operators of complex rides, a minimum of five (5) years documented experience in the amusement industry and a current National Association of Amusement

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Ride Safety Officials (NAARSO) level 1 Certification or current Amusement Industry Manufacturer and Suppliers International (AIMS) Level 1 in operation and/or maintenance.

(ii) For certified trainers training operators of non-complex rides, a minimum of two (2) years documented experience in the amusement industry and a current National Association of Amusement Ride Safety Officials (NAARSO) Limited Specialty Certification or documented completion of a class in Train the Trainer or other verifiable equivalent training.

(3) Operators:

(A) Operators who have not been trained by a certified trainer will be required to pass a test administered by a Department inspector on each ride the applicant intends to operate. The test will be conducted in accordance with the standards contained in the most current edition of the ASTM Standards for Amusement Rides and Devices. A passing score of no less than seventy percent (70%) will be acceptable. Failure to pass this test will prevent the applicant from being issued a certificate for that ride. An applicant who fails a test may not be retested until the earlier of five (5) days or the next setup. All testing should be completed prior to operation. If testing cannot be completed prior to operation, the operator may continue to operate the ride until the Department verifies the qualifications and certifies the operator.

(B) Operators who have been trained by a certified trainer may be issued a certificate which allows the operator to operate any amusement ride for which the operator has been trained to operate by a certified trainer.

(C) Applications for an operator certificate shall be submitted on forms provided by the Department of Labor.

(e) Certificates must be carried on the certificate holder's person while operating the ride, or in the case of a permanent park, may be displayed or kept on file on the premises. The certificate will indicate the applicant's name, address, date of birth, and type of ride approved to operate. Should the applicant have the required training and pass a test for additional rides or submit documentation of additional training by a certified trainer, the certificate will be revised to indicate the new ride or rides for which the applicant was approved.

(f) Lost or mutilated certificates may be replaced with a duplicate certificate at no cost.

(g) All certificates, except temporary, shall be issued with an expiration date of the last day of March of the following year. All certificates shall be renewed prior to the first day of April each year. Renewal applications may be in person or by mail. Failure to renew prior to the first day of April shall require recertification.

(h) Any certificate issued in accordance with this Section may be suspended or revoked by the Department after due investigation of the competence of the certificate holder, or for the willful falsification of any matter or statement contained

in his/her application or in a report of any inspection made by him/her. Written notice of any such suspension or revocation and the grounds therefore shall be transmitted by the Department to the licensee and his/her employer within ten (10) days following the suspension or revocation.

(i) All operators/applicants may be subject to a background check by the Department. Completion thereof will not delay an operator's receipt of a temporary certificate. If there is reason to believe the operator/applicant may be in violation of 57 O.S. § 589(A) and/or (B), the operator/applicant may not be granted a certificate.

(j) Any operator/applicant for which there is reason to believe is under the influence of drugs or alcohol may be subject to the following:

(1) A request for a voluntary drug/alcohol test by competent/qualified facility.

(2) Failure to submit to a voluntary drug/alcohol test may result in the loss of the operator's certificate to operate a ride.

(3) A positive drug/alcohol test result will result in loss of the certificate to operate a ride for a minimum of thirty (30) days but no more than ninety (90) days.

(4) Any test will be at the expense of the individual taking the test.

(k) Amusement rides owned by a non profit corporation and operated by a member of the organization or under the control of the organization may be granted a temporary certificate for a specific date or function, provided each operator passes a test administered by the Oklahoma Department of Labor to assure the operator is competent to operate a specific ride.

(l) In the event an operator who has been previously certified for a specific ride is either terminated or quits after the show has been inspected, the owner may train new operators to operate a specific ride or rides. In this event, the owner must notify the inspector who last inspected the rides or his/her designee within two (2) hours after the new operator or operators are trained and qualified. The new operator may continue to operate the ride until the Department verifies the qualifications and certifies the new operator or operators.

(m) Any operator of a large inflatable amusement device who is under the direction and control of the owner of the device shall be certified in accordance with this Section. In the event a large inflatable amusement device is rented to an operator/responsible party who is not under the direction and control of the owner, the owner must either provide an operator who has been certified or provide training to the operator/responsible party in accordance with (a). In this event, the owner must notify the Department within two (2) hours of the completion of the training (if during normal business hours of 8 a.m. to 5 p.m., otherwise the next working day) and provide the Department with the location of the device, name of the operator/responsible party, expected duration of use, and documentation confirming the required training has been completed. This Section shall not apply to small inflatable rides.

(n) Any person whose certificate has been suspended or revoked shall be entitled to a hearing as provided by the Oklahoma Administrative Procedures Act, if written request for

such hearing is received by the Department within fifteen (15) days of the date of suspension/revocation letter.

380:55-13-2. Rides kept clean Sanitation and water quality of rides

- (a) Rides shall be kept clean and trash removed to prevent accidents or injury.
- (b) Water quality shall be tested by the Department of Labor personnel in accordance with standards developed by the Oklahoma Department of Health, OAC 310:320.
- (c) Water parks shall maintain the water quality in accordance with standards developed by the Oklahoma Department of Health, OAC 310:320.

[OAR Docket #09-857; filed 5-7-09]

TITLE 395. OKLAHOMA LAW ENFORCEMENT RETIREMENT SYSTEM CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #09-816]

RULEMAKING ACTION:

PERMANENT Final adoption

RULES:

395:1-1-3. Board meetings and records [AMENDED]

AUTHORITY:

Oklahoma Law Enforcement Retirement Board; Title 47 §2-300- 2-315.

DATES:

Comment period:

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No public hearing was or requested.

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Failure of the Legislature to disapprove the rules resulted in approval on April 21, 2009.

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June 11, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The purpose of these amendments is to get our rules in compliance with IRS regulations and to change the address of our physical location.

CONTACT PERSON:

Ginger Poplin, Executive Director, 421 NW 13th Street, Suite 100, Oklahoma City, OK 73103, 405-522-4931.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S.,

SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

395:1-1-3. Board meetings and records

(a) Conduct of meetings. The Board will normally meet on the third Thursday of each month and at such other times, dates, and locations as may be set by the Board. Special and emergency meetings will be called in accordance with the provisions of the retirement law and the Open Meeting Law. Meetings will be held in accordance with the Open Meeting Law (Title 25, O.S. Section 301-314.) Written minutes shall be an official summary of the proceedings, signed by the President, and shall be on file in the Oklahoma Law Enforcement Retirement System's administrative office in Oklahoma City, Oklahoma, located at ~~4545 N. Lincoln Blvd.~~ 421 NW 13th, Suite 257.100. The minutes and other public records that are under the administration of the Oklahoma Law Enforcement Retirement System are open to the public for inspection during normal working hours of the Oklahoma Law Enforcement Retirement System.

(b) Voting. Seven (7) Board members shall constitute a quorum for the transaction of business. Any official action of the Board shall be based on a favorable vote of at least seven (7) Board members at a regular or special meeting of the Board.

[OAR Docket #09-816; filed 5-1-09]

TITLE 395. OKLAHOMA LAW ENFORCEMENT RETIREMENT SYSTEM CHAPTER 10. RETIREMENT AND PENSION BENEFIT PROGRAM

[OAR Docket #09-817]

RULEMAKING ACTION:

PERMANENT Final adoption

RULES:

395:10-1-4. Benefits [AMENDED]

395:10-1-4.3. Qualified health insurance premiums [NEW]

395:10-1-10. Sick leave as credited service [AMENDED]

395:10-1-11.1. Direct Rollovers [AMENDED]

395:10-1-11.3. Direct Trustee-to-Trustee Transfer by Nonspouse Beneficiary [NEW]

395:10-1-16. Direct Payment of Qualified Health Insurance Premiums [NEW]

AUTHORITY:

Oklahoma Law Enforcement Retirement Board; Title 47 §2-300- 2-315.

DATES:

Comment period:

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Public hearing:

No public hearing held or none requested.

Adoption:

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March 12, 2009

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Final adoption:

April 21, 2009

Effective:

June 11, 2009

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

ANALYSIS:

The purpose of these amendments is to get our rules in compliance with IRS regulations and to change the address of our physical location.

CONTACT PERSON:

Ginger Poplin, Executive Director, 421 NW 13th Street, Suite 100, Oklahoma City, OK 73103, 405-522-4931.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

395:10-1-4. Benefits

All benefits shall be paid in accordance with 47 O.S. § 2-305.

- (1) Each new member shall make written application for membership and said application shall be presented to the Board at the next meeting of the Board for approval.
- (2) Each application for membership may be approved effective on the first (1st) of the month following date of employment, so long as the applicant meets the qualifications for membership stated in 47 O.S. § 2300, para. 6.
- (3) Written requests for retirement benefits must be received in the administrative office located at ~~4545 North Lincoln Blvd, 421 NW 13th Street, Suite 257, 100~~, Oklahoma City, Oklahoma, by the first Wednesday of the month prior to the desired effective date of retirement, in order that such matters may be properly posted on the agenda as required by the Open Meeting Laws.
- (4) The Board shall have the authority to call a disabled member for a complete physical examination by two (2) physicians selected by the Board, any time between the regularly called for examination; provided the Board has reason to believe that such member has or may have recovered to the extent that he can again perform service in any division covered by the System. After complete evaluation by the examining physicians, if the member is found no longer disabled for performance of duties, the member shall be required to return to duty and complete twenty (20) years of service.
- (5) Retirement pursuant to 47 O.S. § 2-305, has at all times included reemployment of a member by a state agency in a position which is not covered by OLERS. Thus, in-service distributions from OLERS to such a member are permitted. Prior to September 19, 2002, if such member was reemployed by a state agency in a position which is covered by OLERS, such member will continue to receive in-service distributions from OLERS and will not accrue any further credited service. On and

after September 19, 2002, if a retired member is reemployed by a state agency in a position which is covered by OLERS, such member's monthly retirement payments shall be suspended until such member retires and is not reemployed by a state agency in a position which is covered by OLERS.

395:10-1-4.3. Qualified health insurance premiums

If the requirements of OKLA. ADMIN. CODE Section 395:10-1-16 are satisfied, a member who, by reason of disability or attainment of normal retirement date or age, separates from service as a public safety officer with his or her participating employer, may elect to have payment made directly to the provider for qualified health insurance premiums by deduction from the member's monthly disability benefit or monthly retirement payment, after December 31, 2006.

395:10-1-10. Sick leave as credited service

- (a) A member, upon retirement, electing a Deferred Option Plan or electing a vested benefit, shall be credited with not more than 1,040 hours of unused accumulated sick leave. For the purposes of this computation, 1,040 hours shall total six (6) months, fifteen (15) days, with 20 days totaling one month of credit.
- (b) Effective July 1, 2008, a member, upon retirement, electing a Deferred Option Plan or electing a vested benefit, shall be credited with not more than 1,920 hours of unused accumulated sick leave. For the purposes of this computation, 1,920 hours shall total twelve (12) months, with 20 days totaling one month of credit.

395:10-1-11.1. Direct Rollovers

- (a) A Distributee may elect, at the time and in the manner prescribed by the Board, to have any portion of an Eligible Rollover Distribution paid directly to an Eligible Retirement Plan specified by the Distributee in a Direct Rollover.
- (b) Definitions:
 - (1) "Eligible Rollover Distribution" is generally a lump sum distribution except that an Eligible Rollover Distribution does not include monthly retirement benefits and minimum distribution payments. A portion of the distribution shall not fail to be an Eligible Rollover Distribution ~~may consist merely because the portion consists of after-tax member contributions which are not includible in gross income; however, such after-tax distributions may only be paid to an IRA or qualified defined contribution plan that separately accounts for such distributions.~~ contributions. However, such portion may only:
 - (A) from January 1, 2002 through December 31, 2006, (i) be transferred in a direct trustee-to-trustee transfer to a qualified trust which is part of a defined contribution plan described in Section 401(a) of the Internal Revenue Code of 1986, as amended, or an annuity plan described in Section 403(a) of the Internal Revenue Code of 1986, as amended, that provides for separate accounting for the after-tax contributions

and earnings thereon, or (ii) be transferred to an Individual Retirement Account or Annuity (IRA), as described in Section 408(a) or Section 408(b) (other than an endowment contract) of the Internal Revenue Code of 1986, as amended; or

(B) on or after January 1, 2007, (i) be transferred in a direct trustee-to-trustee transfer to a qualified trust described in Section 401(a) of the Internal Revenue Code of 1986, as amended, an annuity plan described in Section 403(a) of the Internal Revenue Code of 1986, as amended, or an annuity contract described in Section 403(b) of the Internal Revenue Code of 1986, as amended, that provides for separate accounting for the after-tax contributions and earnings thereon, or (ii) be transferred to an Individual Retirement Account or Annuity (IRA), as described in Section 408(a) or Section 408(b) (other than an endowment contract) of the Internal Revenue Code of 1986, as amended.

(2) "Eligible Retirement Plan" means an IRA (excluding a Roth IRA) an Individual Retirement Account or Annuity (IRA), as described in Section 408(a) or Section 408(b) (other than an endowment contract) of the Internal Revenue Code of 1986, as amended, a Section 403(a) annuity plan, and a 401(a) qualified plan that accepts the Distributee's Eligible Rollover Distribution. An Eligible Retirement Plan also means a 403(b) annuity and an eligible 457(b) plan which is maintained by a state, political subdivision of a state, or any agency or instrumentality of a state or political subdivision of a state and which agrees to separately account for amounts transferred into such plan from OLEERS. The definition of Eligible Retirement Plan also applies to a distribution to a surviving spouse, or to a spouse or former spouse who is the alternate payee pursuant to a qualified domestic order as defined in Subsection B of Section 2-303.3 of Title 47.

(3) "Distributee" means an employee or former employee. In addition, effective June 7, 1993, the employee's or former employee's surviving spouse and the employee's or former employee's spouse or former spouse who is the alternate payee under a qualified domestic order, as defined in Subsection B of Section 2-303.3 of Title 47, are Distributees with regard to the interest of the spouse or the former spouse. For distributions after December 31, 2006, the member's nonspouse designated beneficiary is also a Distributee.

(4) "Direct Rollover" means a payment by OLEERS to the Eligible Retirement Plan specified by the Distributee or, on or after January 1, 2008, to a Roth IRA specified by the Distributee (if the Distributee meets the Roth IRA requirements). A nonspouse beneficiary is allowed to make a Direct Rollover only to an IRA (other than an endowment contract). The IRA must be: established on behalf of the designated beneficiary, treated as an inherited IRA, and titled in the name of the deceased member, for the benefit of the beneficiary. The determination of

any required minimum distribution that is not eligible for roll over must be made in accordance with Notice 2007-7, Q&A 17 and 18, 2007-5 I.R.B. 395, as clarified by the Special Edition dated February 13, 2007, of Employee Plans News of the Internal Revenue Service Tax Exempt and Government Entity Division.

(c) At least thirty (30) days and before and effective January 1, 2007, not more than ~~ninety (90)~~ one hundred eighty (180) days before the date of distribution, the Distributee must be provided with the IRS Notice regarding rollover options and tax effects. The distribution may be paid less than thirty (30) days after the notice is given, provided that:

(1) The Board clearly informs the Distributee that the Distributee has a right to a period of at least thirty (30) days after receiving the notice to consider the decision of whether or not to elect a distribution; and

(2) The Distributee, after receiving the notice, affirmatively elects a distribution.

395:10-1-11.3. Direct Trustee-to-Trustee Transfer By Nonspouse Beneficiary

(a) An individual who has been designated either by a member, on a beneficiary designation form supplied by OLEERS, or pursuant to state statutes governing OLEERS, as a beneficiary of the deceased member, and who is not the surviving spouse of the member, may elect, at the time and in the manner prescribed by the Board, to have a direct trustee-to-trustee transfer of any portion of his or her lump-sum payment from OLEERS after December 31, 2006, made to an Individual Retirement Account or Annuity (IRA), as described in Section 408(a) or Section 408(b) (other than an endowment contract) of the Internal Revenue Code of 1986, as amended. If such transfer is made, then:

(1) the transfer is treated as an eligible rollover distribution;

(2) the transferee IRA is treated as an inherited account, and thus,

(A) the transferee IRA must be titled in the deceased member's name (e.g., "John Smith f/b/o Tom Smith"); and

(B) the nonspouse beneficiary may name a successor beneficiary if permitted to do so by the transferee IRA, so long as the distribution continues to meet the required minimum distribution rules under Section 401(a)(9) of the Internal Revenue Code of 1986, as amended, applicable to the original nonspouse beneficiary; and

(3) the required minimum distribution rules (other than the special rules for the surviving spouse of the employee) which are applicable when the member dies before the entire interest is distributed apply to the transferee IRA.

(b) A trustee-to-trustee transfer can be made to a trust if the beneficiaries of the trust are individuals. The transferee IRA must be titled in the name of the deceased member (e.g., "John Smith f/b/o the Smith Family Trust").

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395:10-1-16. Direct Payment of Qualified Health Insurance Premiums

(a) **Election.** A member who is an eligible retired public safety officer and who wishes to have direct payments made toward his or her qualified health insurance premiums from his or her monthly disability benefit or monthly retirement payment, must make a written election, on the form provided by the System.

(1) The election must be made after he or she separates from service as a public safety officer with his or her participating employer.

(2) The election will only apply to distributions from the System after December 31, 2006, and to amounts not yet distributed to the eligible retired public safety officer.

(3) Direct payments for an eligible retired public safety officer's qualified health insurance premiums can only be made from his or her monthly disability benefit or monthly retirement payment from OLEERS and cannot be made from the Oklahoma Law Enforcement Deferred Option Plan.

(4) Amounts deducted from an eligible retired public safety officer's monthly disability benefit or monthly pension payment, and paid toward his or her qualified health insurance premiums, may not exceed \$3,000 per calendar year.

(b) **Payments.** Monthly payments toward qualified health insurance premiums will be sent by OLEERS to the provider when the monthly disability benefit and monthly retirement payments are sent. Such monthly payments will continue month-to-month and year-to-year in the amount specified on the member's most recent election form unless the System office receives at least thirty (30) days advance written notice to change or terminate such payments or the monthly disability benefit or monthly retirement payment terminates.

(c) **Eligible Retired Public Safety Officer.** A "public safety officer" is an individual serving a public agency in an official capacity, with or without compensation, as a law enforcement officer, firefighter, chaplain, or as a member of a rescue squad or ambulance crew. An "eligible retired public safety officer" is an individual who, by reason of disability or attainment of normal retirement date or age, is separated from service as a public safety officer with his or her participating employer.

(d) **Qualified Health Insurance Premiums.** "Qualified health insurance premiums" are for coverage for the eligible retired public safety officer, his or her spouse, and dependents by an accident or health insurance plan (which may be a self-insured plan, in accordance with Notice 2007-99, Q&A-23, 2007-52, I.R.B. 1243) or a qualified long-term care insurance contract. The health plan does not have to be sponsored by the eligible retired public safety officer's former participating employer. Qualified health insurance premiums do not include amounts contributed pursuant to Chapter 395:10-1-4.2.

(e) **Miscellaneous.** A completed election form with all required information must be received by the System office at least thirty (30) days before:

(1) any deduction will be made from the eligible retired public safety officer's monthly disability benefit

or monthly retirement payment and paid directly to the provider; and

(2) a change or termination of such monthly deductions and payments will be made.

[OAR Docket #09-817; filed 5-1-09]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 3. MANAGEMENT SERVICES DIVISION

[OAR Docket #09-875]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 5. Policy Development and Program Standards

Part 1. General Provisions

612:3-5-1. Purpose [AMENDED]

Part 3. Policy Development

612:3-5-12. Policy Development [AMENDED]

612:3-5-13. Drafting of new or revised policy [AMENDED]

AUTHORITY:

The Oklahoma Commission for Rehabilitation Services; Rehabilitation Act, United States Code Title 29, sections 701 through 791; Oklahoma Statute Title 74, Section 166.1 et seq.

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SUPERSEDED EMERGENCY ACTIONS:

N/A

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N/A

ANALYSIS:

The proposed changes to Chapter 3 involve updating language by removing the reference to forms; specifying that the Policy Development Unit manages and maintains Departmental regulations but not departmental memoranda; and requiring the appropriate Program Administrator to provide reasons for (and budget impact of) policy changes.

CONTACT PERSON:

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**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING RULES ARE CONSIDERED
FINALLY ADOPTED AS SET FORTH IN 75 O.S.,**

SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 5. POLICY DEVELOPMENT AND PROGRAM STANDARDS

PART 1. GENERAL PROVISIONS

612:3-5-1. Purpose

(a) The purpose of this Subchapter is to present the methods the Department of Rehabilitation Services will use to comply with the Administrative Procedures Act. Authority for the policies contained in this Subchapter derive from enabling legislation for the Department, 74 O.S., Sections 166.1 et seq.; and the Administrative Procedures Act, 75 O.S., Sections 250 et seq. These policies are also based upon regulations published by the Office of Administrative Rules, OAC Title 655. Where Department policy is silent on policy development or program standards, decisions will be based upon regulations published by the Office of Administrative Rules, or upon regulations published by the Rehabilitation Services Administration.

(b) Agency policy communicates the expected standards for staff conduct and provides the necessary ~~forms and~~ direction for carrying out the agency' mission. The intent of policy is to provide a common basis for decision making so that individuals can expect equitable treatment when dealing with the agency. Our policy is a public document so that the public will have the opportunity to know the mission of our program and how this agency intends to carry out that mission.

(c) Those who carry out policy, and those who are affected by it, will be given the opportunity to influence its development. This will be accomplished through direct involvement of appropriate agency staff and consumer representatives, as appropriate, in the policy development process.

(d) The success of fulfilling the agency's mission will be evaluated through measures appropriate to the particular program. Compliance with regulatory requirements will also be measured. The results of such evaluations will be reported to appropriate entities, including consumer councils.

PART 3. POLICY DEVELOPMENT

612:3-5-12. Policy Development

(a) Policy Development is charged with assuring that the Department complies with the Administrative Procedures Act. This responsibility includes:

(1) Ensuring that all Department statements of general applicability and future effect that implement, interpret, or prescribe law or policy, or describe the procedures or practice requirements of the Department are promulgated in accordance with the APA.

(2) That the public receives proper notice of the Department's intent to adopt, amend, or revoke rules so that opportunity is provided for public and consumer input during the rulemaking process.

(3) Management of the promulgation process for the Department in an efficient and effective manner that complies with the APA.

(b) The Administrator of the Policy Development and Program Standards Unit serves as the Department's liaison to the Office of Administrative Rules in the Office of the Secretary of State. This administrator also serves as the attestation officer, as delegated by the Oklahoma Commission for Rehabilitation Services, for purposes of 75 O.S., Section 254. An Administrative Officer within Policy Development will be designated as the back-up attestation officer for the Department.

(c) Once a Division or the Executive Office has developed proposed policy and supporting documentation, Policy Development staff will format and prepare the resulting documents for submission to the Commission for action. From that point, Policy Development staff will be responsible for the promulgation process from initial notices through distribution of the adopted policy.

(d) Policy Development staff is responsible for review of Departmental publications to assure consistency with existing policy, and conformance with the APA.

(e) Policy Development staff will manage and maintain Departmental regulations and Rehabilitation Services Administration memoranda and regulations. Copies of State statutes and relevant Federal statutes will also be managed and maintained as directed.

612:3-5-13. Drafting of new or revised policy

(a) The administrators in each division, at each school, and in the executive offices are responsible for keeping informed of the statutes and regulations which govern the operation of programs under their authority. These administrators are also in the best position to know the needs of his or her programs' consumers, staff, and service partners. Each Division Administrator, Unit Administrator, and School Superintendent is therefore responsible for ensuring that Departmental policies for his or her program conform to the requirements of applicable statutes and regulations, and are effective in achieving their program's mission. Whenever possible, drafting of new or revised policies should begin at least twelve months in advance of their intended effective date.

(b) When an administrator, or the Director, decides there is a need to draft new policy, or to amend existing policy, the Unit Administrator, Division Administrator, Superintendent, Deputy Director or Director will assure that sufficient opportunity for input on the needed changes will be given to individuals and groups as designated by the administrator or Director. The appropriate program administrator will provide the Policy Development staff the reasons for changing policy as well as any budget impact these changes may incur and is to consult with Policy Development staff about the need to arrange for, announce, and hold any public forums. Public comments and responses to them must be submitted to the Policy Development Section for inclusion in the rulemaking record. Policy Development staff assistance in developing a summary of comments and responses is available.

(c) The appropriate program administrator will initiate drafting of policy content through whatever method deemed most

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effective by the administrator. Policy Development Section staff will provide assistance as requested. The Policy Development Section will be responsible for drafting Departmental policy pages using the content drafts provided by the appropriate program administrator. Once this first draft is completed, Policy Development staff will consult with the appropriate administrator concerning any needed revisions. When these are completed, the draft policy will be distributed to Executive Team members for review and response. Administrators will consider comments and revise drafts as appropriate, providing final draft versions to the Policy Development Section. The appropriate program administrator will determine when the draft policy is ready for distribution to Departmental staff for comment. Staff comment will be obtained as follows:

- (1) A memo will be addressed to all Departmental staff advising them that the draft policy is being distributed for comment, and will include:
 - (A) identification and summary of the draft policy being distributed;
 - (B) general instructions on where the draft policy can be accessed;
 - (C) how to submit comments, and the due date for submission of comments; and
 - (D) where to direct questions about the draft policy.
- (2) Policy as drafted by the Policy Development Section will be distributed to each office of the Department (including alternative formats). The Bulletin Board memo will provide instructions for providing comments and where to direct questions about the draft policy. Alternative formats are also to be made readily available.
- (3) Comments will be returned to the Policy Development Section where they will be collated, and a summary of them developed. The summary and collated comments will be provided to the appropriate program administrator. The appropriate program administrator will decide on what policy changes to make in response to the submitted comments, if any. The appropriate program administrator will draft responses to the comments, which will at a minimum explain any instance in which staff recommendations were not adopted and will be forwarded to the respective commentator as well as the Policy unit.
- (4) Policy Development staff will work with the appropriate program administrator to finalize draft policy. This step will include a final check for consistency with existing policies, regulations, and applicable statutes. Policy Development staff will obtain authorization from the appropriate program administrator to proceed with promulgation of the draft policy.
- (d) When the draft policy pages are submitted to the Policy Development Section for promulgation, the draft policy is then referred to as proposed policy. Policy Development staff will submit the proposed policy and/or notice, including executive summary and resolution, to the Director for review prior to submission to the Commission for discussion or action.

[OAR Docket #09-875; filed 5-8-09]

TITLE 612. STATE DEPARTMENT OF REHABILITATION SERVICES CHAPTER 10. VOCATIONAL REHABILITATION AND VISUAL SERVICES

[OAR Docket #09-876]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1, General Provisions

612:10-1-2. Definitions [AMENDED]

Subchapter 7, Vocational Rehabilitation and Visual Services

Part 1. Scope of Vocational Rehabilitation and Visual Services

612:10-7-4. Basic eligibility requirements for vocational rehabilitation services [AMENDED]

Part 5. Case Status and Classification System

612:10-7-50. Eligibility accepted for services and IPE under development [AMENDED]

612:10-7-62. Post-employment services [AMENDED]

Part 9. Actions Requiring Review and Approval

612:10-7-88. Actions requiring field coordinator's approval [AMENDED]

Part 13. Supportive Services

612:10-7-131. Transportation [AMENDED]

Part 15. Training

612:10-7-152. Payment of tuition and fees at colleges and universities [AMENDED]

Part 21. Purchase of Equipment, Occupational Licenses and Certificates

612:10-7-219. Purchase of motor vehicles [AMENDED]

612:10-7-220. ~~Purchase of special equipment for motor vehicles~~ Vehicle modification services [AMENDED]

Part 23. Self-employment Programs and Other Services

612:10-7-233. Special consideration in state government employment for persons with severe disabilities [AMENDED]

AUTHORITY:

The Oklahoma Commission for Rehabilitation Services; Rehabilitation Act, United States Code Title 29, sections 701 through 791; Oklahoma Statute Title 74, Section 166.1 et seq.

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INCORPORATIONS BY REFERENCE:

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ANALYSIS:

The proposed changes to Chapter 10 involve adding a definition for "severe disability" to eliminate confusion and match state law; clarifies eligibility of diabetics and substance abuse clients if there is a substantial impediment to employment; removes the exclusion of post-employment services for the purpose of upgrading a person's financial status; pays a transportation allowance based on actual fuel costs and average car mileage; and allows the agency to assist a client in obtaining a vehicle with modifications already installed thereby reducing agency and client costs.

CONTACT PERSON:

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1 (A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

612:10-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Act" means the Rehabilitation Act [29 USC 701 et seq.].

"ADL" Activities of Daily Living often refer to the routine activities carried out for personal hygiene and health (including bathing, dressing, feeding) and for operation of a household.

"Applicant" means an individual who has completed and signed an agency application form or has otherwise requested vocational rehabilitation services; who has provided information necessary to initiate an assessment to determine eligibility and priority for services; and who is available to complete the assessment process.

"Assistive technology" means technology designed to be utilized in an assistive technology device or service.

"Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.

"Authorized Representative" means a client's or applicant's parent, guardian, advocate (i.e. Client Assistance Program) or other person designated by the client or applicant as the individual authorized to deal with the Department on behalf of the client or applicant, consistent with provisions of the Act. Authorized representative does not include an employee of the Department of Rehabilitation Services, another state agency, or vendor of the Department unless the person is actually the parent, guardian, or is serving in the capacity of guardian (for example: court appointed).

"Blind" means persons who are blind within the meaning of the State Law relating to Vocational Rehabilitation. Legal blindness means a visual acuity of 20/200 or less in the better eye with best correction, or a visual field of 20 degrees or less.

"Client/Consumer" means an individual found eligible and receiving services under the Act.

"Clubhouse model" means a psychosocial and vocational approach to work adjustment for people with mental illness. The work-ordered day is a core element of the clubhouse, which focuses on strengths, talents and abilities. Work

in the clubhouse helps members develop appropriate social skills and gain self worth, purpose, and confidence. The clubhouse enables members to return to paid work through Transitional Employment, Supported Employment and independent employment.

"Community rehabilitation program" (CRP) means a program that directly provides or facilitates the provision of vocational rehabilitation services to individuals with disabilities, and provides singly or in combination, services for an individual with a disability to enable the individual to maximize opportunities for employment, including career advancement.

"Comparable benefits" means services and/or funding available through any other programs and/or resources which will meet in whole or in part the cost of rehabilitation services provided to an eligible individual. For the purposes of this definition, the term "resources" does not include client assets as determined under 612:10-3-1 through 612:10-3-7.

"Compensatory training" means training required before the client can enter a formal training program or employment, such as pre-vocational or personal adjustment training.

"Competitive employment" means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and for which the individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who do not have disabilities.

"Consumer Independence Support Services" (CISS) are defined as providing independent living assessment, intensive counseling, community integration, and housing modifications to further assist consumers with severe disabilities in achieving independence.

"Continuity of Services" means once an individual is selected for services in accordance with policy, regardless of the priority category from which the individual was selected, the individual will receive the necessary purchased services, including post-employment services.

"Counselor" means the qualified rehabilitation professional, who is an employee of the designated state unit, and who has primary responsibility for the management of an individual's rehabilitation services case record, including determination of eligibility, service planning and management, and determination of successful or unsuccessful rehabilitation. Counselor is equivalent to such terms as VR/VS Specialist, VR/VS Coordinator, and Rehabilitation Teacher who manage Visual Services cases with Homemaker goals.

"Department" unless otherwise indicated in the text, means the Department of Rehabilitation Services as constituted in 74 O.S., Section 166.1 et seq.

"DRS" means the Department of Rehabilitation Services.

"Durable Training Supplies" means general training supplies which are not consumable, and are required for any student taking a particular course of study at an institution of learning, or required by a client as a reasonable accommodation for training. In general, any training supply which a client could not continue to use past successful rehabilitation, or which could not be used by other clients in future terms of

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training, would not meet the definition of "durable training supply".

"DVR" means the Division of Vocational Rehabilitation.

"DVS" means the Division of Visual Services.

"Eligibility" or "Eligible" means:

(A) when used in relation to an individual's qualification for Vocational Rehabilitation services, a determination that the individual has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment; can benefit in terms of an employment outcome from rehabilitation services; and requires vocational rehabilitation services to prepare for, enter, engage in, or retain gainful employment;

(B) when used in relation to an individual's qualification for Supported Employment services, a determination that the individual is eligible for Vocational Rehabilitation services; is an individual with the most severe disabilities (priority group one); and

(i) for whom competitive employment has not traditionally occurred; or

(ii) for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and

(iii) who, because of the nature and severity of their disability, need intensive supported employment services, and extended services after the transition from intensive supported employment services, in order to perform such work;

(C) when used in relation to an individual's qualification for Rehabilitation Teaching services, certification that the individual is legally and/or functionally blind or has a rapidly progressive condition and may have secondary disabilities; the individual has identifiable deficiencies in independent living due to disabilities; and it is expected services will improve the individual's independence in the home and community;

(D) when used in relation to an individual's qualification for Independent Living Rehabilitation services, certification that the individual has a severe physical or mental disability; the disability results in a substantial limitation or inability to function independently in the family or community or to continue in employment; and a reasonable expectation that independent living services will significantly assist the individual improve his/her ability to function independently.

"**Employment and Retention**" (E&R) means short-term job coach support for individuals with severe disabilities who require assistance preparing for, obtaining, and maintaining employment.

"**Employment outcome**" means, with respect to an eligible individual, entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market to the greatest extent practicable; supported employment; or any other type of employment (including self-employment, telecommuting, or business ownership) that is consistent with

an individual's strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

"**Extended employment**" means work in a non-integrated or sheltered setting for a public or private nonprofit agency or organization that provides compensation in accordance with the Fair Labor Standards Act and any needed support services to an individual with a disability to enable the individual to continue to train or otherwise prepare for competitive employment, unless the individual through informed choice chooses to remain in extended employment.

"**Extended period of time**" means when appropriate services are provided in a timely and orderly manner, completion of the Individualized Plan for Employment (IPE) will be expected to require a minimum of 6 months.

"**Extended services**" means ongoing support services provided to individuals with the most severe disabilities after the time-limited vocational rehabilitation services have been completed and job stabilization has been achieved. They consist of specific services, including natural supports, needed to maintain the supported employment placement. Extended services are paid from funding sources other than DRS and are specifically identified in the IPE.

"**Extreme medical risk**" means a risk of substantially increasing functional impairment or risk of death if medical services are not provided expeditiously.

"**Functional capacities**" means a client's assets, strengths, and resources which maintain or increase the individual's ability to work. Functional capacities include mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills.

"**Functional limitations**" means physical or mental conditions, emergent from a disability, which impair, interfere with, or impede one or more of an individual's functional capacities.

"**Higher education**" means universities, colleges, community/junior colleges, vocational schools, technical institutes, or hospital schools of nursing.

"**Highly challenged**" describes a client receiving supported employment services who, due to the nature of the disability, requires a greater level of support from the job coach to achieve and maintain employment.

"**Homemaker**" means a person whose primary work is performance of duties related to upkeep and maintenance of a home.

"**IEP**" means Individualized Education Program as required by the Individuals with Disabilities Education Act.

"**Independent Living (IL) Core services**" is defined as information and referral services; independent living skills training; peer counseling; and individual and systems advocacy.

"**Individual with a disability**" means an individual having one or more physical or mental conditions which materially limits, contributes to limiting or, if not corrected, will probably result in limiting an individual's employment activities or vocational functioning.

"Individual with a severe disability" means with respect to eligibility for the state's Optional Program for Hiring Applicants with Disabilities, an individual who has a

physical or mental impairment which seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome.

"Individual with significant disability" means an individual with a significant barrier to employment, as used in the Rehabilitation Act amendments of 1998, and an individual:

(A) who has a physical or mental impairment seriously limiting one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome;

(B) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and

(C) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental illness, mental retardation, multiple sclerosis, muscular dystrophy, musculoskeletal disorder, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease or other disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs to cause comparable substantial functional limitation.

"Individual with the most significant disability" means an individual with the most significant barrier to employment as used in the Rehabilitation Act amendments of 1998, and an individual with physical or mental disabilities:

(A) who has a severe physical or mental disability that seriously limits three or more major life activities in terms of an employment outcome;

(B) whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and

(C) who has one or more physical or mental disabilities resulting from amputation, arthritis, autism, blindness, burn injury, cancer, cerebral palsy, cystic fibrosis, deafness, head injury, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental illness, mental retardation, multiple sclerosis, muscular dystrophy, musculoskeletal disorder, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, other spinal cord conditions, sickle cell anemia, specific learning disability, end-stage renal disease or other disability or combination of disabilities determined on the basis of an assessment for determining eligibility and vocational rehabilitation needs to cause comparable substantial functional limitation.

"Integrated setting" means:

(A) With respect to the provision of services, a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals other than non-disabled individuals who are providing services to those applicants or eligible individuals.

(B) With respect to an employment outcome, means a setting typically found in the community in which applicants or eligible individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those applicants or eligible individuals, to the same extent that non-disabled individuals in comparable positions interact with other persons.

"Intercurrent (acute) conditions" means an illness or injury occurring during the actual course of an individual's rehabilitation which, if not cared for, will complicate or delay achievement of the client's employment outcome as identified in the client's IPE.

"IPE" means the Individualized Plan for Employment.

"Job Club" is a structured learning experience for a client to build skills in self-assessment, resume development, job search and research strategies, and interview techniques to assist the person to enter a career of their choice.

"Job Coach/Employment Training Specialist" means a qualified individual providing support services to eligible individuals in supported employment and employment and retention programs. Services directly support the eligible individual's work activity including marketing and job development, applied behavioral analysis, job and work site assessment, training and worker assessment, job matching procedures, and teaching job skills.

"Long-term treatment" means medical or psychological treatment that is expected to last more than three months.

"Maintenance" is a service provided to assist with the out-of-ordinary or extra expenses to the individual resulting from and needed to support the individual's participation in diagnostic, evaluative, or other substantial services in the IPE. Activities of Daily Living (ADL) expenses are not eligible for maintenance payments.

"Milestones" means a payment system that reimburses a vendor based on incentives and outcomes. The vendor is paid when the client completes pre-defined checkpoints on the way to a desired employment goal.

"Multiple services" means the counseling and guidance provided as a routine part of case management plus two or more VR services. Comparable benefits and/or services can count toward meeting the definition of multiple services. Services routinely provided as a package do not count as multiple services for the purpose of determining the presence of a significant disability, even if two or more services are included in the package.

"Natural supports" means any assistance, relationships or interactions that allow a person to maintain employment in ways that correspond to the typical work routines and social interactions of other employees. Natural supports may be developed through relationships with people or put into place

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by the adaptation of the work environment itself, depending on the support needs of the person and the environment.

"Occupational license" means any license, permit, or other written authority required by a state, city or other governmental unit to be obtained in order to enter an occupation.

"Ongoing support services" means services specified in the IPE according to individual need, which support and maintain an individual with the most severe disabilities in supported employment. Sponsored ongoing support services are provided from the time of placement until the individual is stabilized on the job. Ongoing support services are provided by one or more extended services providers, or by natural supports, following transition throughout the individual's term of employment. In transitional employment, the provision of ongoing support services must include continuing sequential job placements until job permanency is achieved.

"Package of services" means several services which are usually provided together for the same purpose. The services in a package are usually, but not always, from the same category of services (see definition of multiple services, this section). Examples include, but are not limited to: surgery, anesthesia, and hospitalization; or personal computer, software, and peripheral equipment.

"Personal assistance services" means a range of services provided by one or more persons designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability.

"Physical and mental restoration services" means services which are necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive, within a reasonable period of time.

"Physical or mental disability" means a physical or mental condition which, if not corrected, materially limits, contributes to limiting or will result in limiting an individual's activities or functioning.

"Referral" means information provided to agency staff regarding an individual who may need vocational rehabilitation services; information or direction provided to an individual regarding services and resources available from other agencies or service providers; or information and direction provided to an individual regarding opportunities for employment. A referral may include arranging for appointments on behalf of the individual.

"Rehabilitation Act" means the Rehabilitation Act [29 USC 701 et seq.].

"Related factors" means those factors which are not directly attributable to the impediment to employment, but which have impact on the potential for successful rehabilitation. They frequently become evident only from an assessment of the person's social, vocational, educational, and environmental circumstances.

"Section 504 Plan" is a plan designed as a protection for students with disabilities who may not be considered eligible for special education under IDEA in compliance with Section 504 of the Rehabilitation Act of 1973 as amended.

"Small business enterprises" means a small business operated by blind or other individuals with severe disabilities

under the management and supervision of the state DRS. Such businesses include only those selling, manufacturing, processing, servicing, agricultural, and other activities which are suitable and practical for the effective utilization of the skills and aptitudes of individuals who are blind or individuals who have severe disabilities. Small business enterprise provides substantial gainful employment or self-employment commensurate with the time devoted by the operators to the business, the cost of establishing the business and other factors of an economic nature.

"Stabilization" means the period of time when job coach support is reduced to the long-term maintenance level while the individual retains employment, and personal satisfaction with the job, as well as employer satisfaction with the person's job performance. Stabilization must include appropriate individualized supports, including a minimum of two employee contacts and one employer contact per month.

"Substantial impediment to employment" means that a physical or mental disability (in the light of related medical, psychological, vocational, educational, cultural, social or environmental factors) that impedes an individual's occupational performance, by preventing his/her obtaining, retaining, or preparing for a gainful occupation consistent with his/her capacities and abilities.

"Supported employment" (SE) means competitive work in integrated work settings, or employment in integrated work settings in which individuals are working toward competitive work, consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals, for individuals with the most severe disabilities who meet the eligibility criteria for supported employment. This term includes transitional employment for persons who are individuals with the most severe disabilities due to mental illness (see the definition for "transitional employment").

"Transitional employment" (TE) means, when referring to the Supported Employment Program, a series of temporary job placements in competitive work in integrated settings with ongoing support services for individuals with the most severe disabilities due to mental illness.

"Transportation" is a service provided to assist with the costs of travel, including instruction in the use of public transportation vehicles and systems, which result from and are needed to support the individual's participation in diagnostic, evaluative, or other substantial and necessary VR services.

"Unpaid family worker" means a person who works without pay on a family farm or in a family business, operated by a family member who is related by blood or marriage.

"VR" means the Division of Vocational Rehabilitation, or the more general term vocational rehabilitation services, depending upon the context.

"VS" means the Division of Visual Services, or the more general term visual services, depending upon the context.

SUBCHAPTER 7. VOCATIONAL REHABILITATION AND VISUAL SERVICES

PART 1. SCOPE OF VOCATIONAL REHABILITATION AND VISUAL SERVICES

612:10-7-4. Basic eligibility requirements for vocational rehabilitation services

(a) An individual is eligible for vocational rehabilitation services under the Rehabilitation Act through the State Department of Rehabilitation Services if the individual:

- (1) has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment;
- (2) can benefit in terms of an employment outcome from vocational rehabilitation services; and
- (3) requires vocational rehabilitation services to prepare for, enter, engage in, or retain gainful employment.

(b) An individual who has a disability or is blind as determined pursuant to Titles II (federal old age, survivors, and disability insurance benefits) or XVI (SSI) shall be:

- (1) considered to have a significant disability under the order of selection; and
- (2) presumed to be eligible for vocational rehabilitation services, (provided that the individual intends to achieve an employment outcome consistent with the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual) unless clear and convincing evidence demonstrates that the individual is incapable of benefiting in terms of an employment outcome from vocational rehabilitation services due to the severity of the individual's disability.

(c) Determinations by other agencies, particularly education agencies, regarding whether an individual has an impairment or is an individual with a severe disability are to be used to the extent appropriate, available and consistent with the Rehabilitation Act.

(d) Every person must be evaluated individually regarding history, prognosis and functional limitations to determine if the individual can benefit from rehabilitation services in terms of an employment outcome.

(e) Some conditions have unique criteria that must be considered when determining eligibility.

- (1) **Alcoholism/Drugs.** Eligibility documentation for vocational rehabilitation services requires ~~both medical and psychological and/or medical records. Clients who are accepted on the basis of alcoholism and/or drug dependency, whether a primary or secondary disability, must be enrolled in a treatment or maintenance program and be willing to undergo random alcohol/drug screening. DRS does not pay for detoxification or replacement drug treatment. DRS will not provide services to individuals who abuse drugs and/or alcohol. The client must provide the agency with supportive documents.~~ Individuals may be eligible for vocational rehabilitation services based on a substance abuse diagnosis that may be made by a psychiatrist, psychologist, medical doctor or certified substance abuse counselor. Eligibility requirements shall be applied without regard to the particular service needs or anticipated cost of services required by an applicant or applicant's family. Documentation from qualified Drug

and Alcohol treatment professionals indicating that the client is presently substance-free, maintaining sobriety, and actively participating in a treatment or maintenance program; if recommended by the treating professional must be filed in the case record upon IPE development and ready to engage in vocational rehabilitation services. ~~Those individuals who are alcohol/drug free for two or more years will not be eligible on a primary disability of alcoholism/drug dependency.~~

(2) **Allergies/Asthma.** Only the most serious allergies/asthmatic condition requiring continuous medical intervention will be considered eligible for services.

(3) **Deafness and Hearing Loss.** The rehabilitation professional will base eligibility determination upon one of the measurement methods listed below. The case record must document the method chosen provides the most accurate evaluation of functional hearing level for the individual.

(A) **Eligibility criteria.** Eligibility criteria for each method of measurement are listed in (i) through (iv) of this Subsection. An individual will also be considered to have a qualifying disability when documentation indicates the hearing loss is progressive and the progression is substantial enough to result in an impediment to employment.

(i) **Average hearing loss.** Average hearing loss, which is determined by computing average of the pure tone thresholds for each ear at 1000Hz, 2000Hz, 3000Hz and 4000Hz. An individual is considered to have a qualifying disability based upon average hearing loss when:

- (I) The hearing loss in one ear is profound (91 dB or greater) and the hearing loss in the better ear is at least 15 dB; or
- (II) The hearing loss in the better ear is 30 dB or greater.

(ii) **Speech recognition threshold (SRT).** An individual is considered to have a qualifying disability when:

- (I) the speech reception threshold in one ear is 91 dB or greater and is at least 15 dB in the better ear; or
- (II) the speech reception threshold in the better ear is 30 dB or greater.

(iii) **Speech discrimination or word recognition score.** An individual is considered to have a qualifying disability when the speech discrimination or word recognition score is 70% or less.

(iv) **Articulation index.** An individual is considered to have a qualifying disability when the articulation index is 70% or less.

(B) **Severity of Hearing Loss.** All individuals who qualify as having a severe hearing loss will be referred to a Rehabilitation Counselor for the Deaf and Hard of Hearing (RCD). Relevant information provided will include copies of the initial interview narrative recording, medical information, eligibility

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data entry form, Individualized Plan for Employment, pertinent copies of case narratives and DRS application form. On receipt of a referral, the RCD will contact the client and make a determination of potential for Deaf and Hard of Hearing services. The referring counselor will be informed in writing of the RCD's findings.

(i) **Severe Hearing Loss.** Average hearing loss, as calculated above, is considered severe when:

(I) The hearing loss in one ear is profound (91 dB or greater) and the hearing loss in the better ear is at least 31 dB; or

(II) The hearing loss in each ear is 55 dB or greater.

(ii) **Severe Speech Recognition Threshold (SRT).** An individual is considered to have severe disability when;

(I) The SRT in one ear is 91 dB or greater and the SRT in the better ear is at least 31 dB; or

(II) The SRT in each ear is 55 dB or greater.

(iii) **Severe Speech Discrimination or word recognition score.** An individual is considered to have a severe disability when the speech discrimination or word recognition score is 59% or less.

(C) **Evaluation of need for visual examination.** Clients with a disability of deafness or hearing loss will be offered a visual exam annually unless adequate existing records are available.

(4) **Diabetes:** The individual must require prescribed medication to control the condition. Those persons whose diabetes is controlled by diet and exercise alone or whose condition does not result in a substantial impediment to employment will not be considered eligible. Eligible clients will be required to undergo a visual exam by a licensed ophthalmologist at least once a year. All insulin dependent diabetics are required to attend diabetic education training as part of their IPE. This can be provided by a consumer's personal physician, in coordination with the VR specialist. If diabetic education is provided, a separate intermediate objective addressing this service must be included on the IPE.

(5) **Facial and Disfigurement Conditions.** Treatment of any of these conditions may also be provided under intercurrent illness policy. Treatment may be provided when:

(A) it is necessary to correct or substantially modify a condition which is stable or slowly progressive;

(B) such correction or modification may reasonably be expected to eliminate or reduce the impediment to employment within a reasonable length of time.

(6) **Learning Disabilities.** Individuals must meet one of the following three criteria to be identified as learning disabled:

(A) Have a marked discrepancy between verbal and performance intellectual level;

(B) Be diagnosed or identified as having a specific learning disability from the local educational system; or

(C) When the individual's achievement on individually administered, standardized test in reading, mathematics or written expression is substantially below that expected for age, schooling and level of intelligence (DSM IV).

(7) **Mental Disorders:** Treatment must be incorporated as a service in the IPE for individuals with a diagnosis of mental disorder. Comparable benefits will be used when available.

(8) **Mental Retardation.** To be eligible, individuals having an I.Q. of 69 or below and substantially limited adaptive functioning, as measured by an individual intelligence test, will be considered to have a substantial disability. For individuals eligible under IDEA with an I.Q. level higher than 69 may be considered to have a substantial impairment provided the documentation used by the school in determining eligibility under IDEA, in the counselor's judgment, confirms the individual is functioning in the mentally retarded range of ability. Individuals not enrolled in public school special education classes with an I.Q. higher than 69 may be considered to have a substantial impairment provided appropriate documentation confirms the individual is functioning in the mentally retarded range of ability.

(9) **Height.** To be eligible, a person's stature must constitute or result in a substantial impediment to employment.

(10) **Obesity.** To be eligible, a person must be 100% over normal weight using the designated weight chart and unable to participate in activities of daily living. Any radical surgery i.e., bypass or stapling of the stomach, treatment plans are beyond the scope of VR services. Any vocational plan for a person who is obese must include some type of treatment plan. A licensed dietician or a physician skilled in weight reduction must monitor any treatment program authorized by the agency.

(11) **Visual.** The individual must be found to have at least a 25% loss of total visual efficiency with best correction, or there must be evidence the condition is progressive and will soon reach the visual loss described above. Any one or all of the following factors may be used to determine whether a 25% loss of total efficiency exists.

(A) **Central visual acuity (Snellen method or equivalent).** Acuity of 20/60 or less in the better eye after best correction (in the case of difference of acuity between reading and distance use the greater loss).

(B) **Loss of depth perception or stereopsis.**

(i) **Eligibility on the basis of depth perception loss.** When defining eligibility based on depth perception alone, it is generally accepted a total loss of depth perception would not constitute a 25% loss of visual efficiency. Other factors to consider include: Is the client's loss of depth perception acute? Did the client recently lose his or

her depth perception? Did the client's past vocational experience require good depth perception? If the client is currently working, does his/her present vocation require good depth perception? After considering these factors the counselor will determine if there are functional limitations to the extent the individual would be prevented from obtaining, retaining or preparing for employment.

(ii) **Eligibility based on loss of stereopsis.** Stereopsis is defined as the blending into one-picture two images of an object seen from slightly different points of view so as to produce the impression of relief and solidity. This type of loss usually results from suppression of vision in one eye due to alternating exotropia, esotropia, hyperopia or a difference in the refractive power of the two eyes so great that separate images cannot be fused. When determining eligibility based on lack of stereopsis the counselor will take into account most of the factors used in determining eligibility based on loss of depth perception. One major difference is stereopsis cannot be learned. In other words, if an individual does not have binocular vision, it is impossible for the individual to have stereopsis. From a functional standpoint, stereopsis is considerably different from depth perception. The individual can still do many jobs with various degrees of depth perception yet these same jobs may have certain steps that require acute stereopsis. Thus an employee losing the stereopsis part of his visual function would be at risk for injuring himself or other workers or might be considered as a target for termination.

(iii) **Limited peripheral vision.** This is restriction of visual fields by 25% or more as documented by a formal visual field examination. The examination should report the qualitative percentage of visual field loss and/or remaining percentage of visual efficiency.

(iv) **Diplopia (Double Vision).** There are different degrees of double vision. The type of double vision most disabling is the type that manifests itself in the primary direction of gaze.

(v) **Aphakia.** In cases of binocular Aphakia the central visual efficiency of the better eye will be accepted at 75% of its value (25% loss of visual efficiency) and in monocular Aphakia the central visual efficiency will be accepted at 50% of its value (50% loss of visual efficiency). Individuals with intraocular lens implants are not considered to have a visual disability as a result of an aphakic condition.

(vi) **Color deficiency.** When total absence of color discrimination or red-green deficiency exists it will be considered a disability. Supervisory approval is necessary for establishing an impediment to employment when the disabling condition is a red-green deficiency.

(12) **Hearing evaluation.** Individuals who have been identified as "legally blind" will be carefully evaluated regarding the need for a hearing evaluation. When a hearing deficit is indicated by a medical examination report, statement of the client and/or family, or observation of one of the professional staff members working with the individual, it is noted in the case record. The counselor will make arrangements for a hearing examination unless existing records are adequate and appropriate for this assessment.

(13) **Re-evaluation.** Individuals with chronic disabilities that can be removed with little or no residual limitations will not be eligible for purchase of services other than those related to the required treatment.

PART 5. CASE STATUS AND CLASSIFICATION SYSTEM

612:10-7-50. Eligibility - accepted for services and IPE under development

(a) **Use of Eligibility Status.** An active case is defined as one which has been accepted as meeting the basic eligibility requirements. An individual who is placed in an order of selection priority group that is not currently being served will be placed on a waiting list and held there pending further directives from the Director concerning opening or closing of priority groups. Once an individual is determined eligible, the comprehensive assessment is completed to provide a basis for the formulation of the client's IPE. The comprehensive assessment is used to determine the client's employment goal, and the scope and nature of services to be provided to accomplish the employment goal of the client. The counselor records activities during this period by individual entry or by summary recording at regular intervals in case narratives. Copies of pertinent case information will be shared with all DVR or DVS professionals involved in the case. Pertinent case information will also be shared with contracted vendors, when appropriate, with a release signed by the client. During the provision of services, the counselor and teacher will share pertinent information including narrative recording. If an IPE cannot be developed during this period, the client's case is closed with a full explanation to the client and documentation as to the reason for closing the case. This documentation will be completed on a closure letter and a copy given to the client. The counselor may not find an individual ineligible for supported employment services because a resource for providing extended services cannot be identified. In this instance, the counselor will:

- (1) accept the individual as eligible for VR services;
- (2) plan VR services as appropriate, including the expected availability of extended services; and
- (3) seek out and/or help in developing the needed extended services resource.

(b) **Case recording requirements.**

- (1) **Notification of eligibility.** The VR counselor will discuss eligibility with the individual, and provide a written notification of eligibility and priority group placement to the individual.

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(2) **Comprehensive assessment.** A comprehensive assessment will be done in every case. It is conducted once the individual has been accepted as eligible for VR services. Additional assessments may be obtained for the comprehensive assessment to the extent information additional to that already obtained is necessary to determine the vocational rehabilitation needs of the individual and to develop the IPE. Existing information, and information supplied by the individual, or the individual's authorized representative, is to be used for the comprehensive assessment to the maximum extent possible. Rehabilitation technology will be used in the comprehensive assessment when necessary to assess and/or develop the capacities of the individual to perform in a work environment. The results of the comprehensive assessment and the VR Counselor's analysis of them will be recorded in a case narrative titled "Comprehensive Assessment". This case narrative will contain reasonable justification of the employment goal and services that will be provided in the IPE, considering the unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual. For individuals who find selection of a vocational objective difficult because of unsuccessful or limited exposure to work, the counselor may refer the client to a Community Rehabilitation Provider (CRP) or an Independent Living (IL) provider for additional assessments to establish a vocational goal. Employment and Retention (ER) contracts offer standardized, commercial assessments, work skills assessments, as well as short-term situational assessments in community settings. Employment and Retention contractors also provide job readiness services through work experience programs or Job Clubs, as well as benefits analysis to assure the individual understands the effect of work on public benefits.

(3) **The comprehensive assessment for supported employment.** In supported employment cases, the record must document, in a case narrative titled "Comprehensive Assessment", the counselor's determination that the client is an individual:

- (A) for whom competitive employment has not traditionally occurred; or
- (B) for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and
- (C) who, because of the nature and severity of the disability, needs intensive supported employment services, and extended services after the transition from intensive supported employment services, in order to perform such work.

(4) **Referral.** The counselor refers the client to a supported employment provider to gather the information necessary to complete the comprehensive assessment, and authorizes the "Assessment and Career Planning" milestone. The provider will conduct situational assessments in community settings based on client choice and negotiations with the counselor, and in accordance with their contract requirements. Results of the assessments will

assist the client and counselor in establishing a vocational goal.

(c) **Development of the Individualized Plan for Employment.** The VR counselor will provide the eligible individual, or the individual's authorized representative, in writing and in appropriate mode of communication, with information on the individual's options for developing the IPE.

(1) The required information will include the following:

(A) information on the availability of assistance, to the extent determined to be appropriate by the eligible individual, or authorized representative, from a qualified VR counselor in developing all or part of the IPE, and the availability of technical assistance for this purpose;

(B) a description of the required content of the IPE;

(C) as appropriate:

(i) an explanation of agency requirements for client participation in cost of services;

(ii) additional information requested by the individual or authorized representative;

(iii) information on the availability of assistance in completing DVR/DVS forms required in developing the IPE;

(iv) For cases involving ~~Alcoholism/Drugs~~, Mental Disorders and Obesity, treatment must be incorporated as a service in the IPE (See 612:10-7-4(e)(4), (7) and (10) respectively).

(D) a copy of a DRS publication addressing client's rights and responsibilities.

(2) For cases in an open priority group, the IPE must be completed and signed as soon as possible, consistent with the needs of the individual, but not more than 90 calendar days following the eligibility determination, unless the individual or the authorized representative and the VR or VS counselor jointly agree to an extension of time of a specific duration. The 90-day time frame for development of the IPE will be applied from the date a closed priority group is reopened.

(d) **Vocational objective.** The primary purpose in providing vocational rehabilitation services is to assist an eligible individual obtain appropriate competitive employment in an integrated setting consistent with the individual's informed choice. The choice of a vocational objective for an individual receiving vocational rehabilitation services must be based primarily upon the individual's strengths, resources, priorities, concerns, abilities, and capabilities.

(1) **Informed choice.** The vocational objective is to be chosen with the full participation of the client. The client's interests and informed choice determine his or her vocational goal to the extent these factors are consistent with the client's strengths, resources, priorities, concerns, abilities, and capabilities.

(2) **External conditions.** Factors such as the local labor market or local economy must also be taken into consideration. However, in most cases these factors cannot be used as the only basis upon which to determine whether a vocational objective is appropriate.

(3) **Currently employed individuals.** When post-employment is not appropriate, the individual's functioning in current employment must be judged against the basic eligibility criteria for vocational rehabilitation services. Services may be provided to an eligible individual who is employed when:

- (A) the employment is not consistent with the individual's strengths, resources, priorities, concerns, abilities, and capabilities; and
- (B) vocational rehabilitation services are required to assist the individual to obtain an employment outcome consistent with the individual's strengths, resources, priorities, concerns, abilities, and capabilities.

(e) **Non-competitive vocational objectives.** The primary mission of DVR and DVS is to help eligible individuals achieve competitive employment in an integrated work setting. Therefore, careful consideration and planning are required when services are to be provided to achieve a long term goal of non-competitive employment.

(1) **Homemaker.** A homemaker is defined as a person whose primary work is performance of duties related to the upkeep and maintenance of a home. This work takes place in the individual's own home, without remuneration.

(A) The IPE can have a vocational objective of homemaker only when services will directly and substantially improve the individual's ability to perform the primary homemaking work activities for their home.

(B) Self-care activities are not sufficient to meet the definition of gainful occupation. The individual must not be receiving any type of assistance in performing primary homemaking duties.

(C) A vocational objective of homemaker can be established for only one person within the same household.

(2) **Unpaid family worker.** A vocational objective of unpaid family worker is appropriate when services will enable the individual to perform work without pay on a family farm or in a family business operated by one or more members of the client's family. The record must document how the services will substantially improve the productivity of the client and his/her contribution to the family farm or business.

612:10-7-62. Post-Employment services

(a) **Use of Post-Employment services.** Post-employment services may be provided to assist rehabilitated clients to retain, regain, or advance in employment. Planning for and provision of post-employment services is one of the more important elements of the agency's service. The need for post-employment services will be assessed at initiation of the IPE. Ongoing assessment continues during case services, is documented as needed, and is reassessed just prior to case closure. Post-employment services may also be provided for needs that were not anticipated in the original IPE or prior to case closure. Counseling and guidance is the primary service around which all other post-employment services are

provided. Post employment services can be provided to individuals who receive Supported Employment Services if such services are needed to maintain the supported employment placement and those services are not available from an extended services provider. Some examples of post employment services are maintenance of assistive technology, job station redesign, and replacement of prosthetic and orthotic devices. Post employment services are not to be used in instances of underemployment when extensive retraining is needed. Cases reopened on a post-employment basis do not require re-establishment of eligibility. New diagnosis is needed only if there has been a change in the client's physical or mental condition. Any vocational rehabilitation service or combination of services necessary to assist the individual retain, regain, or advance in employment may be provided if the service(s) does not involve a complex or comprehensive effort ~~unrelated to the original IPE.~~ If comprehensive services are indicated, a new application is taken. Federal regulations forbid the setting of arbitrary time limits on the provision of post-employment services. If the client has been employed for a long period of time, the counselor must carefully review the client's situation before making the decision to provide post-employment services as opposed to opening a new case.

(b) **Other considerations.** Other considerations in determining a client's eligibility for post-employment services are:

(1) **Financial Status.** A new financial status determination must be made if services requiring consideration of client participation in the cost of services are to be provided.

(2) **Emergency conditions.** Treatment of an emergency condition will not be considered as a post-employment service.

(3) **Upgrading.** ~~Post-employment services are not provided to upgrade an individual's financial status.~~ Post-employment services are provided to help the individual advance in employment only when the nature of the individual's impediment to employment makes advancement the most appropriate post-employment outcome consistent with the individual's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice.

(c) **Transfer of cases.** Clients needing post-employment services who have moved to another area of the state will have their cases transferred. When a rehabilitant who has moved out of state requests post-employment services, the counselor will refer the individual to the rehabilitation program in the state where the individual resides. Upon receipt of a release signed by the client, copies of the requested information from the closed case record will be forwarded to the receiving state agency. If an individual who was a rehabilitant in another state requests post-employment services from our state, information must be requested from the state where services were previously provided. All requests must include a specific release of confidential information signed by the applicant. The case will be processed as a new referral, but will be served and documented as a post-employment case.

(d) **Criteria for terminating post-employment services.** Decisions to terminate post-employment services must be

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made on an individual basis in consultation with the client and will be recorded in the case. The counselor will need to work with the individual to achieve a satisfactory level of self sufficiency independent of post-employment support.

(e) **Case recording requirements.** Post-employment services is the same as any other service status. The same principles of client involvement are required in the IPE for Post-Employment Services as are required under any other IPE. Case recording will be made at significant times during the process, including assessment of progress, and the results achieved at the completion or termination of services.

PART 9. ACTIONS REQUIRING REVIEW AND APPROVAL

612:10-7-88. Actions requiring field coordinator's approval

Field coordinator approval is requested by written memorandum from the counselor, accompanied by a written recommendation from the supervisor. The field coordinator gives his or her approval in a written memorandum to the counselor, with a copy going to the supervisor. Verbal approval may be given when circumstances warrant, but must be followed immediately by written approval. The field coordinator must approve:

- (1) all IPE's which include DVR and DVS funding of training beyond the bachelor's degree level;
- (2) delegation or substitution for supervisory approval in case of supervisor's prolonged absence or similar circumstances.
- (3) dental services during active job search.
- (4) dental services requiring hospitalization.
- (5) self-employment funding over \$15,000.00.
- (6) vehicle or home modifications over \$2,500.00.
- (7) purchase of Cochlear implants.
- (8) Individual Plans for Employment that include vehicle repairs exceeding \$1,000.00 for the life of the case.

PART 13. SUPPORTIVE SERVICES

612:10-7-131. Transportation

Transportation, including adequate training in the use of public transportation vehicles and systems, may be provided for a client as a service to enable the client to receive diagnosis, evaluation or other rehabilitation services. Authorizations for transportation will not be issued to pay the cost, or part of the cost, for any other service.

- (1) **Public transportation.** The authorization is made directly to the vendor or client for actual cost.
- (2) **Private transportation.** ~~Mileage for use of a private vehicle is paid at 75% of the rate allowed by the State Travel Reimbursement Act and is authorized directly to the client. In these instances, mileage will be restricted to the most direct route and to the least possible number of trips. A payment of mileage is a service to enable the~~

~~client to receive diagnosis, evaluation or other rehabilitation services. Case narrative documentation is required explaining how the amount was determined. Transportation allowance will only be provided if there is a clearly defined need to enable the client to participate in vocational rehabilitation. The amount of transportation allowance for the use of a private vehicle will take into account the individual's unique circumstances and any available comparable services and benefits. To compute the amount paid for transportation allowance, multiply the mileage for one trip by the number of trips; then multiply that number by the state daily average cost of gas per gallon; then divide this figure by the average gas mileage of the vehicle in question. The transportation allowance will be directly authorized to the client. Case narrative documentation is required explaining how the amount was determined. A client who receives a transportation allowance must present a valid driver's license, a copy of which must be maintained in the case record. If the client is not a driver, he/she must provide a plan to the counselor that describes how he/she will utilize family members or others as drivers for transportation to participate in vocational rehabilitation services. The counselor will document this in the case record.~~

(3) **Vehicle Repairs.** Vehicle repairs will only be provided if there is a clearly defined need to enable the client to participate in vocational rehabilitation. Maintaining and repairing a private vehicle is primarily the responsibility of the owner. Assistance with vehicle repair is intended for emergency situations where services have been initiated under the IPE and participation in the IPE cannot continue without the repair. Generally, this will mean that the vehicle cannot be driven without the repair. The cost of vehicle repairs will not exceed \$1,000.00 for the life of the case unless approved by the appropriate Field Coordinator. All vehicle repairs will be directly authorized to the client including situations where the ownership of the vehicle is other than the client's. Clients requesting assistance with vehicle repairs must provide counselors with the driver's valid driver's license and current vehicle registration for the vehicle considered for repair. If the client is not a driver, he/she must provide a plan to the counselor that describes how he/she will utilize family members or others as drivers for transportation to participate in vocational rehabilitation services. Copies of these documents will be maintained in the case file. Prior to vehicle repair, clients will provide counselors with an estimate outlining the repairs and cost for counselor's approval. Upon completion of repairs, clients will provide counselors with a receipt verifying the completion of the repairs. Counselors will secure copies of the estimate and receipts for any repairs and these documents will be maintained in the case file.

(34) **Out-of-state/air transportation.** Transportation by airplane or out of state travel may be provided to allow a client to receive services not available in the state. Transportation may also be provided for a client to seek

employment out of state provided the counselor has written documentation that the significance of the disability, or the nature of the vocational objective, makes in-state placement unusually difficult. The case must also contain documentation of efforts made to place the client with an appropriate in-state employer. If air fare is to be provided, arrangements for such fares will be made through the State Travel Coordinator, Department of Rehabilitation Services State Office.

(45) **Transportation for an attendant.** Transportation may also include the cost of travel for an attendant of an individual with a significant disability. Subsistence will be paid at the rates established by the State and described in OAC 340:2-1. The counselor will have an agreement with the client regarding allowable expenses before the trip is made.

(56) **Training for use of public transportation.** Expertise available within DVR and DVS, or within the community will be used to provide this service when possible. If this service must be purchased, the authorization is made directly to the vendor or client for actual cost.

PART 15. TRAINING

612:10-7-152. Payment of tuition and fees at colleges and universities

(a) Tuition and fees for DVR and DVS clients attending colleges and universities will be paid at the rate set for resident students by the Oklahoma Regents for Higher Education and within limits prescribed by the Legislature. DVR and DVS will pay those fees charged to all students and special fees associated with required courses in the student's major field of study. The supervising counselor of a particular school will authorize payment for these services. However, the home counselor will authorize payment for these services using a direct client payment when the client will be attending schools which do not have an assigned supervising counselor. No authorization will be issued for tuition and fees until the client submits the applicable grade report, enrollment and award letter.

(b) Tuition and fees for students in attendance at accredited private or denominational schools will be paid at the same rate as that paid at state-supported colleges or universities of equal rank.

(c) Pell Grant and all other Federal/State aid (excluding merit awards) must be applied to tuition and fees as a first dollar source prior to the consideration of the expenditure of DRS funds regardless of whether the student is attending a public or private institution of higher education.

(ed) Any rehabilitation program which includes training beyond the bachelor's degree level must be approved by the field coordinator.

(de) No approval for authorization will be issued for the current semester's cost after the college or university's designated "Drop and Add" date. No authorization will be issued for previous semester's costs.

PART 21. PURCHASE OF EQUIPMENT, OCCUPATIONAL LICENSES AND CERTIFICATES

612:10-7-219. Purchase of motor vehicles

It is DRS policy not to purchase motor vehicles either for an individual or group of individuals. ~~When the need for these items is anticipated, the counselor will help the client budget available income to allow purchase of a vehicle.~~ DRS may assist with the cost attributable to the existing accessibility modifications on a new or used vehicle.

612:10-7-220. Purchase of special equipment for motor vehicles Vehicle modification services

(a) ~~Special equipment for a motor vehicle may be purchased and installed when needed for an individual to drive his/her own vehicle or enable a family member to provide transportation for the client for job retention services, training for employment or active participation in an Independent Living Program. Purchases of special equipment for motor vehicles which are projected to cost \$2,500 or less will be made in accordance with 612:10-1-7. Purchases of special equipment for motor vehicles projected to cost more than \$2,500 will require a requisition to the Department's Central/Departmental Services Unit, Purchasing Section.~~ Vehicle modification services may be provided as needed to enable a Vocational Rehabilitation client to prepare for, enter or retain employment. Vehicle modifications include the range of modifications and special equipment needed by a person with an impairment to drive or be a passenger in a vehicle.

(b) Vehicle modification services provided to an individual in the Vocational Rehabilitation program may include:

(1) purchase and installation of adaptations or devices in a vehicle;

(2) assistance with payment of the portion of the cost attributable to modifications pre-installed in a new or used vehicle purchased from a dealer;

(3) evaluation of an individual's ability to operate a motor vehicle;

(4) prescription of required devices specific to both the individual's needs and the vehicle; and

(5) training in the operation of the vehicle.

(c) Vehicle modifications which are projected to cost \$2,500 or less will be made in accordance with 612:10-1-7. Vehicle modifications projected to cost more than \$2,500 will require additional processing by DRS Central/Departmental Services after the process is completed by the counselor as outlined in Categories A through E below. The counselor is required to submit the requisition, the authorization, the bid documents if applicable and all supporting bid documentation if applicable for Purchasing to award the Purchase Order. Once the Purchase Order is received by the counselor, the vendor can be notified of the award. Categories A through D will be purchased in accordance with this section. Clients purchasing new vehicles shall apply for any mobility equipment rebate available from the vehicle manufacturer and the amount of any such rebate shall be assigned to DRS.

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(1) Category A: New Vehicle with structural modifications: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications.

(2) Category B: New Vehicle with structural modifications and accessibility modifications additions: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications and the accessibility modification additions.

(3) Category C: Used Vehicle with structural modifications: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications and the accessibility modification additions. DRS will participate in this method only if the client obtains warranty from the mobility aids vendor. A copy of the warranty agreement will be obtained by the counselor and maintained in the case file.

(4) Category D: Used Vehicle with structural modifications and accessibility modifications additions: In this process, the vehicle will be purchased by client choice and not obtained through a bid process. The client will be responsible for the purchase of the vehicle and DRS will be responsible for the costs attributable to the structural modifications and the accessibility modification additions. DRS will participate in this method only if the client obtains warranty from the mobility aids vendor. A copy of the warranty agreement will be obtained by the counselor and maintained in the case file.

(5) Category E: Any modifications to a new or used vehicle not purchased as part of the vehicle package will require additional processing by C/DS after the bid process is completed by the counselor in accordance with 612:10-1-7.

(bd) Some clients with significant disabilities will not have a valid driver's license. These clients are to be referred to the Department of Public Safety for determination of whether the client is able to obtain a license. Arrangements will be made by the counselor for the individual to take special driver's training following acquisition of the driving permit. If the client is to drive the vehicle, equipment will not be purchased until the client has a valid driver's license and the client has successfully completed training in the use of the special equipment for his/her vehicle.

(ee) The qualifications in (1) - (9) of this Subsection apply to all vehicle modifications.

(1) The client or individual providing the transportation must have a current, valid driver's license.

(2) A used vehicle must be inspected by an ASE_ or manufacturer certified mechanic to assure it is mechanically_ and structurally_ sound before equipment can be installed. This inspection may be authorized by the counselor, if necessary. If the AWSE or manufacturer certified

mechanic recommends it, a separate inspection related to structural soundness will be completed. This inspection may be authorized by the counselor.

(3) The name of the client must appear on the title to the vehicle and current vehicle registration. The client may be listed as a co-owner on these documents.

(4) The vehicle must be evaluated by an Assistive Technology Specialist or person with equivalent qualifications (Driver Rehabilitation Instructor, Occupational Therapist, Rehab Engineer, etc.) for identification of the appropriate adaptive equipment and assessment of the compatibility of the vehicle with recommended adaptive equipment. Existing modifications on a new or used vehicle shall be inspected for the appropriateness of the adaptive equipment for the consumer's need by the Assistive Technology Specialist or other qualified person. DRS also requires documentation that existing modifications on a used vehicle have been inspected by the mobility equipment dealer/vendor to determine efficiency, quality and fair market value of the modification or adaptive equipment. This documentation may be obtained directly from the mobility equipment dealer/vendor or from the lender when such documentation has been required for loan approval.

(5) Vehicle modifications provided by the agency must be limited to ~~the purchase and installation of those modifications~~ and adaptive devices which are required to meet the client's need.

(6) The client must agree to retain ownership of the vehicle and maintain the vehicle for the predictable life of the equipment. The counselor completes the Receipt for Equipment and Title Agreement and has the client sign it, as per guidelines in 612:10-1-7(e).

(7) The client must maintain both collision and comprehensive insurance on the vehicle, including the equipment.

(8) DRS will not pay the expense of replacing the equipment unless the equipment no longer meets the needs of the client based on disability related issues, as determined through review of current medical reports and assistive technology evaluation indicating replacement is required to meet the IPE goals.

(9) Certain types of vehicle modification equipment are considered "transferable" by design: i.e., hand controls, left foot accelerator, and hitch lift systems for wheelchairs/scooters. DRS may assist with the cost of transferring this type of equipment to meet the IPE goals. These modifications are categorized as non-structural modifications.

(df) When vehicle modifications are completed, installation is to be inspected by an Assistive Technology Specialist or person with equivalent qualifications, to determine if the authorized equipment conforms to prescribed standards, is properly installed, and meets the functional needs of the client. The A.T. Specialist will inform the counselor if the installation is satisfactory and ready for delivery to the client. The counselor must also obtain a statement of satisfaction from the client.

(eg) The client is responsible for maintaining special equipment for vehicles in good working order. DRS may pay for repairs to such equipment during the life of the case unless there is clear evidence the special equipment has been damaged due to client abuse or neglect as determined by the dealer, vendor or Assistive Technology Specialist.

PART 23. SELF-EMPLOYMENT PROGRAMS AND OTHER SERVICES

612:10-7-233. Special consideration in state government employment for persons with severe disabilities

(a) Oklahoma statute [74 O.S. 840-4.12] gives state agencies the option of waiving entrance examinations and modifying other hiring procedures for legal residents of Oklahoma who are certified as persons with severe disabilities under the definition established by the Office of Personnel Management (OPM) establishes provisions to promote the employment of persons with severe disabilities in state government. The law waives written entrance examinations and certain other hiring procedures administered by the Office of Personnel Management (OPM) for persons who are certified as having a severe disability based on standards and criteria established by the Administrator of OPM. Such applicants must be legal residents of Oklahoma and must meet minimum qualifications specified in applicable job specifications. Rules implementing the provisions of 74 O.S. 840-4.12 are found at OAC 530:10-9-100. OPM rules refer to these provisions as the Optional Program for Hiring Applicants with Disabilities.

(b) The definition of person with a severe disability established by OPM is a person who has a severe physical or mental disability which seriously limits one or more functional capacities in terms of an employment outcome. For purposes of the Optional Program for Hiring Applicants with Disabilities, the Department of Rehabilitation Services (DRS) shall certify that an applicant has a severe disability according to the definition of "individual with a severe disability" in OAC 612:10-1-2, which the OPM Administrator has established as the standard for disability certification. DRS shall provide electronic or written verification of an applicant's severe disability to the applicant and to the Office of Personnel Management.

(c) Certification of individuals as persons with severe disabilities under 74 O.S. 840-4.12 is the responsibility of DRS. Counselors will document the severity of the disability using existing DRS case information for current or former clients. Individuals who have not been DRS clients will provide the necessary information to the counselor with documentation necessary for determining that the individual has a severe physical or mental impairment which seriously limits one or more functional capacities. Medical examinations may not be purchased solely to certify eligibility under 74 O.S. 840-4.12.

[OAR Docket #09-876; filed 5-8-09]

**TITLE 730. DEPARTMENT OF TRANSPORTATION
CHAPTER 35. MAINTENANCE AND CONTROL OF STATE HIGHWAY SYSTEM**

[OAR Docket #09-850]

RULEMAKING ACTION:
PERMANENT final adoption

RULES:
Subchapter 5. Highway Advertising Control
730:35-5-3 [AMENDED]
730:35-5-4 [AMENDED]
730:35-5-6 [AMENDED]
730:35-5-8 [AMENDED]
730:35-5-12 [AMENDED]
730:35-5-13 [AMENDED]
730:35-5-16 [AMENDED]
730:35-5-17 [NEW]

AUTHORITY:
Transportation Commission; 69 O.S. Sections 1271 et seq.; 23 U.S.C. Sections 131 and 136; 23 CFR Parts 750 and 751

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Failure of the Legislature to disapprove the rules resulted in approval on April 28, 2009

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n/a

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n/a

ANALYSIS:
The proposed amendments to Subchapter 5 reflect changes in federal and state laws, clarification of the permit renewal process, deleting reference to the reconsideration process, a change in the name of the office that administrates this program and correction to several typographical errors.

CONTACT PERSON:
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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 1, 2009:

SUBCHAPTER 5. HIGHWAY ADVERTISING CONTROL

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730:35-5-3. Definitions

The following words or terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Abandoned sign" means a registered sign in need of substantial repair, or which is overgrown by trees or other vegetation not on the highway right-of-way or is otherwise no longer being utilized as an outdoor advertising device, for a period of one (1) year, shall be considered "abandoned" and any nonconforming or grandfather status granted by the Highway Advertising Control Act shall be terminated. Leasing information shall not be considered advertising content for purposes of this definition.

"Adjacent area" or **"~~controlled~~ control area"** within urban areas means the area which is adjacent to and within six hundred sixty (660) feet of the nearest edge of the right-of-way on any Interstate or the National Highway System. The six hundred sixty foot (660) distance shall be measured horizontally along a line perpendicular to, or ninety degrees (90°) to the centerline of the highway. Outside of urban areas, adjacent area or ~~controlled~~ control area means the area which is visible from the main traveled way on any interstate or the National Highway System and has the purpose of being read. All spacing considerations are determined by whether or not they exist within the adjacent or control area. Signs located outside the "control area" will not be registered.

"Advertisement" means any writing, printing, picture, painting, display, emblem, drawing, sign or similar device which is posted or displayed outdoors on real property and is intended to invite or to draw the attention or to solicit the patronage or support of the public to any goods, merchandise, real or personal property, business, services, entertainment or amusement manufactured, produced, bought, sold, conducted, furnished, or dealt in by any person; the term shall also include any part of an advertisement recognizable as such, whether a permanent or portable installation, but shall not include surface markers showing the location or route of underground utility facilities or pipelines or public telephone coin stations installed for emergency use; nor shall same include temporary election candidate campaign signs or voters' referendum signs, if erected not more than forty-five (45) days prior to an election and removed within seven (7) days following the election or within seven (7) days following the final election if more than one is required to settle the advertised candidate election or non-election, or referendum issue.

"Agreement" means the agreement between the Director of the Oklahoma Department of Transportation and the Secretary of the Transportation of the United States, regarding the enforcement of the Highway Beautification Act of 1965.

"Business area" means any part of an adjacent (control) area which is zoned for business, commercial or industrial activities under the authority of any law of this state, or not zoned, but which constitutes an unzoned commercial or industrial area as herein defined.

"Centerline of the highway" means a line equidistant from the edges of the median separating the main-traveled ways of a divided highway, or the centerline of the main-traveled way of a non-divided highway.

"Commercial or industrial area" means any part of a ~~controlled~~ control area which is within six hundred sixty (660) feet of the nearest edge of the right of way and is:

(A) Zoned for industrial or commercial activities under the authority of any state zoning law, or city or county zoning ordinance of this State. Any commercial or industrial area created or established by any zoning authority must actually be capable of supporting commercial or industrial activities. A zoning action which is not a part of a comprehensive zoning plan and is created primarily to allow outdoor advertising structures does not constitute valid zoning for outdoor advertising control purposes.

(B) Not zoned, but which constitutes an unzoned commercial or industrial area as herein defined.

"Commercial and industrial activities" means those activities, clearly visible and recognized as a commercial or industrial activity from the main traveled way, generally recognized as commercial or industrial by zoning authorities in the state.

"Comprehensive zoning" means a complete approach to land use within the jurisdiction of a zoning authority. For example, the mere placing of the label "zoned commercial or industrial" on land does not constitute comprehensive zoning, but rather, the establishment of a complete set of regulations to govern the land use within the entire jurisdiction of the zoning authority.

"Control of access" means the Department shall not issue a permit for any sign which cannot be erected or maintained from private property without violating control of access boundaries.

"Customary maintenance" means maintenance that shall only include, change of message, replacing electrical wiring and bulbs, painting of the face and structure, clearing vegetation (not on right-of-way), reinforcing the structure with banding or nails, and repairing the apron or catwalks. Additional maintenance activities may be approved upon written request to the Department. An increase in dimension, any change in location, increase in height, change in location in lighting, or the addition of lighting does not constitute customary maintenance. An increase, change, addition or any maintenance which is not listed above, shall terminate any nonconforming or grandfather status granted by the Act and the sign shall be considered illegal, thus a public nuisance subject to summary abatement and removal without compensation.

"Damage" means injury or harm as a result of wear and tear, storms, or other natural causes including, but not limited to, insect damage. If such damage occurs, the owner of the damaged sign shall notify the Department by letter within thirty (30) days of the occurrence, giving the ~~signs~~ sign's registration number, date damage occurred, whether or not the sign will be repaired, an itemized list of repairs, and a picture of the damaged structure. Failure to comply with any part of the above requirements before repairing a damaged sign shall result in forfeiture of any nonconforming or grandfather status granted by the 1972 Highway Advertising Control Act. After receiving authorization and repairs have been completed,

the owner shall send a picture of the repaired structure to the Department.

"Department" means the Oklahoma Department of Transportation.

"Destruction" ~~Destroyed~~ means that a sign shall be considered destroyed when damaged, from any cause except a criminal or tortious act, exceeds fifty percent (50%) of the sign structure.

"Directional signs" means signs giving directional information about goods and services of interest to the traveling public. Such signs shall be limited to those pertaining to rest stops, camping grounds, food services, fuel and automotive services, and lodging.

"Director" means the Director of the Department of Transportation or his designee.

"Discontinued or blank sign" means a registered sign not displaying products or service advertising contents for a period of one (1) year shall be considered discontinued and removed at the expense of the sign owner. Leasing information shall be considered advertising content for purposes of this definition.

"Divided highway" means that part of a primary highway which has been constructed as divided, dual lane fully controlled access to the throughways except for the established interchanges.

"Federal-aid primary highway" means any highway at any time officially designated as part of the Federal-aid Primary System by the Department and approved by the appropriate authority of the federal government.

"Grandfathered sign" means a sign which was lawfully erected but does not comply with all the provisions of the State law or State regulations passed at a later date or later fails to comply with State law or State regulations due to changed conditions. Illegally erected or maintained signs are not non-conforming signs. (Same as Non-conforming (grandfathered) sign.)

"Illegal sign" means signs that are situated in ~~controlled~~ control areas adjacent to Interstate and Federal-aid Primary Systems which are outside zoned and unzoned commercial or industrial areas, are not listed on the 1972 inventory and do not qualify either as on-premise, directional or official signs and notices required or authorized by law. Signs erected within zoned and unzoned commercial and industrial areas without the benefit of a permit or which are erected or maintained not in accordance with permit requirements are also illegal.

~~Information~~ Informational signs mean signs containing directions or information about public persons or public places which are owned or operated by federal, state, or local governments or their agencies. It also refers to public or privately owned natural phenomenon, historic, cultural, educational, or religious sites, and areas of natural scenic beauty or naturally suited for outdoor recreation, when deemed to be of interest to the traveling public. Informational signs do not include political campaign signs or posters.

"Interstate highway" means any highway at any time officially designated a part of the National System of Interstate and Defense Highways by the Department and approved by the United States Department of Transportation.

"Lease" means an agreement, in writing, by which possession or use of land or interests therein is given by the owner to another person for a specified period of time.

"License" means the privilege granted by the Department to do business as an outdoor advertising company in the State of Oklahoma.

"Main traveled way" means the traveled portion of a highway on which through traffic is carried. In the case of a divided highway, the traveled way of each of the separated roadways for traffic in opposite directions is a main traveled way. It does not include such facilities as frontage roads, turning roadways, or parking areas.

"Maintain" means to hold or keep in a state of continuing existence.

"Non-conforming (grandfathered) sign" means a sign which was lawfully erected but does not comply with all the provisions of the State law or State regulations passed at a later date or later fails to comply with State law or State regulations due to changed conditions. Illegally erected or maintained signs are not non-conforming signs.

"Non-conforming (grandfathered) sign maintenance" means the sign must remain substantially the same as it existed on the effective date of State law. (Also see "Customary Maintenance" and "~~Destruction-Destroyed~~" above.)

"Official signs and notices" mean signs and notices erected and maintained by public officers or public agencies within their territorial or zoning jurisdiction and pursuant to and in accordance with direction or authorization contained in federal or state law for the purpose of carrying out an official duty or responsibility. These signs must not exceed thirty-two (32) total square feet in area.

"On-premise sign" mean signs consisting solely of the name of the establishment, or which identify the establishment's principal or accessory products, or the services which are offered on the business premises. Signs advertising the sale or lease of the property on which they are located, are considered on-premise signs. Signs located on narrow strips of land contiguous to the advertised activity when the purpose clearly is to circumvent the Oklahoma Highway Advertising Control Act shall not qualify as on-premise signs. (See 730:35-5-14)

"Outdoor advertising business" means any person, firm or corporation which builds, leases, sells, or rents advertising space upon an outdoor advertising sign, display or device to others for profit.

"Primary highway" means any highway at any time officially designated a part of the Federal-aid Primary System by the Department and approved by the United States Department of Transportation.

"Public utility signs" mean warning signs, informational signs, notices or markers which are customarily erected and maintained by publicly or privately owned utilities, as essential to their operations.

"Rest area" means an area or site established and maintained within or adjacent to the highway right-of-way by or under public supervision or control for the convenience of the traveling public.

"Scenic turnout" means an area or site established and maintained within or adjacent to the highway right-of-way by

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or under public supervision or control which provides a shelter off the main-traveled way for stopped vehicles for the purpose of viewing an area of scenic significance.

"Service club and religious notices" mean signs and notices relating to the existence or meetings of non-profit service clubs, including but not limited to, garden clubs, charitable associations or religious services. Service club or religious notice signs shall not exceed eight (8) square feet in area.

"Sign, outdoor advertising or outdoor advertising device" means any outdoor sign, display, device, notice, figure, painting, drawing, message, placard, poster, billboard or other thing which is designed, intended or used to advertise or inform, any part of the advertising or information contents of which is visible from any place on the main-traveled way of the Interstate or National Highway System. It includes permanent or portable installations, but shall not include surface markers showing the location or route of underground utility facilities or pipelines or public telephone coin stations installed for emergency use. It also shall not include temporary election candidate campaign signs or voters' referendum signs, if erected not more than 45 days prior to an election and removed within 7 days following the election or within 7 days following the final election if more than one election is required to fill the office or settle the referendum issue.

"Sign facing" means the total advertising surface of an outdoor advertising sign, display or device which is visible from the main-traveled way of the highway. For purposes of this definition, a single sign facing may consist of one or more sign panels facing in one direction.

"Sign panel" means a separate advertising area contained upon a sign facing, including any border or trim, but excluding ornamental base or apron supports; provided however, that such ornamental base or apron supports shall not contain an advertising message or messages.

"Sign standards by sign type" means Class "A" signs, Class "B" signs, Class "C" signs, Class D signs, "on premise" signs, exempt signs, prohibited signs and all their zoning, spacing, lighting and size requirements. (See 730:35-5-12, 730:35-5-13, 730:35-5-14, 730:35-5-15, and 730:35-5-16.)

"Sign structure support" includes all structures, poles, bracings, lateral supports and other material of every kind and nature used to support a face or surface on which outdoor advertising is placed, whether located on or attached to the surface of the earth or man-made structure.

"The Act" means the Highway Advertising Control Act contained in Title 69 O.S., Section 1271 et seq., and any amendments thereto.

"To erect", and variants of the verb "to erect", means to construct, build, raise, assemble, place, affix, attach, create, paint, draw, or in any other way bring into being or establish. These shall not include any of the foregoing activities when performed as incident to the change of advertising message or customary maintenance of the sign structure. Any relocation of the sign structure, however slight, from one site to another site shall be deemed to be within the meaning of the verb "to erect" and its variants.

"Truck weighing station" means an area or site established and maintained within or adjacent to the highway

right-of-way and upon which are located permanent truck weighing facilities operated by the Department, the Department of Public Safety, and/or the Oklahoma State Tax Commission.

"Unzoned commercial or industrial areas" means those areas which are not zoned by state or local law, regulation or ordinance, and on which there is located one or more permanent structures devoted to a commercial or industrial activity or on which a commercial or industrial activity is actually conducted, whether or not a permanent structure is located thereon. No area upon which a commercial or industrial activity is conducted shall be considered as an unzoned commercial or industrial area if the commercial or industrial activity is conducted as a method, scheme or ruse designed for the purpose of conducting the business of outdoor advertising.

"Urban area" means an urbanized area or, in the case of an urbanized area encompassing more than one state, that part of the urbanized area in each state, or an urban place as designated by the Bureau of the Census having a population of five thousand (5,000) or more and not within any urbanized area, within boundaries to be fixed by responsible state and local officials in cooperation with each other, subject to approval by the Secretary of Transportation. Such boundaries shall, as a minimum, encompass the entire urban place designated by the Bureau of the Census.

"Visible" means capable of being seen without visual aid by a person of normal visual acuity.

"Zoned commercial or industrial areas" means those area zoned for commercial or industrial activities under the authority of any state law, or city or county zoning ordinance of this state. Any commercial or industrial area created or established by any zoning authority must actually be capable of supporting commercial or industrial activities. Any state or local zoning action which is not a part of a comprehensive zoning plan, such as strip zoning, spot zoning, or variances created primarily to allow outdoor advertising structures, will not be recognized by the Department as zoning for outdoor advertising purposes.

730:35-5-4. Licensing outdoor advertising businesses

(a) No person, firm or corporation shall engage in, or continue in, the outdoor advertising business by the erection and/or maintenance of outdoor advertising signs, displays, or devices in the adjacent area or ~~controlled control~~ area on any Interstate or Primary highway in this State without first obtaining a license from the Department authorizing such person, firm, or corporation to conduct such business as an outdoor advertising company. The license fee shall be payable in advance, by certified check or money order only, in the amount of four hundred dollars (\$400.00). Each license shall expire on June 30 of each year and the license fee shall not be prorated for a part of a year. Applications for licenses shall be made upon forms provided by the Department and shall state the name and address of the applicant and such additional information as may be required by the Department for the purpose of administering the Act. The information contained in the application shall be verified under oath by the applicant, a partner of the firm or an authorized officer of the corporation.

(b) Applications for renewals of licenses shall be made to the Department, upon forms provided by the Department, on or prior to June 1st preceding the expiration date. Applications shall be accompanied by the annual renewal fee of two hundred dollars (\$200.00), payable by certified check or money order only. Renewal applications shall contain such information as may be required by the Department for the purpose of administering the Act and the information thus submitted shall be verified under oath of the applicant, a partner of the firm or an authorized officer of the corporation.

(c) Any person, firm, or corporation erecting only outdoor advertising signs, displays, and devices which advertise his own business, products, or profession, and which signs are located upon the property where such business is conducted, products sold, or profession practiced, shall not be considered as being in the outdoor advertising business and shall not be required to obtain a license or sign permit from the Department.

(d) A late fee consisting of fifty dollars (\$50.00) per month or any part thereof shall be charged by the Department for any late filing for a license or license renewal. (Date of receipt will be determined by postmark.) All such fees are to be payable in advance by certified check or money order only.

(e) Failure to obtain a license as required by this rule or failure to renew a license when required shall immediately cause all outdoor advertising signs owned by the party to be in violation of these regulations and therefore a public nuisance subject to removal as provided by law.

(f) Providing false information on the application or renewal shall be sufficient grounds to deny the license or license renewal.

730:35-5-6. Permits for outdoor advertising signs, displays, and devices

(a) All signs, except for signs considered exempt, (see 730:35-5-14) that are adjacent to or located within six hundred sixty (660) feet of the right-of-way, and visible from the mail traveled way of an Interstate or Federal-aid Primary highway in the state, are required to be registered and permitted by the Department.

(b) Application forms to register and permit sign locations are provided by the Department, prior to the construction or relocation of any sign. The application form is to be filled out in its entirety, notarized and submitted to the Department, along with the application fee (\$100.00), two (2) photographs of the proposed site location and a copy of the current lease agreement with landowner of the site location. Upon receipt of all required data, the Department will then process the application as expeditiously as possible. The applicant shall be notified of the Department's decision on the application and the reasons therefore, if denied, within sixty (60) days of receipt of the completed application. If approved, the sign location is assigned a registration number and issued a registration certificate (title), permit, and tag.

(c) Permits for new signs shall be renewed every two (2) years from the date of issuance thereof, and permit renewal invoice shall be accompanied by a twenty dollar (\$20.00) fee. ~~Applications for renewal of permits shall be made to the Department fourteen (14) days in advance of the expiration~~

~~date. Renewal applications shall contain such information as may be required by the Department for the purpose of administering the Act and the information thus submitted shall be verified under oath of the applicant, a member of the firm or an authorized officer of the corporation. The Department may require additional documentation to accompany any renewal(s) if deemed necessary.~~

(d) Failure to renew a permit when required shall cause the non-permitted outdoor advertising device to be in violation of these regulations and subject to removal according to law.

(e) The holder of a permit shall, during the term thereof, have the right to change the advertising copy, ornamentation, or trim on the outdoor advertising structure or device for which it was issued without payment of any additional fee.

(f) Educational, veterans, religious, charitable, governmental or civic organizations, not operated for profit, shall obtain a permit in accordance with the provisions of this Subchapter for each outdoor advertising sign, display, or device having more than eight (8) square feet in area maintained or erected; provided, however, that no permit renewal fee shall be charged.

(g) Submission of false information in an application or in support of an application shall be sufficient grounds to deny or cancel the permit, renewal, or transfer.

(h) Upon failure of the permit holder to make lease payments or other agreed upon compensation to the land owner, or when the lease for the use of the land is canceled for any other lawful reason, the Department shall, upon submission of a sworn affidavit and such other proper documentation as may be necessary, revoke the outdoor advertising permit. In the event that the lessee presents a sworn affidavit or other proper documentation that the lease remains valid, the Department shall accept no new applications, issue further permits or renew existing permits on the property until the lease expires or its validity is determined in a court of competent jurisdiction. Priority shall be to the existing permit holder.

(i) In the event that the ~~Registrations and Permits Outdoor Advertising Control~~ Branch determines that the permit should not be issued, renewed, or transferred, the applicant shall be so notified in writing. The letter shall state specifically the grounds upon which the requested action is to be denied.

~~(j) Within fifteen (15) days of the receipt of the notice from the Registrations and Permits Branch the applicant may request a new consideration of the application. The new consideration request should be in writing and addressed to the General Counsel's Office of the Department. If a new consideration is requested, the application shall be evaluated by an individual designated by the Secretary of Transportation or Department Director. The individual so designated to perform the new evaluation shall provide the applicant and the Registration and Permits Branch an opportunity to submit written arguments and evidence as well as to appear and make oral presentations. The individual designated shall make a written recommendation to the Director who may review the evidence and who shall issue the final decision of the Department.~~

(kj) If a sign structure has not been completed within one hundred eighty (180) days of the issuance of the permit, a permanent marker shall be erected to allow for placement of the registration tag.

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730:35-5-8. Data required for licensing, registration, and permit application and renewal application forms

(a) The Department shall require the following information and data from the applicant for the registration and permit for an outdoor advertising sign, display, or device. This information shall be written upon the application form supplied by the Department, or attached as collateral appendages thereto:

- (1) One or more prints of a photograph of the staked or marked location, outdoor advertising sign, display, or device, taken contemporaneously with the date of the application, the print size to be as specified by the Department.
- (2) Name and address of the applicant.
- (3) Sign location data, including highway identification, county, municipality if pertinent, identification of nearest intersecting numbered state highway and, if specifically requested to resolve a location dispute, a plotted land survey giving the distance from that highway intersection, and the legal description of the real property tract upon which the sign is located.
- (4) Name and address of the owner or owners of real property on which the sign is located.
- (5) Whether or not the sign was erected and is being maintained under a lease or other authorizing agreement with the owner or owners of the real property on which the sign is located.
- (6) Physical description of the sign as to size, sign panels, and sign facings arrangements, illumination, and contemporary sign advertising message.
- (7) Whether or not the area in which the sign is located is zoned and, if zoned, the zoning classification.
- (8) If the sign is not in a zoned area, whether or not it is within 600 feet of an identified business.

(b) In connection with the application for renewal of a permit for a sign, the Department may require a photograph of the subject outdoor advertising sign, display or device, taken contemporaneously with the date of the application for renewal, if a material change in the outdoor advertising sign, display, or device, other than in the advertising content, occurred or was brought about during the permit period preceding the renewal date.

(c) The Department shall require the applicant for registration, permit, or transfer of an outdoor advertising sign, display, or device, to furnish a copy of the current lease with the owner or owners of the real property on which the sign is located, authorizing the presence of the subject sign on the property.

(d) Any applicant for a license or for registration and permit for an outdoor advertising sign, display, or device, who is not a resident of this State must appoint and maintain an agent upon whom service or process may be had in any action to which the applicant may be a party. The agent shall reside in the State of Oklahoma and shall file with the Department a formal declaration as to his place of residence in the State of Oklahoma.

(e) The requirements to furnish information, data, proofs, and agent designations set forth in the foregoing 730:35-5-8, (a) through (d) shall not be deemed to restrict the information and data the Department may require, and the Department may

require such other information, data, and proofs as it may reasonably deem necessary for the administration of its authority to implement and enforce the provisions of the Act. The Department may require the applicant to furnish written authority or permission from the owner of the real property upon which the pertinent sign is located, authorizing the Department, its agents, contractors, servants, or employees, to enter upon the property for such purpose or purposes as are reasonably necessary to promote the effective control of outdoor advertising and to carry out the Department's duties and responsibilities under this subchapter.

730:35-5-12. Class "A" signs

(a) **Zoning Site requirements.** Class "A" permitted signs must be located in a commercial or industrial area as defined in 730:35-5-3.

(1) **Zoning Qualifications.**

(A) Property upon Signs which signs are to be erected within the control area must be zoned comprehensively for business, commercial or industrial activities under the authority of any state zoning law, or city or county zoning ordinance of this state, ~~or~~ but shall not include areas which reflect strip or spot zoning granted strictly for the purpose of outdoor advertising.

(B) To determine whether a zoning action, past or present, is an attempt to circumvent outdoor advertising law or regulations, the following factors shall be taken into consideration:

- (i) expressed reason for zoning
- (ii) zoning for the surrounding area
- (iii) actual land use
- (iv) existence of plans for commercial or industrial development
- (v) proper access to property
- (vi) availability of utilities (water, electricity, sewage) in the newly zoned area, and
- (vii) whether or not the property is being assessed in accordance with zoning.

(C) Failure to meet zoning qualifications based on the factors set forth in this subsection is grounds for permit denial. It is the responsibility of the applicant to provide support documentation if zoning is determined to be questionable. Questionable zoning would include areas which have no visible indications of development, are separated from the primary urban area under which authority they are zoned and areas which are being primarily used for agricultural, ranching or residential purposes.

(2) Not zoned, but which are located in an unzoned commercial or industrial area. (See definition.) Commercial or Industrial Activity Requirements. Property upon which signs are to be erected must be unzoned but the sign is to be located within six hundred (600) feet of a qualifying commercial or industrial activity. The considerations are as follows:

(A) Such an ~~area~~ activity shall be equipped with all customary utilities, facilities and open to the public

regularly or regularly used by the employees of the business as their principal work station or which due to the nature of the business is equipped, staffed, and accessible to the public as is customary. The activity must be clearly identified and recognized as a business from the main-traveled way. The majority of the business activity must be conducted on the premises during normal business hours. Permit applicant may be required to provide sufficient documentation to demonstrate the status of the activity as a qualifying commercial or industrial business.

(B) It includes the area along the highway extending outward six hundred (600) feet from and beyond the edge of the regularly used area of said activity in each direction and a corresponding zone directly across a primary highway which is not also a limited or controlled access highway. All measurements shall be made from the edge of the regularly used building, parking lots, storage or processing areas of the commercial or industrial activity, not from the property lines of the activity and shall be along or parallel to the edge of the pavement of the highway. Provided however, the unzoned area shall not include land on the opposite side of an interstate or dual-laned limited access primary highway from the commercial or industrial activity establishing the unzoned commercial or industrial area.

(C) None of the following, but not limited to the following, shall be considered commercial or industrial activities for the purpose of outdoor advertising:

- (i) outdoor advertising structures
- (ii) agricultural, forestry, ranching, grazing, farming, and related activities, including but not limited to wayside fresh produce stands
- (iii) transient or temporary businesses and activities
- (iv) activities more than six hundred sixty (660) feet from the nearest edge of the right-of-way
- (v) activities conducted in a building principally used as a residence
- (vi) local, county, state or federal governmental offices or entities
- (vii) recreational activities which are designed to present park-like or pastoral aesthetic features to the travelling public. (Including but not limited to golf course greens and fairways, hunting club acreages, or other such type activities.)

(b) **Spacing.**

(1) **Interstates and Controlled Access Primary Highways.**

(A) No two (2) registered sign structures which are visible from the highway at any one time shall be spaced less than ~~five hundred (500)~~ one thousand (1,000) feet apart on the same side of the highway.

(B) Outside incorporated municipalities, no structure shall be located within five hundred (500) feet of an interchange/ramp, intersection, intersection at grade, or rest area (measured along the interstate

or freeway from the sign to the nearest point of the beginning or ending of the pavement widening at the exit or entrance to the main-traveled way).

(2) **Primary Highway System (non-controlled access).**

(A) Inside the limits of an incorporated municipality, no two (2) registered sign structures shall be spaced less than one hundred (100) feet apart on the opposite side of the highway and three hundred (300) feet on the same side of the highway.

(B) Outside the limits of an incorporated municipality, no two (2) registered sign structures shall be spaced less than three hundred (300) feet apart.

(C) Such spacing applies unless the signs are separated by a building or other obstruction in such a manner that only one display is visible from the highway at any one time from either lane of traffic.

(3) **Explanatory notes.**

(A) Directional, official, and exempt signs as herein defined, shall not be counted nor shall measurements be made from them for the purpose of determining compliance with spacing requirements.

(B) The minimum distance between signs shall be measured along the nearest edge of the pavement between points directly opposite the signs along each side of the highway. Distances shall be measured utilizing the points of signs or staked locations nearest the highway.

(4) **Disqualifiers-Disqualifiers.**

(A) Signs shall not be located within five hundred (500) feet of any of the following which are adjacent to any interstate (on the same side of the highway) or federal-aid primary highway:

- (i) public park
- (ii) public forest
- (iii) playground
- (iv) cemetery

(B) Signs in unzoned commercial or industrial areas shall not be located within five hundred (500) feet of the following which are adjacent to any interstate (on the same side of the highway) or federal-aid primary highway:

- (i) church
- (ii) school
- (iii) historical battlefield
- (iv) rest area

(C) Signs in unzoned commercial or industrial areas shall not be located within three hundred (300) feet of any residence without a written consent.

(5) For the purpose of providing a method and opportunity to minimize the cost of acquiring legally erected outdoor advertising signs to be taken when the state purchases land under eminent domain, the Director of the Department shall have the option to approve the issuance of permits for outdoor advertising signs visible from interstate and freeway primary facilities which are to be erected less than one thousand (1,000) feet from another such sign. Permits issued pursuant to this option shall be only for

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the purpose of providing a relocation site for a sign being taken by the state, and in no case shall such permits allow an outdoor advertising sign to be erected less than the distance provided for in this title from another such sign. Provided, when the Department issues a permit pursuant to this subsection to accommodate the relocation of a structure:

(A) If the structure to be removed is visible from an interstate highway inside an incorporated area, the relocation site shall be inside the same incorporated area and shall be visible from an interstate highway.

(B) If the structure to be removed is visible from a freeway primary highway inside an incorporated area, the relocation site shall be inside the same incorporated area and shall be visible from a freeway primary highway or an interstate highway.

(C) If there are not suitable relocation sites meeting the provisions of subparagraph A of this paragraph and the structure to be removed is visible from an interstate highway inside an incorporated area, notwithstanding the provisions of subparagraph A of this paragraph, the Department may issue a permit for a relocation site outside of the incorporated area which shall be visible from an interstate highway, and

(D) If there are no suitable relocation sites meeting the provisions of subparagraph B of this paragraph and the structure to be removed is visible from a freeway primary highway inside an incorporated area, notwithstanding the provisions of subparagraph B of this paragraph, the Department may issue a permit for a relocation site outside of the incorporated area which shall be visible from a freeway primary highway or an interstate highway.

(E) Provided further, the square footage of display face on the relocated sign shall not exceed the square footage of display face of the taken sign. The Transportation Commission shall have the authority to promulgate rules necessary to implement the use of the permit option provided for in this subsection and to request the cooperation of municipalities where local permits are required.

(6) Notwithstanding any other provision of law, the Department shall, after determining the need to acquire property upon which outdoor advertising structures are located, have the authority to negotiate directly with the owner of the outdoor advertising structure the terms for maintaining such structures in their current position or for the relocation of such structures. Such negotiations may begin prior to the Department's initiation of formal condemnation proceedings and shall be completed within six (6) months or at the time of the court-appointed appraiser's report, whichever occurs first. The owner of the outdoor advertising structure shall initiate such negotiations by written request to the Department, provided such request shall include proof of sole ownership of the structure. Nothing in this section shall be construed to prevent the owner of the land from pursuing a claim of

interest in any lease existing between the landowner and the outdoor advertising structure owner, or to prevent the outdoor advertising structure owner from pursuing a claim for fair market value of the owner's interest if negotiations with the Department for a lease or structure relocation arrangement are not successful.

(c) **Lighting.** Signs may be illuminated, subject to the following restrictions:

(1) Signs which contain, include, have attached or are illuminated by any flashing, intermittent or moving light, or lights which involve moving parts are prohibited, except on-premise signs and those giving public service information, such as, but not limited to, time, date, temperature, weather, news, or similar information.

(2) Signs which are not effectively shielded as to prevent beams or rays of light from being directed at any portion of the traveled way of any interstate or primary highway and are of such intensity or brilliance as to cause glare or impair vision of the driver of any motor vehicle, or which otherwise interferes with any driver's operation of a motor vehicle, are prohibited.

(3) No sign shall be so illuminated that it interferes with the effectiveness of, or obscures any official traffic sign, device or signal, or imitates or may be confused with any such official traffic sign, device or signal.

(4) A non-conforming (grandfathered) sign cannot have lighting added after it has become non-conforming.

(5) Signs which include the steady illumination of sign faces, panels or stats that rotate to different messages in a fixed position, commonly known as tri-vision faces or multiple message signs are allowed; provided, the rotation of one (1) sign face to another is no more frequent than every eight (8) seconds and the actual rotation process is accomplished in four (4) seconds or less. Some LED type displays may be used under these guidelines, however moving or flashing lights are strictly prohibited. Change from one panel to another must be accomplished with static displays only. Scrolling or fading from one display to the next is not allowed.

(6) Approval to upgrade an existing Class A registered sign to allow Tri-Vision or LED technology to a registered sign not already designated with such use must be obtained from the Outdoor Advertising Control Branch prior to actual changes being made. Request for approval must be submitted in writing, listing the Registration Number, type of technology intended and a document confirming current land use consent.

(d) **Size.**

(1) The maximum area for any one sign shall be one thousand two hundred (1,200) square feet including border and trim, but not including the base or apron, supports and other structural members. If an advertising message appears on the base or apron, it must be included as part of maximum allowable area. The sign may not be more than twenty-five (25) feet in height or sixty (60) feet in length.

(2) The area shall be measured by the smallest square, rectangle, triangle, circle, or combination thereof which

will encompass the entire sign, including any cutouts or extensions.

(3) The maximum size limitations shall apply to each side (facing) of a sign structure. Two (2) signs not exceeding six hundred (600) square feet each may be erected in a facing, "side by side" or "double decked" (stacked.) "Back to back" and "V-type" signs will be permitted and shall be treated as one structure with one thousand two hundred (1,200) square feet permitted for each facing. "V-type" signs shall not exceed thirty (30) feet between faces at the widest point. "Tri-face" signs are prohibited.

730:35-5-13. Information Informational or class "C" signs

(a) An "informational" or Class "C" sign, is one that is owned by a public person, place or organization, which contains directions or information about public places, owned or operated by federal, state or local governments or their agencies, publicly or privately owned natural phenomena, historic, cultural, educational and religious sites (not including churches), and areas of natural scenic beauty or naturally suited for outdoor recreation, deemed to be in the interest of the traveling public. Commercial advertisement is prohibited on informational signs. There are no zoning requirements.

(b) **Size requirements.** Maximum area shall not exceed one hundred fifty (150) square feet. Sign height or width shall not exceed twenty (20) feet.

(c) **Spacing requirements.**

(1) Interstate and Limited Access Federal-aid Primary Highways (Divided) (Applies to same side of highway only) - An informational sign can not be erected within ~~five hundred (500)~~ one thousand (1,000) feet from another registered sign.

(2) Non-Interstate Federal Aid Primary Highway (Non-Divided)

(A) An informational sign can not be erected less than three hundred (300) feet from another registered sign outside the limits of any incorporated municipality.

(B) An informational sign ~~can not~~ cannot be erected less than one hundred (100) feet from another registered sign on the opposite side of the highway and three hundred (300) feet on the same side of the highway within the limits of an incorporated municipality.

(3) On all Interstates and Federal-aid Primary highways (applies only to same side of highway when adjacent to Interstates or Limited Access Federal-aid Primary highways), no informational sign shall be erected within five hundred (500) feet of the following:

- (A) park
- (B) playground
- (C) cemetery
- (D) forest preserve

(d) **Lighting requirements.**

(1) Signs shall not be erected which contain, include or are illuminated by any flashing, intermittent, revolving or moving light, except on-premise signs and those giving public service information such as but not limited to, time, date, temperature, weather or news. Steadily burning lights in configuration of letters or pictures are not prohibited.

(2) Signs shall not be erected or maintained which are not effectively shielded to prevent beams or rays of light from being directed at any portion of the traveled way of any interstate or federal-aid primary highway and are of such intensity or brilliance as to cause glare or to impair the vision of the driver of any motor vehicle.

(3) Signs shall not be erected or maintained which shall be so illuminated that they obscure any official traffic sign, device, or signal or may be confused with any such official traffic sign, device or signal.

(4) Signs which include the steady illumination of sign faces, panels or slats that rotate to different messages in a fixed position, commonly known as tri-vision faces or multiple message signs are allowed; provided the rotation of one (1) sign face to another is no more frequent than every eight (8) seconds and the actual rotation process is accomplished in four (4) seconds or less. Some LED type displays may be used under these guidelines, however moving or flashing lights are strictly prohibited. Change from one panel to another must be accomplished with static displays only. Scrolling or fading from one display to the next is not allowed.

730:35-5-16. Prohibited signs

(a) Signs shall not be erected or maintained which:

- (1) Imitate or resemble any official traffic sign, signal or device.
- (2) Are erected or maintained upon trees or painted or drawn upon rocks or other natural features.
- (3) Are not permanently affixed to real property or a sign structure (mobile signs).
- (4) Are "Tri-face" signs.

(b) Scenic Byway Prohibition. Off-premise advertisement is prohibited adjacent to routes of highway that are officially designated as state or federal scenic byways under the National Scenic Byways Act. This applies only to portions of scenic byways which coincide with the regulated routes.

730:35-5-17. Signs - directions to recreation areas

In counties that do not have county planning or zoning, signs located outside of incorporated municipalities which advertise or give directions to local outdoor recreation areas may be allowed adjacent to interstate highways if such signs are otherwise in compliance with this section, approval may be given by the Director of the Department.

[OAR Docket #09-850; filed 5-6-09]

TITLE 785. OKLAHOMA WATER RESOURCES BOARD CHAPTER 5. FEES

[OAR Docket #09-779]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions

785:5-1-6. Stream water permit application and administration fees
[AMENDED]

785:5-1-10. Groundwater application fees[AMENDED]

785:5-1-11. Well driller and pump installer licensing fees [AMENDED]

AUTHORITY:

Oklahoma Water Resources Board, 82 O.S., § 1085.2 and 82 O.S., §1085.4; House Joint Resolution 1105 of the Second Regular Session of the 51st Legislature.

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Failure of the Legislature to disapprove the rules resulted in approval on April 16, 2009.

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April 16, 2009

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SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The Oklahoma Water Resources Board ("OWRB") has amended three sections in OAC 785, Chapter 5 as follows:

OAC 785:5-1-6, Stream water permit application and administration fees, has been amended to be consistent with House Joint Resolution 1105 enacted in May 2008. The Oklahoma Water Resources Board promulgated fee revisions in 2008 to double the application fees for stream water permits, including a doubling of the maximum fee from \$2000 to \$4000, and to establish a fee of \$100 for filing annual water use reports. Those rules were approved by the Governor and Legislature in April, 2008. The Legislature then passed HJR 1105 which limited the fees Board could charge. The Legislature authorized charging $1\frac{1}{2}$ times the previous application fees, not the 2X that had been adopted by the Board, with a \$3000 maximum application fee. A \$50 limit was imposed for the stream water annual use report filing. The amendments of 785:5-1-6 adopted by the OWRB on February 10, 2009 revise the rule adopted in 2008 to bring it in line with the provisions of HJR 1105. The newly-adopted stream water permit application fees and stream water annual fees are as follows:

1 to 320 a.f.- currently \$250, now decreased to \$190

321 to 640 a.f.- currently \$400, now decreased to \$300

641 to 1500 a.f.- currently \$500, now decreased to \$375

For each 500 a.f. increment above 1500 a.f.- currently \$200, now decreased to \$150

Maximum fee amount - current \$4000 limit now decreased to \$3000

Annual administration fee - current \$100 per permit, now decreased to \$50 with a \$500 limit for any one water right holder.

OAC 785:5-1-10, Groundwater application fees, has also been amended. The one-time groundwater permit application fees have been reduced similar

to the amendments for stream water permits. The groundwater permit application fee amendments are as follows:

1 to 320 a.f.- currently \$250, now decreased to \$190

320 to 640 a.f.- currently \$400, now decreased to \$300

640 a.f. to 1500 a.f.- currently \$500, now decreased to \$375

For each 500 a.f. increment above 1500 a.f. - currently \$200, now decreased to \$150

Maximum fee amount - current \$4000 limit, now decreased to \$3000.

Finally, OAC 785:5-1-11, Well driller and pump installer licensing fees, has been amended. The fee for variances from requirements relating to monitoring wells and geotechnical borings has been amended as follows:

The fee to file a request for a variance or exception from any construction, completion, plugging or other requirement set forth for monitoring wells or geotechnical borings in Chapter 35 shall be increased from \$50.00 to \$150.00.

These amendments to 785:5-1-6 and 785:5-1-10 are needed in order to be in compliance with House Joint Resolution 1105 enacted in May 2008. The amendment to 785:5-1-11 is necessary in view of the additional staff time needed for the review of variances for monitoring wells and geotechnical borings.

CONTACT PERSON:

Dean A. Couch, General Counsel, 405-530-8800.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

785:5-1-6. Stream water permit application and administration fees

(a) A filing fee based on amount requested in the application must be submitted with each application for a permit to appropriate stream water as follows:

(1) 1 through 320 acre-feet - ~~\$250.00~~ \$190.00

(2) 321 through 640 acre-feet - ~~\$400.00~~ \$300.00

(3) 641 through 1,500 acre-feet - ~~\$500.00~~ \$375.00

(4) More than 1,500 acre-feet - ~~\$500.00~~ \$375.00, plus an additional ~~\$200.00~~ \$150.00 for each increment of 500 acre-feet above 1,500 acre-feet requested, provided that no person shall be charged a total amount in excess of Three Thousand Dollars (\$3,000.00) per application.

(5) If the applicant proposes to divert or use stream water from a scenic river or an area designated as an outstanding water resource by the State, the applicant must submit an additional fee of \$200.00 (see also Chapter 45 of this Title).

(b) Applications for provisional temporary permits to appropriate stream water except expedited applications require a fee of \$150.00.

(c) Expedited applications for provisional temporary permits to appropriate stream water require a fee of \$200.00.

(d) Annual water right administration fee for the submittal of water use reports shall be ~~\$100.00~~ \$50.00 for each permit or vested right, provided that the cumulative maximum water right administration fees imposed on any one permit or vested right holder shall not be more than \$500.00 per year.

(e) If the annual water use report is filed later than 30 days after the due date as set forth in the report form mailed to the water right holder, an additional amount of \$30.00 for each permit shall be due (see also 785:20-9-5).

785:5-1-10. Groundwater application fees

(a) A filing and application fee based on amount requested must be submitted with each application for a permit for the withdrawal of groundwater as follows:

- (1) 1 through 320 acre-feet - ~~\$ 250.00~~ \$190.00
- (2) 321 through 640 acre-feet - ~~\$ 400.00~~ \$300.00
- (3) 641 through 1,500 acre-feet - ~~\$ 500.00~~ \$375.00
- (4) More than 1,500 acre-feet - ~~\$ 500.00~~ \$375.00, plus an additional ~~\$200.00~~ \$150.00 for each increment of 500 acre-feet above 1,500 acre-feet requested, provided that no person shall be charged a total amount in excess of Three Thousand Dollars (\$3,000.00) per application.

(b) Applications for provisional temporary permits except expedited applications require a fee of \$150.00.

(c) Expedited applications for provisional temporary permits require a fee of \$200.00.

785:5-1-11. Well driller and pump installer licensing fees

(a) The filing application and license fee for issuance of individual, partnership, or corporation well driller licenses for one activity to be certified under 785:35-3-1 which shall include the operator certification for the individual license or, in the case of a partnership or corporation, one operator certification for such activity shall be \$300.00 for two years.

(b) The license application fee for each additional activity shall be \$40.00 for two years.

(c) The application fee for each additional operator certificate which includes certification to conduct one activity shall be \$60.00 for two years.

(d) The application fee for each additional activity under an operator certificate shall be \$30.00.

(e) The renewal fee for each license for one certified activity, which shall include the operator certification shall be \$200.00, if the application to renew is filed by May 31, and \$250.00 if the application to renew is filed after May 31; provided that a late fee of \$150.00 shall be due for the completed license renewal application if received by the Board after July 1 of the year to be renewed, but before the end of the applicable grace period.

(f) The license renewal fee for each additional activity shall be \$40.00 for a two (2) year period.

(g) The fee for each additional operator certification renewal which includes certification to conduct the authorized activities shall be \$40.00 for a two (2) year period.

(h) The fee for examination of any operator shall be \$50.00.

(i) The fee for transfer of individual licensee designation to partnership, corporation or other entity or certified operator from one firm or corporation to another shall be \$50.00.

(j) The license fee for a nonresident shall be the amount charged in the state of the nonresident but in no case less than \$500.00 for two years.

(k) The initial fee for the Indemnity Fund for one activity certified under 785:35-3-1 shall be \$200.00 for a two (2) year period.

(l) The initial fee for the Indemnity Fund for each additional activity certified under 785:35-3-1 shall be \$75.00 for a two (2) year period.

(m) The renewal fee for the Indemnity Fund for each activity certified under 785:35-3-1 shall be \$75.00 for a two (2) year period.

(n) The fee to file a request for a variance or exception from any well construction, completion, plugging or other requirement set forth for groundwater wells, fresh water observation wells, heat exchange wells or test holes ~~or geotechnical borings~~ in Chapter 35 in this Title shall be \$50.00.

(o) The fee to file a request for a variance or exception from any construction, completion, plugging or other requirement set forth for monitoring wells or geotechnical borings in Chapter 35 shall be \$150.00.

[OAR Docket #09-779; filed 4-27-09]

**TITLE 785. OKLAHOMA WATER RESOURCES BOARD
CHAPTER 35. WELL DRILLER AND PUMP INSTALLER LICENSING**

[OAR Docket #09-780]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1. General Provisions
785:35-1-4. Violations and Penalties [AMENDED]
785:35-1-5. Indemnity Fund [AMENDED]

AUTHORITY:

Oklahoma Water Resources Board; 82 O.S. §§ 1020.16 and 1085.2.

DATES:

Comment period:

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February 20, 2009

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March 12, 2009

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Failure of the Legislature to disapprove the rules resulted in approval on April 16, 2009.

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April 16, 2009

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June 11, 2009

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The Oklahoma Water Resources Board ("Board") has adopted amendments to various provisions of OAC 785:35 as follows:

Permanent Final Adoptions

OAC 785:35-1-4, Violations and penalties, has been amended to be consistent with statutory changes made as a result of House Bill 3135 enacted in 2008. HB 3135 increased the maximum potential administrative penalties per violation. The newly-adopted administrative penalties are as follows:

The maximum potential administrative penalties have been increased from \$500 per violation to \$5000 per violation.

OAC 785:35-1-5, Indemnity Fund, has been amended to be consistent with statutory changes made as a result of House Bill 3135 enacted in 2008. HB 3135 increased the amount of Well Drillers Indemnity Fund monies that could be used to plug abandoned wells. The amended Well Driller Indemnity Fund amounts are as follows:

The maximum amount of Well Driller Indemnity Fund monies that can be used to plug abandoned wells has been increased from a maximum of \$5000 to a maximum of \$15,000.

These amendments to 785:35-1-4 and 785:35-1-5 are necessary in order to be in compliance with House Bill 3135 enacted in 2008.

CONTACT PERSON:

Dean A. Couch, General Counsel, 405-530-8800.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 1. GENERAL PROVISIONS

785:35-1-4. Violations and penalties

(a) **Misdemeanor violations.** Any person who, after notice from the Board violates or refuses or neglects to comply with any provision of 82 O.S. 1991, §§1020.1 through 1020.22, as amended and the rules of this Chapter, or who commits waste shall be guilty of a misdemeanor, and upon conviction shall be fined not less than Twenty-Five Dollars (\$25.00) nor more than Two Hundred Fifty Dollars (\$250.00) for each offense. Any person who, after notice that he is in violation thereof continues to violate any provision of this act, and fails to comply therewith within a reasonable length of time, is guilty of a separate offense for each day the violation continues.

(b) **Administrative penalties.** *The Board may, after notice and hearing, impose on any person administrative penalties of up to ~~Five Hundred Dollars (\$500)~~ Five Thousand Dollars (\$5,000.00) and may revoke, suspend or deny renewal of the any license or operator certification for each violation of the Board's rules and regulations regarding license or certification requirements, the requirement to obtain a license or certification, or minimum construction or installation standards. Each day a violation continues shall constitute a separate violation. Such administrative penalties shall be deposited in the Well Drillers and Pump Installers Remedial Action Indemnity Fund except as otherwise provided in 785:35-1-5(c).* [82:1020.16(E)]

(1) Notice of violation and proposed assessment.

In addition to revoking, suspending or not renewing a license or operator certification, the Board may impose administrative penalties against drillers or operators who fail, refuse or neglect to comply with rules or orders of the Board. Such administrative penalties shall be imposed only after notice and opportunity for hearing on the proposed imposition of such penalties. The notice of

the proposed assessment of administrative penalties shall inform the respondent of the provisions of the Board rules or order at issue and the proposed amount of the penalty. A letter, petition, notice of violation, consent order or final order may constitute a notice of proposed assessment for purposes of initiating administrative penalty proceedings if it meets the requirements of this section.

(2) **Determining amount of penalty.** In setting the administrative penalty amount, the Board may consider the following:

(A) The nature, duration and number of previous instances of failure by respondent to comply with requirements of law, Board rules and orders;

(B) The efforts of the driller or operator to correct deficiencies or other instances of failure to comply with the requirements of law, Board rules and orders subject of the proposed penalty;

(C) The cost of carrying out actions required to meet the requirements of law and Board rules and orders;

(D) Any established penalty set forth in these rules;

(E) Other factors deemed appropriate by the Board.

(3) Procedures for penalty assessment.

(A) The notice of proposed assessment of administrative penalties shall specify a time, date and place for a hearing.

(B) Failure of respondent to appear at the hearing shall be deemed to constitute an agreement with the imposition of the penalty in the amount proposed as set forth in the notice, and proposed findings, conclusions and order shall not be prepared in that instance. The Board and respondent may also agree to an informal disposition of the matter. In either situation, the matter shall be presented to the Board for consideration of entering a final order assessing the administrative penalty.

(C) The administrative penalty is due and payable immediately upon issuance of the final order, unless otherwise provided therein.

(D) If the Board believes that violations are continuing after issuance of the administrative penalty order, it may seek the issuance of additional orders to assess penalties occurring in the period after issuance of the previous assessment orders.

(4) Established penalty for failure to submit reports.

Unless otherwise specifically determined by the Board, the penalties to be assessed for the failure to submit multipurpose completion reports within sixty (60) days after completion of the activity as required by Board rules shall be as follows, provided that to avoid such an assessment the Board may from time to time provide an amnesty period of a duration and under such conditions to be set forth in a written notice to be provided to all licensees:

(A) For the first time penalties are assessed against a licensee or operator for failure to submit such reports, \$50 for each report, provided that the licensee or operator shall submit an acceptable report with the

associated penalty within thirty (30) days after receipt of the notice; and

(B) For the second or additional times that penalties are assessed against a licensee or operator for failure to submit such reports, \$250 for each report, provided that the licensee or operator shall submit an acceptable report with the associated penalty within thirty (30) days after receipt of the notice.

785:35-1-5. Indemnity Fund

(a) **Purpose of the Indemnity Fund.** *Monies in the Indemnity Fund shall only be expended for remedial actions necessary without notice and hearing to protect groundwater from pollution or potential pollution from wells or boreholes that do not meet the minimum standards for construction or that have been abandoned. [82:1020.16(B)(2)] Expenditures from the indemnity fund...shall not exceed ~~Five Thousand Dollars (\$5,000.00)~~ Fifteen Thousand Dollars (\$15,000.00) for each well, borehole, or pump for which action is taken. [82:1020.16(B)(4)]* Monies from the Indemnity Fund shall be expended solely for the repair or plugging of improperly constructed wells. Unless otherwise determined by the Board, a finding that a well has been improperly constructed shall be based on the rules and statutes in place at the time the well was constructed.

(b) **Reimbursement.** The establishment of the Indemnity Fund in no way relieves the driller or pump installer from liability incurred or responsibility for wells or boreholes drilled or plugged or pumps installed which are not in compliance with the Board's rules and regulations. If the Board makes an expenditure from the Indemnity Fund to remedy a deficient condition, then any driller or pump installer responsible therefor shall, within a reasonable time specified in a written notification by the Board, reimburse the Indemnity Fund for the full amount of the expenditure. If the driller or pump installer does not make such reimbursement, then the Board shall not renew the license or certification of the driller or pump installer and may pursue other available remedies. *The Board shall seek reimbursement as recommended by the Well Drillers and Pump Installers Advisory Council for any remedial action taken or required by the Board.* Any monies received as reimbursement shall be deposited in the Well Drillers and Pump Installers Remedial Action Indemnity Fund except as otherwise provided in 785:35-1-5(c). [82:1020.16(B)(5)]

(c) **Well Drillers and Pump Installers Regulation Account.** When the Well Drillers and Pump Installers Remedial Action Indemnity Fund reaches Fifty Thousand Dollars (\$50,000.00), the annual fees received from well drillers and pump installers, *monies received as reimbursement, and administrative penalties recovered under 785:35-1-4(b) [82:1020.16(C)]* shall be deposited in a separate account in the *Water Resources Board Revolving Fund* designated as the Well Drillers and Pump Installers Regulation Account. *Monies in said account shall be used by the Board for inspections, licensing, enforcement, and education, reimbursing per diem and travel costs for members of the Well Drillers and Pump Installers Advisory Council pursuant to the State Travel Reimbursement Act, and as otherwise determined to be necessary*

to implement the provisions of this section [82:1020.16(C)], including but not limited to the payment for damage or destruction of property caused by activities related to inspections and enforcement by the Board.

[OAR Docket #09-780; filed 4-27-09]

**TITLE 785. OKLAHOMA WATER RESOURCES BOARD
CHAPTER 50. FINANCIAL ASSISTANCE**

[OAR Docket #09-781]

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

- Subchapter 7. Water and Sewer Program (Bond Proceed Loans and Emergency Grants) Requirements and Procedures
- 785:50-7-5. Emergency grant priority point system [AMENDED]
- 785:50-7-7. Disbursement of funds [AMENDED]
- Subchapter 9. Clean Water State Revolving Fund Regulations
- Part 1. General Provisions
- 785:50-9-9. Definitions [AMENDED]
- Part 3. General Program Requirements
- 785:50-9-38. Construction phase [AMENDED]
- Part 7. SRF Environmental Review Process
- 785:50-9-60. Requirement of environmental review [AMENDED]
- 785:50-9-61. Environmental information required by the Board [AMENDED]
- 785:50-9-62. Environmental review by the Board [AMENDED]
- Subchapter 13. Oklahoma Water Conservation Grant Program [NEW]
- 785:50-13-1. Purpose [NEW]
- 785:50-13-2. Definitions [NEW]
- 785:50-13-3. Eligible Entities [NEW]
- 785:50-13-4. Eligible Projects [NEW]
- 785:50-13-5. Pilot Project Criteria [NEW]
- 785:50-13-6. Process for consideration of proposals [NEW]
- 785:50-13-7. Requirements for operation of projects [NEW]
- 785:50-13-8. Funding availability [NEW]
- 785:50-13-9. Funding disbursement and limitations [NEW] and
- 785:50-13-10. General terms and conditions for grants [NEW]

AUTHORITY:

Oklahoma Water Resources Board; 82 O.S. §1085.2; 82 O.S. §§ 1085.31, et seq.; 62 O.S. § 2003.

DATES:

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SUPERSEDED EMERGENCY ACTIONS:

Superseded rules:

- Subchapter 13. Oklahoma Water Conservation Grant Program [NEW]
- 785:50-13-1. Purpose [NEW]

Permanent Final Adoptions

- 785:50-13-2. Definitions [NEW]
- 785:50-13-3. Eligible Entities [NEW]
- 785:50-13-4. Pilot Project Criteria [NEW]
- 785:50-13-5. Process for consideration of proposals [NEW]
- 785:50-13-6. Requirements for operation of projects [NEW]

Gubernatorial approval:

December 8, 2008

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09-778

INCORPORATIONS BY REFERENCE:

n/a

ANALYSIS:

The Oklahoma Water Resources Board ("OWRB") has adopted amendments to various provisions of Oklahoma Administrative Code 785:50 as follows:

Section 785:50-7-5 has been amended with respect to two different subjects. First, one set of amendments is to modify language to include water or sewer systems that are extended to serve areas where residents are without sewer service or without water service. These amendments are needed to extend the Category 3 emergency grant criteria to include existing systems or systems that may only treat either water or sewer. The other proposed amendment is to restore language to the priority points for school districts, which was inadvertently changed in a previous rulemaking. The intended effect of the amendments is to create a balanced priority system for applicants for emergency grants and to restore language to properly calculate priority points for school districts.

Section 785:50-7-7 has been amended to include language that would allow for applicants who have been approved for an emergency grant to be able to request an extension of time for circumstances outside their control that prevent them from completing the construction process. The intended effect of the amendments is to accommodate emergency grant applicants that have an unexpected delay with construction requirements to be able to request an extension in order to still receive the emergency grant funding.

Sections 785:50-9-9 and 785:50-9-38 have been amended to change terminology from "minority and women owned business enterprise" to "disadvantaged business enterprise". These amendments are needed because the U.S. Environmental Protection Agency ("EPA") has changed its terminology and guidelines on how to include disadvantaged business enterprises in the State Revolving Fund ("SRF") program. The intended effect of the amendments is to make the rules consistent with state and federal law and EPA requirements for the SRF program.

Sections 785:50-9-60, 785:50-9-61, and 785:50-9-62 have been amended to provide for greater flexibility in environmental requirements of loans for the Clean Water SRF projects. These amendments will correspond to changes made by the EPA. The intended effect of the amendments is to make the rules consistent with the environmental process and other loan terms allowed by state and federal law.

Sections 785:50-13-1 through 785:50-13-10 are a new subchapter and sections which have been adopted to implement a new provision of law enacted by House Bill 3135 that established the Oklahoma Water Conservation Grant Program Act to be codified in the Oklahoma Statutes as Section 1088.1 of Title 82. The intended effect of the new rules is to provide guidance and policy to implement the new law.

CONTACT PERSON:

Dean A. Couch, General Counsel, 405-530-8800.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JUNE 11, 2009:

SUBCHAPTER 7. WATER AND SEWER PROGRAM (BOND PROCEED LOANS AND EMERGENCY GRANTS) REQUIREMENTS AND PROCEDURES

785:50-7-5. Emergency grant priority point system

(a) Basis of priority system and formula.

(1) **General description.** The priority system consists of a mathematical equation rating the applicants and the proposed project in accordance with the requirements of the statutes by means of a formula awarding points for each criteria used in the evaluation. The maximum point total under the system is one hundred twenty (120). The Board may consider each month, and in order from the highest rating, those applications awarded point ratings of 60 or more priority points. If the Board determines that the applicant with the highest point rating cannot promptly proceed with the project due to delays, including but not limited to those caused by legal problems, engineering problems, feasibility problems or availability of other funding sources, the Board may pass over consideration of such application then proceed to consider in order the next highest rated application. Applications which are bypassed shall retain their ratings and thus remain eligible for further consideration. Applications preliminarily determined by Board staff to have point ratings of 59 or fewer shall be deemed denied; provided, such applications may be reevaluated if the applicant submits additional information showing changed circumstances within 120 days after the date of staff's determination, and such information improves the applicant's preliminary point rating.

(2) **Statutory criteria.** The basis of the priority formula has been developed from the enacting legislation. The two primary statutory criteria are:

(A) The emergency situation of the applicant.

(B) Whether or not the applicant can reasonably finance the project without assistance from the state.

(3) **Total priority points.** Total priority points will be calculated and awarded for individual projects. Therefore, eligible entities will be required to complete separate applications for each project for which grant funds are requested. Priority lists compiled and published by other Oklahoma State agencies and/or seniority dates of applications submitted shall be utilized to decide ties in point totals among applicants.

(b) Priority formula for eligible entities other than school districts.

(1) **Formula.** The following formula has been devised to rank grant applications: $P = E + WR + I + L + MHI + FP + AR + BP - AN$, Where:

(A) P = Priority ranking

(B) E = Emergency ranking

(C) WR = Water and sewer rate structure

(D) I = Indebtedness per customer

(E) L = Amount of local contribution toward project

(F) MHI = Median household income

(G) FP = Applicant's ability to finance project

(H) AR = Amount of grant requested

(I) BP = Benefit of project to other systems

(J) AN = Application number

(2) **Explanation.** Each of these criteria are explained below:

(A) **Emergency rankings (E).** Emergencies are ranked by severity with Category 1 being the most severe and Category 3 being the least severe. Points awarded range from a maximum of 50 points for Category 1 and a minimum of 30 points for Category 3. If an applicant requests funds to correct more than one emergency category need, only the amount of assistance needed to correct the most severe need will be considered in the calculation for the application ranking. The applicant will be informed that separate and additional applications must be filed for other needs and projects. An applicant who receives funding for a project under any of the listed emergencies may not reapply under the same emergency. The three (3) emergency ranking categories are as follows:

(i) **Category 1.** Total loss of a water supply or sewage system or loss of a major component of a system due to a natural or unforeseen disaster which could not have been prevented by the exercise of reasonable care by the applicant. Examples of such disasters may include but are not necessarily limited to: tornado; flood; fire; severe weather; landslide; sudden loss of a water supply system; sudden collapse of a major structural portion of a system; signs of imminent failure of a public water supply lake dam, spillway or outlet structure such as settlement or slumping of the crest, excessive seepage, slides, cracks or sloughs along the upstream and downstream slopes of the dam. Also included under this category is the construction of a new water system to serve areas where residents are supplied by domestic sources or domestic systems whose quantity does not supply the basic needs of the residents. In such cases where new or extended systems are proposed, the Board shall consider and determine whether an adequate population density is available to utilize the proposed system. Notwithstanding any other provisions of this Chapter, if the density is preliminarily determined by Board staff to be inadequate for the applicant to feasibly provide operation and maintenance of the new or extended system, then the application will not be recommended for approval until the proper density, which will make the extension feasible, is achieved. Category 1 emergencies receive 50 points.

(ii) **Category 2.** Water or sewer emergencies which could not have been prevented by the exercise of reasonable care by the applicant and which cause immediate danger or an imminent health hazard to the community or other nearby citizens. Such emergencies may include but are not necessarily limited to: users or systems whose water supply is deemed to be dangerous or unhealthy; systems whose supply source becomes contaminated by man-made pollution caused by a person other than the applicant; overflow of raw sewage into homes or streets due to structural failure in

the collection mains and/or structural, mechanical, or electrical failure at a lift station due to disasters which could not have been prevented by the exercise of reasonable care by the applicant, including but not limited to tornado, flooding, fire, or landslides; sewage treatment systems which discharge raw or inadequately treated sewage effluent whose quality and/or quantity causes an immediate and imminent health or safety danger to a public water supply due to a structural, mechanical or electrical failure of a process unit(s) caused by disasters which could not have been prevented by the exercise of reasonable care by the applicant, including but not limited to tornado, flooding, fire, or landslides. Also included under this category is the construction of a new water system to serve areas where residents are supplied by domestic sources or domestic systems whose quality is dangerous or unhealthy as a consequence of circumstances that could not have been prevented by the exercise of reasonable care by the applicant. In such cases where new or extended systems are proposed, the Board shall consider and determine whether an adequate population density is available to utilize the proposed system. Notwithstanding any other provision of this Chapter, if the density is preliminarily determined by Board staff to be inadequate for the applicant to feasibly provide operation and maintenance of the new or extended system, then the application will not be recommended for approval until the proper density, which will make the extension feasible, is achieved. Category 2 emergencies receive 40 points.

(iii) **Category 3.** Water system improvements needed to meet the average and/or maximum daily demands of a system's customers caused by a large increase in the number of customers. The increase could result from annexation or the sale of treated water to another entity(ies) based on an engineering study that indicates purchasing to be the most cost effective alternative. Also included under this category is the construction of a new or extended water or sewer system to serve areas where residents are without sewer system service or without water. In such cases where new or extended systems are proposed, the Board shall consider and determine whether an adequate population density is available to utilize the proposed system. Notwithstanding any other provision of this Chapter, if the density is preliminarily determined by Board staff to be inadequate for the applicant to feasibly provide operation and maintenance of the new or extended system, then the application will not be recommended for approval until the proper density, which will make the extension feasible, is achieved. Category 3 emergencies receive 30 points.

(B) **Water and Sewer rate structure (WR)**

Permanent Final Adoptions

(i) **For Systems Providing Water Service Only:**

- (I) If the cost per 5000 gallons is \$34 or greater, the applicant shall be given 10 points.
- (II) If the cost per 5000 gallons is \$31 to \$33.99, the applicant shall be given 9 points.
- (III) If the cost per 5000 gallons is \$29 to \$30.99, the applicant shall be given 8 points.
- (IV) If the cost per 5000 gallons is \$26 to \$28.99, the applicant shall be given 7 points.
- (V) If the cost per 5000 gallons is \$24 to \$25.99, the applicant shall be given 6 points.
- (VI) If the cost per 5000 gallons is \$21 to \$23.99, the applicant shall be given 5 points.
- (VII) If the cost per 5000 gallons is \$18 to \$20.99, the applicant shall be given 4 points.
- (VIII) If the cost per 500 gallons is \$16 to \$17.99, the applicant shall be given 3 points.
- (IX) If the cost per 5000 gallons is \$13 to \$15.99, the applicant shall be given 2 points.
- (X) If the cost per 5000 gallons is less than \$10 to \$12.99, the applicant shall be given 1 point.
- (XI) If the cost per 5000 gallons is less than \$10, the applicant shall be given 0 points.

(ii) **For Systems Providing Water and Sewer Services:**

- (I) If the cost per 5000 gallons is \$39 or greater, the applicant shall be given 10 points.
- (II) If the cost per 5000 gallons is \$38 to \$38.99, the applicant shall be given 9 points.
- (III) If the cost per 5000 gallons is \$35 to \$37.99, the applicant shall be given 8 points.
- (IV) If the cost per 5000 gallons \$31 to \$34.99, the applicant shall be given 7 points.
- (V) If the cost per 5000 gallons is \$29 to \$30.99, the applicant shall be given 6 points.
- (VI) If the cost per 5000 is \$27 to \$28.99, the applicant shall be given 5 points.
- (VII) If the cost per 5000 gallons is \$26 to \$26.99, the applicant shall be given 4 points.
- (VIII) If the cost per 5000 gallons is \$24 to \$25.99, the applicant shall be given 3 points.
- (IX) If the cost per 5000 gallons is \$21 to \$23.99, the applicant shall be given 2 points.
- (X) If the cost per 5000 gallons is \$17 to \$20.99, the applicant shall be given 1 point.
- (XI) If the cost per 5000 gallons is less than \$17, the applicant shall be given 0 points.

(iii) **For Systems Providing Sewer Service Only:**

- (I) If the cost per connection per month is \$23 or greater, the applicant shall be given 10 points.
- (II) If the cost of connection per month is \$21 to \$22.99, the applicant shall be given 9 points.

(III) If the cost of connection per month is \$19 to \$20.99, the applicant shall be given 8 points.

(IV) If the cost of connection per month is \$17 to \$18.99, the applicant shall be given 7 points.

(V) If the cost of connection per month is \$15 to \$16.99, the applicant shall be given 6 points.

(VI) If the cost of connection per month is \$13 to \$14.99, the applicant shall be given 5 points.

(VII) If the cost of connection per month is \$11 to \$12.99, the applicant shall be given 4 points.

(VIII) If the cost of connection per month is \$10 to \$10.99, the applicant shall be given 3 points.

(IX) If the cost of connection per month is \$8 to \$9.99, the applicant shall be given 2 points.

(X) If the cost of connection per month is \$7 to \$7.99, the applicant shall be given 1 point.

(XI) If the cost of connection per month is less than \$7, the applicant shall be given 0 points.

(iv) The Board will deduct 3 points from the total of the Water and Sewer Rate Structure ranking for any system which charges a flat water or sewer rate (unmetered) without regard to the amount of water or sewer used, and 2 points for a decreasing block rate which lowers the cost per 1000 gallons for customers using larger amounts of water. No points will be added or subtracted for systems using a fixed rate per 1,000 gallons above the minimum. Two points will be added for systems using an increasing block rate. Entities who dedicate sales tax for water and/or sewer improvements will be awarded 1 additional point. Under the category the maximum number of points is 13 and the minimum is -3 points.

(C) **Indebtedness per customer (D).** The indebtedness per customer ranking is calculated by taking the applicant's monthly requirements for debt service on debt incurred for water and/or sewer system purposes and dividing it by the number of customers served.

(i) If the indebtedness per customer is \$15.00 or greater, the applicant shall be given 10 points.

(ii) If the indebtedness per customer is \$13.00 to \$14.99, the applicant shall be given 9 points

(iii) If the indebtedness per customer is \$11.00 to \$12.99, the applicant shall be given 8 points.

(iv) If the indebtedness per customer is \$10.00 to \$10.99, the applicant shall be given 7 points.

(v) If the indebtedness per customer is \$9.00 to \$9.99, the applicant shall be given 6 points.

(vi) If the indebtedness per customer is \$8.00 to \$8.99, the applicant shall be given 5 points.

- (vii) If the indebtedness per customer is \$7.00 to \$7.99, the applicant shall be given 4 points.
 - (viii) If the indebtedness per customer is \$6.00 to \$6.99, the applicant shall be given 3 points.
 - (ix) If the indebtedness per customer is \$5.00 to \$5.99, the applicant shall be given 2 points.
 - (x) If the indebtedness per customer is \$4.00 to \$4.99, the applicant shall be given 1 point.
 - (xi) If the indebtedness per customer is less than \$4.00, the applicant shall be given 0 points.
- (D) **Local participation (L).**
- (i) The Board will not approve nor fund any grant application unless the applicant contributes at least fifteen percent (15%) of the total cost of the proposed project.
 - (ii) The local participation ranking is based on the percent of the total project cost which is locally funded through cash contributions, or incurrence of additional debt through a loan. Grant funds received through other agencies will not be counted as local funding. Points awarded for participation are as follows:
 - (I) If the percentage of the project cost locally funded is 90% or greater, the applicant shall be given 10 points.
 - (II) If the percentage of the project cost locally funded is at least 80% but less than 90%, the applicant shall be given 9 points.
 - (III) If the percentage of the project cost locally funded is at least 70% but less than 80%, the applicant shall be given 8 points.
 - (IV) If the percentage of the project cost locally funded is at least 60% but less than 70%, the applicant shall be given 7 points.
 - (V) If the percentage of the project cost locally funded is at least 50% but less than 60%, the applicant shall be given 6 points.
 - (VI) If the percentage of the project cost locally funded is at least 40% but less than 50%, the applicant shall be given 5 points.
 - (VII) If the percentage of the project cost locally funded is at least 30% but less than 40%, the applicant shall be given 4 points.
 - (VIII) If the percentage of the project cost locally funded is at least 25% but less than 30%, the applicant shall be given 3 points.
 - (IX) If the percentage of the project cost locally funded is at least 20% but less than 25%, the applicant shall be given 2 points.
 - (X) If the percentage of the project cost locally funded is at least 15% but less than 20%, the applicant shall be given 1 point.
 - (XI) If the percentage of the project cost locally funded is less than 15%, the application shall not be approved nor funded.
- (E) **Median household income (MHI).** The median household income is calculated according to the latest federal decennial census.
- (i) The county median figure for median household income will be used in cases where data for the applicant's service area is not available.
 - (ii) Points are awarded as follows:
 - (I) If the median household income is less than \$13,000, the applicant shall be given 10 points.
 - (II) If the median household income is \$13,000 to \$15,999, the applicant shall be given 9 points.
 - (III) If the median household income is \$16,000 to \$17,999, the applicant shall be given 8 points.
 - (IV) If the median household income is \$18,000 to \$20,999, the applicant shall be given 7 points.
 - (V) If the median household income is \$21,000 to \$23,999, the applicant shall be given 6 points.
 - (VI) If the median household income is \$24,000 to \$28,999, the applicant shall be given 5 points.
 - (VII) If the median household income is \$29,000 to \$30,999, the applicant shall be given 4 points.
 - (VIII) If the median household income is \$31,000 to \$33,999, the applicant shall be given 3 points.
 - (IX) If the median household income is \$34,000 to \$36,999, the applicant shall be given 2 points.
 - (X) If the median household income is \$37,000 to \$38,999, the applicant shall be given 1 point.
 - (XI) If the median household income is \$39,000 or greater, the applicant shall be given 0 points.
- (F) **Ability to finance project (FP)**
- (i) The maximum points possible under this criterion for the ability of the applicant to finance the project without assistance from the state is 12.
 - (ii) The FP ranking gives a standardized account of the amount the existing water/sewer rates would have to be raised in order for the applicant to finance the project through a loan. A standard interest rate and term of 10% for 25 years is assumed. The cost per customer per month is calculated using the following formula: FP equals the product of AR multiplied by (0.1102), divided by the product of (12) multiplied by (C), Where:
 - (I) FP = Estimate of the amount monthly water/sewer rates would have to be raised to finance the amount of grant request for the project.
 - (II) AR = Amount of grant request. For this calculation, the amount of available reserve not dedicated to the project will be deducted from the amount requested.

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- (III) (0.1102) = Annual rate factor for a 25 year loan at 10%
- (IV) (12) = Number of months per year.
- (V) (C) = Number of customers
- (iii) In cases where the applicant's current revenues exceed expenses by a large margin, the Board will appropriately adjust the (AR) figure to accurately represent the applicant's ability to finance the project.
- (iv) Points in the FP ranking are awarded as follows:
- (I) If the ability to finance the project is \$10.00 or greater, the applicant shall be given 12 points.
- (II) If the ability to finance the project is \$8.00 to \$9.99, the applicant shall be given 11 points.
- (III) If the ability to finance the project is \$6.00 to \$7.99, the applicant shall be given 10 points.
- (IV) If the ability to finance the project is \$5.00 to \$5.99, the applicant shall be given 9 points.
- (V) If the ability to finance the project is \$4.00 to \$4.99, the applicant shall be given 8 points.
- (VI) If the ability to finance the project is \$3.00 to \$3.99, the applicant shall be given 7 points.
- (VII) If the ability to finance the project is \$2.00 to \$2.99, the applicant shall be given 6 points.
- (VIII) If the ability to finance the project is \$1.75 to \$1.99, the applicant shall be given 5 points.
- (IX) If the ability to finance the project is \$1.50 to \$1.75, the applicant shall be given 4 points.
- (X) If the ability to finance the project is \$1.25 to \$1.49, the applicant shall be given 3 points.
- (XI) If the ability to finance the project is \$1.00 to \$1.24, the applicant shall be given 2 points.
- (XII) If the ability to finance the project is \$0.75 to \$0.99, the applicant shall be given 1 point.
- (XIII) If the ability to finance the project is less than \$0.75, the applicant shall be given 0 points.
- (G) **Amount of grant requested (AR).**
- (i) Points under this category for amount of grant requested are distributed as follows:
- (I) \$95,001 to \$100,000: -5
- (II) \$90,001 to \$95,000: -4
- (III) \$85,001 to \$90,000: -3
- (IV) \$80,001 to \$85,000: -2
- (V) \$75,001 to \$80,000: -1
- (VI) \$70,001 to \$75,000: 0
- (VII) \$65,001 to \$70,000: +1
- (VIII) \$60,001 to \$65,000: +2
- (IX) \$55,001 to \$60,000: +3
- (X) \$50,000 to \$55,000: +4
- (XI) \$45,001 to \$50,000: +5
- (XII) \$40,001 to \$45,000: +6
- (XIII) \$35,001 to \$40,000: +7
- (XIV) \$30,001 to \$35,000: +8
- (XV) \$25,001 to \$30,000: +9
- (XVI) \$25,000 or less: +10
- (ii) If a project exceeds \$75,000 and the amount of funds needed over and above the OWRB grant request are being secured through a loan from OWRB, then there will be no deduction of points under this category.
- (H) **Project benefit to other systems (BP).** If the applicant's project will benefit other adjacent systems as well as applicant's, or result in or lead to consolidation of systems, an additional five (5) priority points will be included in the total of priority points assigned to the application.
- (I) **Number of grants.** Since it is anticipated that entities who have received emergency grants might submit additional grant applications for approval, points will be deducted from such applications according to the following schedule; provided, points shall not be deducted from such any emergency grant which was funds 10 or more years prior to the date of Board action on the pending application and which has been subjected to a Board audit:
- (i) 1 prior grant = 5 reduction points
- (ii) 2 prior grants = 8 reduction points
- (iii) 3 prior grants = 10 reduction points
- (iv) 4 prior grants = 12 reduction points
- (v) 5 or more prior grants = 14 reduction points
- (c) **Priority formula for school districts.**
- (1) School districts, created under Article V of the 1971 School Code, 70 O.S. 1981, §5-101 et seq., are political subdivisions of the State, and therefore are eligible for financial assistance under the Board's program.
- (2) In evaluating and prioritizing grant applications from school districts similar criteria to those applied to municipalities, towns and rural water districts will be utilized.
- (3) In developing a priority formula for school district applicants, again, the two primary statutory criteria are:
- (A) The emergency situation of the school district.
- (B) Whether the school district can reasonably finance the emergency project without the Board's assistance.
- (4) The emergency aspect of each project is ranked with a maximum of 50 points being given to the most serious situations and a minimum of ~~40~~ 30 points to the least serious. The emergency categories and points given for each are the same as those listed in (b)(2) of this Section.

(5) The school district's financial situation is given an maximum of 66 points and is derived by analyzing the following:

- (A) Local tax levies
- (B) Bonded indebtedness
- (C) Local contribution
- (D) Median household income within the school district's geographical area
- (E) Applicant's ability to finance project
- (F) Amount of grant requested
- (G) Application number

(6) Priority lists compiled and published by other Oklahoma state agencies shall be utilized to assess the seriousness of the emergency.

(7) Using the previously mentioned analysis, the following formula has been devised to rank school districts' grant applications: $P = E + LT + BI + L + MHI + FP + AR - AN$, Where:

- (A) P = Priority ranking total points
- (B) E = Emergency ranking
- (C) LT = Local tax levies
- (D) BI - Bonded indebtedness
- (E) L = School's contribution toward the project
- (F) MHI = median household income of population within a school district
- (G) FP = Applicant's ability to finance project
- (H) AR = Amount of grant requested
- (I) AN = Application number

(8) The criteria E, MHI, FP, AR and AN are the same as that set forth in (b) of this section. LT, BI and L are explained as follows:

(A) **Local tax levies (LT).** Points awarded under this category for local tax levies are based on the total amount of miles levied, as follows:

- (i) 95 to 100,00 mills = 13 points
- (ii) 90 to 94.99 mills = 11 points
- (iii) 85 to 89.99 mills = 10 points
- (iv) 80 to 84.99 mills = 8 points
- (v) 70 to 79.99 mills = 6 points
- (vi) 60 to 69.99 mills = 4 points
- (vii) 55 to 59.99 mills = 2 points
- (viii) 50 to 54.99 mills = 1 point
- (ix) 45 to 49.99 mills = 0 points
- (x) 40 to 44.99 mills = -1 points
- (xi) Less than 40 mills = -2 points

(B) **Bonded indebtedness (BI).**

(i) Priority points for Bonded Indebtedness are as follows: Percentage of Indebtedness Points

- (I) 95% to 100% of debt limitation = 10 points
- (II) 90% to 94.99% of debt limitation = 8 points
- (III) 80% to 89.99% of debt limitation = 7 points
- (IV) 75% to 79.99% of debt limitation = 6 points
- (V) 70% to 74.99% of debt limitation = 5 points

- (VI) 65% to 69.99 of debt limitation = 4 points
- (VII) 60% to 64.99% of debt limitation = 3 points
- (VIII) 55% to 59.99% of debt limitation = 2 points
- (IX) 50% to 54.99% of debt limitation = 1 point
- (X) 45% to 49.99% of debt limitation = 0 points
- (XI) 40% to 44.99% of debt limitation = -1 point
- (XII) 30% to 39.99% of debt limitation = -2 points
- (XIII) Less than 30% of debt limitation = -3 points

(ii) A deduction of one (1) point from the indebtedness ranking total will be made for applicants with 75% of existing debts financed at rates of 5% or less, and one (1) point will be added if 75% of existing debts are financed at rates greater than 10%.

(C) **Local participation (L).**

(i) In order to achieve the maximum benefit from available grant funds, the Board will not approve nor fund any grant application unless the applicant contributes at least fifteen percent (15%) of the total cost of the proposed project.

(ii) The local participation ranking is based on the percent of the total project cost which is locally funded through cash contributions or incurrence of additional debt through a loan. Points awarded are as follows:

- (I) If the percentage of the project cost locally funded is 90% or greater, the applicant shall be given 10 points.
- (II) If the percentage of the project cost locally funded is at least 80% but less than 90%, the applicant shall be given 9 points.
- (III) If the percentage of the project cost locally funded at least 70% but less than 80%, the applicant shall be given 8 points.
- (IV) If the percentage of the project cost locally funded at least 60% but less than 70%, the applicant shall be given 7 points.
- (V) If the percentage of the project cost locally funded at least 50% but less than 60%, the applicant shall be given 6 points.
- (VI) If the percentage of the project cost locally funded is at least 50% but less than 60%, the applicant shall be given 5 points.
- (VII) If the percentage of the project cost locally funded is at least 40% but less than 40%, the applicant shall be given 4 points.
- (VIII) If the percentage of the project cost locally funded is at least 25% but less than 30%, the applicant shall be given 3 points.

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(IX) If the percentage of the project cost locally funded is at least 20% but less than 25%, the applicant shall be given 2 points.

(X) If the percentage of the project cost locally funded is at least 15% but less than 20%, the applicant shall be given 1 point.

(XI) If the percentage of the project cost locally funded is less than 15%, the application shall not be approved nor funded.

(iii) Under the Ability to Finance Project (FP) category the Number of Customers (C) as previously discussed will be replaced by the Number of Families within a school district. Points awarded under the FP category are the same as discussed and shown in (b) of this Section.

785:50-7-7. Disbursement of funds

(a) Conditions for disbursements.

(1) After an application for financial assistance under the program authorized by Sections 1085.31 through 1085.49 of Title 82 of the Oklahoma Statutes has been approved by the Board, the following conditions and requirements shall be met prior to the release and disbursement of any assistance funds:

(A) Unless otherwise provided and approved by the Board, applicant must submit to the Board all plans, specifications and engineering reports for the project for staff approval. All of which shall be complete and in sufficient detail as would be required for submission of the project to a contractor for bidding or contracting the project.

(B) Applicant and Board, and all other necessary parties, shall have executed all necessary and incidental instruments and documents for loan closing, including but not limited to all mortgages, notes, financing statements and pledges of project security and revenues where appropriate.

(C) If not previously provided, applicant shall provide Board with a written and verified statement setting forth (i) the amount of funds necessary for release and disbursement at closing which funds are needed for initial commencement of the project; (ii) and, information reflecting the reasonable availability of and/or a commitment from all other revenue or funding sources needed to finance and complete the project.

(2) At the time of and upon compliance with the requirements in (1) of this subsection, the Board may release, advance and disburse financial assistance funds to the applicant for the approved project.

(b) Disbursement of assistance funds.

(1) Unless otherwise provided and approved by the Board, the total amount of financial assistance funds authorized for loan or grant under the program authorized by Sections 1085.31 through 1085.49 of Title 82 of the Oklahoma Statutes to the applicant shall not be released and disbursed to applicant in a total lump sum but instead shall be disbursed to applicant in partial amounts at agreed

upon intervals and stages of construction, all as provided within the financial assistance agreement.

(2) In conjunction with the rule, the Board may require applicant to submit to the Board prior to any release or disbursement of funds such invoices, receipts, contracts, verifications, evidence of expenditure or encumbrance, construction status and progress reports or other information as the Board may require.

(3) Unless otherwise provided and approved by the Board, the Board shall not approve the release nor disbursement of more than ninety-five percent (95%) of the total loan funds authorized for loan until such time as the project has been completed, inspected by the project engineer and the Board, and accepted by the applicant. Furthermore, unless otherwise provided and approved by the Board, the Board shall not release nor disburse more than ninety-five percent (95%) of the total loan funds authorized for engineering services until the project engineer has prepared and submitted three sets of as built project plans (if different from original plans) to the applicant and one set to the Board.

(c) Disbursement of grant funds.

(1) Notwithstanding and in addition to the provisions set out in (a) of this Section, the following specific provision shall apply in all instances of the disbursement of grant (financial assistance) funds under the Water and Sewer Financial Assistance Program.

(2) Upon approval of a grant application, the Board shall furnish to the applicant a letter notice of grant approval and Board commitment. The notice and commitment shall advise the applicant that the grant application has been formally and officially approved by the Board and that the grant funds approved shall be made available to the applicant by the Board for such purposes and upon such other terms and conditions as the Board may require.

(3) Within ninety (90) days following the date of the letter notice of approval, the applicant shall file with the Board an acceptable bid for completion of the proposed project. Where determined necessary and appropriate, the Board or its staff may permit additional time to file such a bid; provided, notwithstanding any approval of additional time, if such a bid is not filed within one (1) year following the date of Board approval of the application, then the Board's approval shall expire and no funds shall be released; provided however, if an acceptable bid for completion has not been filed due to circumstances that lay outside the applicant's control, the applicant may request, and the Board may approve or deny, a one-time extension of time not to exceed six months to file an acceptable bid. Provided further, in the event of such expiration the applicant may file a new application which shall be subject to due consideration on its own merit.

(4) For purposes of final disbursement of funds to the applicant, the grant amount initially approved may be lowered by the Board based on actual project costs.

(5) As the Board may determine and direct, grant funds may be disbursed to the applicant in installments or in lump sum, and may be disbursed prior to, during or upon

completion of the project, all as deemed appropriate under the project circumstances presented. However, prior to the disbursement of any grant funds to the applicant, the applicant must:

- (A) Submit to the Board such evidence as the Board may require to establish that the emergency continues to exist; and
- (B) Establish, in such manner as is acceptable to the Board or its staff, a special and separate federally insured fund or account (within applicant's accounting system) in and through which the grant proceeds shall be administered and accounted for by the applicant.

(6) In all instances, the Board reserves the right to impose additional reasonable and necessary conditions or requirements for the disbursement of grant funds, all as may be deemed appropriate by the Board under the circumstances of the project for which grant assistance is made available.

(d) **Disbursement of contract funding.**

(1) Upon approval of an application for contract funding under the Water and Sewer Financial Assistance Program, the Board shall furnish to the applicant a letter containing notice of application approval and a draft contract.

(2) The contract shall contain, among others, the following provisions:

- (A) A description of the project;
- (B) The requirement that the applicant comply with applicable competitive bidding provisions in the acquisition of materials and services used for the project;
- (C) The requirement that proper invoices be submitted monthly to the Board as funds are expended;
- (D) The requirement that all books and records of applicant containing information pertaining to the project be available for inspection and audit.

(3) The funding contemplated by approval of the application and execution of the contract shall be paid to applicant upon submittal and acceptance of invoices for the work performed.

SUBCHAPTER 9. CLEAN WATER STATE REVOLVING FUND REGULATIONS

PART 1. GENERAL PROVISIONS

785:50-9-9. Definitions

The following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"303(d) List" means the list of impaired waters of the State, or most recent approved revision thereof, developed pursuant to Section 303(d) of the Clean Water Act as amended and maintained on file at the Board.

"Act" means The Federal Clean Water Act, as amended.

"Applicant" means any municipality, as defined, that submits a preapplication/application for financial assistance in accordance with this subchapter.

"Architectural or engineering services" means consultation, investigations, reports, or services for design-type projects within the scope of the practice of architecture or professional engineering.

"As a result of" means funds in the Clean Water SRF including the capitalization grant, repayments of first round loans, bond proceeds, and the State match.

"Binding commitment" means binding commitments are legal obligations by the State to the local recipient that define the terms and the timing for assistance under Clean Water SRF.

"Board" means the Oklahoma Water Resources Board authorized by law to make final adjudications, execute contracts, adopt rules and carry out other powers and duties set forth by law or, for duties authorized by law to be delegated to the Executive Director, the Executive Director or any employee or agent or staff member thereof as assigned by the Executive Director.

"Brownfield" means an abandoned, idled or underused industrial or commercial facility or other redevelopment of the real property is complicated by environmental contamination caused by regulated substances [27A:2-15-103(2)].

"Brownfield assessment" means any phase I, phase II, phase III or other study required by the Department which is used to assess a brownfield.

"Building" means the erection, acquisition, alteration, remodeling, improvement or extension of treatment works.

"Capitalization grant" means an agreement between EPA and State whereby federal dollars are made available to partially fund a Clean Water SRF.

"Collector sewer" means the common lateral sewers, within a publicly owned treatment system which are primarily installed to receive wastewaters directly from facilities which convey wastewater from individual systems, or from private property, and which include service "Y" connections designed for connection with those facilities including:

- (A) Crossover sewers connected more than one property on one side of a major street, road, or highway to a lateral sewer on the other side when more cost effective than parallel sewers; and
- (B) Pumping units and small diameter lines serving individual structures or groups of structures.

"Combined sewer" means a sewer that is designed as a sanitary sewer and a storm sewer.

"Conservation Commission" means the Oklahoma Conservation Commission.

"Construction" means any one or more of the following: brownfield assessment; preliminary planning to determine feasibility, engineering, architectural, legal, fiscal, or economic investigations or studies, surveys, designs, plans, working drawings, specifications, procedures, or other actions or undertakings necessary to a project; erection, building, acquisition, alteration, remodeling, improvement, or extension of a project; or the inspection or supervision of any of the foregoing items.

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"Contingency section" means that portion of the planning portion of the priority list consisting of projects which may receive loans due to bypass provision or due to additional funds becoming available.

"Cross-cutting laws and orders" means Federal laws and authorities that apply to all activities supported with funds "directly made available by" capitalization grants.

"DBE" means Disadvantaged Business Enterprises.

"DBE participation" means the federal requirement for negotiation of a "fair share" objective for minority, disadvantaged and women owned businesses applies to assistance in an amount equal to the capitalization grant.

"Department" means the Oklahoma Department of Environmental Quality.

"Enforceable requirements of the Act" means those conditions or limitations of NPDES or other discharge permits which, if violated, could result in the issuance of a compliance order or initiation of a civil or criminal action. If a permit has not been issued, the term shall include any requirement which would be included in the permit when issued. Where no permit applies, the term shall include any requirement which is necessary to meet applicable criteria for best practicable wastewater treatment technology (BPWTT).

"Equivalency projects" means project cited by the Board as meeting the requirement of the capitalization grant.

"Excessive infiltration/inflow" means the quantities of infiltration/inflow above 120 gallons per capita per day (GPCD), which can be economically eliminated from a sewer system as determined in a cost-effectiveness analysis that compares the costs for correcting the infiltration/inflow conditions to the total costs for transportation and treatment of the infiltration/inflow.

"Fundable portion" means that portion of the Project Priority List which includes projects scheduled for financial assistance during the funding year.

"Funding year" means the first year of the planning period represented by a project priority list.

"Infiltration" means water other than wastewater that enters a sewer system (including sewer service connections and foundation drains) from the ground through such means as defective pipes, pipe joints, connections, or manholes. Infiltration does not include, and is distinguished from inflow.

"Inflow" means water other than wastewater that enters a sewer system (including sewer service connections) from sources such as, but not limited to, roof leaders, cellar drains, yard drains, area drains, drains from springs and swampy areas, manhole covers, cross connections between storm sewers and sanitary sewers, catch basins, cooling towers, storm waters, surface runoff, street wash waters, or drainage. Inflow does not include, and is distinguished from infiltration.

"In perpetuity" means maintaining the principal amounts of the federal capitalization grants and state matching funds within the CWSRF.

"Intended Use Plan" means a document prepared each year by the State, which identifies the intended uses of the funds in the CWSRF and describes how those uses support the goals of the CWSRF.

"Interceptor sewer" means a sewer which is designed for one or more of the following purposes:

(A) To intercept wastewater from a final point in a collector sewer and convey such wastes directly to a treatment facility or another interceptor.

(B) To replace an existing wastewater treatment facility and transport the wastes to an adjoining collector sewer or interceptor sewer for conveyance to a treatment plant.

(C) To transport wastewater from one or more municipal collector sewers to another municipality or to a regional plant for treatment.

(D) To intercept an existing major discharge of raw or inadequately treated wastewater for transport directly to another interceptor or to a treatment plant.

"Loan" means an agreement between the State and the local recipient through which the Clean Water SRF provides funds for eligible assistance on terms consistent with the federal Water Quality Act of 1987 or otherwise approved by the Environmental Protection Agency.

"MGD" means millions of gallons per day.

~~**"MBE"** means Minority Business Enterprise.~~

~~**"MBE/WBE participation"** means the federal requirement for negotiation of a "fair share" objective for minority and women owned businesses (MBE/WBE) applies to assistance in an amount equal to the capitalization grant.~~

"Municipality" means a city, town, county, district, association, or other public body (including an intermunicipal agency of two or more of the foregoing entities) created under State law, or an Indian tribe or an authorized Indian tribal organization, having jurisdiction over disposal of sewage, industrial wastes, or other waste, or a designated and approved management agency consistent with the State Water Quality Management Plan.

"NEPA" means the National Environmental Policy Act.

"Nonexcessive infiltration" means the quantity of infiltration which cannot be economically and effectively eliminated from a sewer system as determined in a cost-effectiveness analysis.

"Nonexcessive inflow" means the rainfall induced peak inflow rate which does not result in chronic operational problems related to hydraulic overloading of the treatment works during storm events. These problems may include surcharging, backups, bypasses, and overflows.

"Nonpoint source" means a source of pollution which is diffuse and does not have a single point of origin or is introduced into a receiving stream from a specific outlet.

"Nonpoint source activities" means capital works, capital improvements, capital equipment, environmental cleanups, land acquisition, or implementation of management practices for the purpose of protecting or improving surface or underground water quality through watershed management or reduction of nonpoint source pollution as authorized by the Act.

"NPDES" means National Pollutant Discharge Elimination System.

"Operable treatment works" means a treatment works that, upon completion, will meet the enforceable requirements of the Act.

"Operation and maintenance" means activities required to assure the dependable and economical function of treatment works.

(A) **"Maintenance"** means preservation of functional integrity and efficiency of equipment and structures. This includes preventive maintenance, corrective maintenance and replacement of equipment.

(B) **"Operation"** means control of the unit processes and equipment which make up the treatment works. This includes financial and personnel management, records, laboratory control, process control, safety and emergency operation planning.

"OWQS" means the Oklahoma Water Quality Standards promulgated by the Board at Oklahoma Administrative Code Title 785, Chapter 45, as amended.

"Planning" means the process of evaluating alternative solutions to water pollution problems, and through a systematic screening procedure, selecting the most cost effective environmentally sound alternative.

"Planning portion" means that part of the Project Priority List containing all projects outside the fundable portion of the list that may, under anticipated allotment levels, receive funding during the five-year planning period represented by the list.

"Project" means the water quality project for which Clean Water SRF assistance is provided. Water quality projects include:

- (A) construction and design, or construction of an operable treatment works or segment thereof the principal purpose of which is for the treatment of domestic users' discharges within the jurisdiction, community, sewer service area, region or district concerned; or
- (B) urban storm water activities;
- (C) nonpoint source activities; or
- (D) other water quality projects as defined by 82 O.S. §1085.52, as amended.

"Project completion" means the date operations of the project are initiated or are capable of being initiated, whichever is earlier.

"Project Priority List" means a contiguous list of projects in order of priority for which Clean Water SRF assistance is expected during a five-year planning period.

"Project priority points" means the total number of points assigned to a project by using the priority ranking formula.

"Reallotment" means allotment of previously allotted unused funds.

"Recipient" means a municipality or other entity which receives assistance under the Clean Water SRF program.

"Repayment" means principal and interest payments on loans which must be credited directly to the Clean Water SRF.

"Replacement" means those expenditures for obtaining and installing equipment, accessories, or appurtenances during the useful life of the treatment works necessary to maintain the

capacity and performance for which such works are designed and constructed.

"Responsible bidder" means a prospective contractor that currently meets the minimum standards of financial and technical ability to perform the tasks identified in the project specifications.

"Revenue programs" means a formally documented determination of sewer use charges which is designed to provide revenues for operation and maintenance (including replacement) cost, and/or any combination of revenue generating programs necessary to meet local debt service requirements.

"Sewer System Evaluation Survey (SSES)" means a study which shall identify the location, estimated flow rate, method of rehabilitation, and cost of rehabilitation versus the cost of transportation and treatment for each defined source of infiltration/inflow.

"State match" means funds equaling at least 20% of the amount of the capitalization grant which the State must deposit into the Clean Water SRF.

"State Revolving Fund" or **"SRF"** means funds for loans or providing other assistance for pollution control projects established through capitalization grants from EPA and State matching funds.

"Storm sewer" means a sewer designed to carry only storm waters, surface runoff, street wash waters, and drainage.

"Treatment works" means any devices and systems used in the storage, treatment, recycling, and reclamation of municipal sewage, including intercepting sewers, outfall sewers, sewage collection systems, pumping, power, and other equipment, and their appurtenances. In addition **"treatment works"** means any other method or system for preventing, abating, reducing, storing, treating, separating, or disposing of municipal waste, including storm water runoff, including on-site systems and waste in combined storm water and sanitary sewer systems.

"Urban storm water activities" means those activities which are conducted under the Oklahoma Brownfields Voluntary Redevelopment Act for eligible entities that have obtained a draft or final permit pursuant to the National Pollution Discharge Elimination Act or Oklahoma Pollutant Discharge Elimination System Act, which are designed to improve water quality, and which are exempt from funds administered under the Nonpoint Source Management Program of the federal Clean Water Act.

"User charge" means a charge levied on users of a treatment works for the user's share of the cost of operation and maintenance (including replacement) of such works.

~~**"WBE"** means Women's Business Enterprise.~~

PART 3. GENERAL PROGRAM REQUIREMENTS

785:50-9-38. Construction phase

(a) **Awarding construction contracts.** The recipient shall be responsible for assuring that every appropriate procedure and incidental legal requirement is observed in advertising for bids and awarding the construction contract. The text of the

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construction contract shall not vary from the text of the Board approved draft contract documents in the approved plans and specifications or addenda to the plans and specifications.

(b) **Inspection during construction.** During the building phase of the project, the recipient shall provide independent engineering or other professional services necessary to assure completion of the project in accordance with the loan agreement and the approved plans and specifications.

(c) **Resident inspection.** After the construction contract is awarded, the recipient shall provide for adequate full-time independent resident inspection of the project and require assurance that the work is being performed in a satisfactory manner in accordance with the approved plans and specifications, approved alterations, and in accordance with sound engineering principles and building practices. The Board is authorized to inspect the building of any project at any time in order to assure that plans and specifications are being followed and that the works are being built in accordance with sound engineering principles and building practices, but such inspection shall never subject the State of Oklahoma to any action for damages. The Board shall bring to the attention of the recipient and the project engineer any variances from the approved plans and specifications. The recipient and the project engineer shall immediately initiate necessary action rectifying construction deficiencies.

(d) **Inspection of materials.**

(1) The Board is also authorized to inspect all materials furnished, including inspection of the preparation or manufacture of the materials to be used. The state inspector is to report the manner and progress of the building or to report conditions relating to the materials furnished and the compliance by the contractor with approved plans and specifications for the project. Such inspection will not release the contractor from any obligation to perform the work in accordance with the requirements of the contract documents or the project engineer from determining compliance with the requirements of the contract documents.

(2) In the event building procedures or materials are determined by the Board to be substandard or otherwise unsatisfactory and/or not in conformity with approved plans and specifications, the Board may order the recipient to take such action in the manner provided for in the construction contract to correct any such deficiency.

(3) In those instances of dispute between the recipient project engineer and the Board's representative as to whether material furnished or work performed conforms with the terms of the construction contract, the Board may order the recipient to direct the project engineer to reject questionable materials and/or initiate other action provided for in the construction contract, including suspension where necessary, until all disputed issues are resolved in accordance with the terms of the construction contract.

(4) The contractor and recipient shall furnish the Board's representative with every reasonable facility for ascertaining whether the work as performed is in accordance with the requirements and intent of the contract.

(5) In addition to normal testing procedures required of the recipient, the Board may require reasonable additional tests of building materials or processes which the Board determines to be necessary during the building of projects financed in whole or in part by Clean Water SRF funds. All tests, whether for the Board or the project engineer, will conform to current American Water Works Association, American Association of State Highway and Transportation Officials, American Society of Testing and Materials, and the Oklahoma Department of Transportation published procedures, or similar criteria. The Board shall specify which tests are applicable. Samples for testing shall be furnished free of cost to the Board upon request on the construction site.

(e) ~~MBE/WBE~~ DBE participation requirements apply to projects constructed with funds directly made available by the federal capitalization grant (equivalency projects).

(1) EPA and the State will negotiate a "Fair Share Objective" (which shall represent a percentage of ~~MBE/WBE~~ DBE participation).

(2) When soliciting for a subcontractor (A/E or construction contractor), the loan recipient shall take the following six ~~steps~~ good faith efforts:

(A) Include qualified Small, ~~MBE and WBE~~ DBE businesses on solicitation lists.

(B) Assure that Small, ~~MBE and WBE~~ DBE businesses are solicited whenever they are potential sources.

(C) When economically feasible, divide total requirements into smaller tasks or quantities so as to permit maximum Small, ~~MBE and WBE~~ DBE business participation.

(D) Where the requirements of the work permits, establish delivery schedules which will encourage participation by Small, ~~MBE and WBE~~ DBE businesses.

(E) Use the services and assistance of the Small Business Administration, the Office of Minority Business Enterprise of the United States Department of Commerce, as appropriate.

(F) If any subcontracts are to be let, require the prime contractor or A/E to take ~~affirmative steps~~ the good faith efforts in (A) through (E) of this paragraph (2).

PART 7. SRF ENVIRONMENTAL REVIEW PROCESS

785:50-9-60. Requirement of environmental review

As required by the provisions of Section 602(b) (6) of the Clean Water Act, the Board shall conduct an interdisciplinary environmental review consistent with the National Environmental Policy Act of the project proposed for funding through the Clean Water State Revolving Fund Loan Account. This review will insure that the project will comply with the applicable local, state and federal laws and Board regulations relating to the protection and enhancement of the environment.

Based upon the staff's review, the Board will make formal determinations regarding the potential social and environmental impacts of the proposed project. As necessary, the determination will include mitigative provisions as a condition of financial assistance for building and no financial assistance will be provided until a final environmental determination has been made. Nothing in this Part shall prohibit any public, private or governmental party from seeking administrative or legal relief from the determinations of the Board. Potential applicants to the Clean Water State Revolving Fund Loan Account should obtain guidance from the staff regarding the scope of the environmental review to be conducted by the Board and the environmental information which the applicant will be required to submit in support of the proposed project.

(1) **Basic environmental determination.** There are three (3) basic environmental determinations that will apply to projects proposed to be implemented with assistance from the Clean Water State Revolving Fund Loan Account. These are: a determination to categorically exclude a project from a formal environmental review; a finding of no significant impact (FNSI) based upon a formal environmental review supported by an environmental information document (EID); and a determination to provide or not to provide financial assistance based upon a Record of Decision following the preparation of an environmental impact statement (EIS). The appropriate determination will be based on the following criteria.

(A) The categorical exclusion determination applies to categories of projects that have shown over time not to entail significant impacts on the quality of the human environment.

(i) Projects which meet any of the following criteria may be categorically excluded from formal environmental review requirements.

(I) The project is directed solely toward rehabilitation of existing facilities, functional replacement of equipment, or toward the construction of related facilities adjoining the existing facilities that do not affect the degree of treatment or the capacity of the works (i.e. infiltration and inflow correction, rehabilitation of existing equipment and structures, and the construction of small structures adjacent to or on existing sites).

(II) The project is in a community of less than 10,000 population and is for minor expansions or upgrading of existing treatment works or on-site disposal systems are proposed.

(III) The project is in an unsewered community involving the replacement of existing on-site systems, providing the new onsite systems do not result in substantial increases in the volume of discharge or the loadings of pollutants from existing sources, or relocate existing discharge.

(IV) The project involves re-issuance of a NPDES permit for a new source providing the conclusions of the NEPA document are still

valid (including the appropriate mitigation), there will be no degradation of the receiving waters, and the permit conditions do not change or are more environmentally protective.

(V) The project is for an award of grants authorized by Congress under EPA's annual Appropriations Act that are solely for the reimbursement of the costs of a project that was completed prior to the date the appropriation was enacted.

(ii) Categorical exclusions will not be granted for projects that entail:

(I) the construction of new collection lines;

(II) a new discharge or relocation of an existing discharge;

(III) a substantial increase in the volume or loading of pollutants;

(IV) providing capacity for a population thirty (30) percent greater than the existing population;

(V) known or expected impacts to cultural resources, threatened or endangered species, or other environmentally sensitive areas; and

(VI) the construction of facilities that are known or expected to be not cost-effective or are likely to cause significant public controversy.

(iii) Categorical exclusions will be granted for the following projects without additional required documentation:

(I) Procedural, ministerial, administrative, financial, personnel, and management actions necessary to support the normal conduct of EPA business.

(II) Acquisition actions (compliant with applicable procedures for sustainable procurement) and contracting actions necessary to support the normal conduct of EPA business.

(III) Actions involving information collection, dissemination, or exchange; planning; monitoring and sample collection wherein no significant alteration of existing ambient conditions occurs; educational and training programs; literature searches and studies; computer studies and activities; research and analytical activities; development of compliance assistance tools; and architectural and engineering studies. These actions include those conducted directly by EPA and EPA actions relating to contracts or assistance agreements involving such actions.

(IV) Actions relating to or conducted completely within a permanent, existing contained facility, such as a laboratory, or other enclosed building, provided that reliable and scientifically-sound methods are used to appropriately

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dispose of wastes and safeguards exist to prevent hazardous, toxic, and radioactive materials in excess of allowable limits from entering the environment. Where such activities are conducted at laboratories, the Lab Director or other appropriate official must certify in writing that the laboratory follows good laboratory practices and adheres to all applicable federal, state, local, and federally-recognized Indian tribal laws and regulations. This category does not include activities related to construction and/or demolition within the facility.

(V) Actions involving emergency preparedness planning and training activities.

(VI) Actions involving the acquisition, transfer, lease, disposition, or closure of existing permanent structures, land, equipment, materials, or personal property provided that the property: has been used solely for office functions; has never been used for laboratory purposes by any party; does not require site remediation; and will be used in essentially the same manner such that the type and magnitude of the impacts will not change substantially. This category does not include activities related to construction and/or demolition of structures on the property.

(VII) Actions involving providing technical advice to federal agencies, state or local governments, federally-recognized Indian tribes, foreign governments, or public or private entities.

(VIII) Actions involving approval of EPA participation in international "umbrella" agreements for cooperation in environmental-related activities that would not commit the United States to any specific projects or actions.

(IX) Actions involving containment or removal and disposal of asbestos-containing material or lead-based paint from EPA owned or operated facilities when undertaken in accordance with applicable regulations.

(X) Actions involving new source NPDES permit modifications that make only technical corrections to the NPDES permit (such as correcting typographical errors) that do not result in a change in environmental impacts or conditions.

(iv) The Board may exclude, by amendment to these regulations, other categories of projects for which there is sufficient documentation demonstrating that they are not likely to have significant effects on the quality of the human environment.

(B) The FNSI will be based upon an environmental review by the staff supported by an EID prepared by the applicant in conformance with 785:50-9-61(2)(A). Based upon its review, the staff will prepare an environmental assessment (EA) resulting in the issuance of either a FNSI or a public

notice that the preparation of an EIS will be required. All applicants whose projects do not meet the criteria for either a categorical exclusion or EIS will be required to prepare an EID. The Board's issuance of a FNSI will be based upon an EA documenting that the potential environmental impacts will not be significant or that they may be mitigated without extraordinary measures.

(C) The Record of Decision may only be based upon an EIS in conformance with the format and guidelines described in 785:50-9-61(3). An EIS will be required when the Board determines any of the following:

(i) the project will significantly affect the pattern and type of land use or growth and distribution of the population;

(ii) the effects of the project's construction or operation will conflict with local or state laws or policies;

(iii) the project may have significant adverse impacts upon:

(I) wetlands,

(II) floodplains,

(III) threatened and endangered species or their habitats,

(IV) cultural resources including parklands, reserves, other public lands or areas of recognized scenic, recreational, agricultural, archeological or historic value;

(iv) the project will displace population or significantly alter the characteristics of existing residential areas;

(v) the project may directly or indirectly (i.e., through induced development) have significant adverse effect upon local ambient air quality, local noise levels, surface and ground water quality or quantity, fish, shellfish, wildlife or their natural habitats;

(vi) the project may generate significant public controversy;

(vii) the treated effluent will be discharged into a body of water where the present classification is too lenient or is being challenged as too low to protect present or recent uses, and the effluent will not be of sufficient quality to meet the requirements of those uses.

(2) Other determinations that are required of the Board.

(A) Recognizing that a project may be altered at some time after an environmental determination on the project has been issued, the Board will provide that, prior to approval, the plans and specifications, assistance application, and related documents will be examined for consistency with the environmental determination. If inconsistencies are found, the Board may revoke a categorical exclusion and require the preparation of an EID or an EIS, consistent with the criteria of this subsection, or require the preparation

of amendments to an EID or supplements to an EIS, as appropriate. Based upon the staff's review of the amended project, the Board will:

- (i) reaffirm the original determination through the issuance of a public notice or statement of finding;
- (ii) issue a FNSI for a project for which a categorical exclusion has been revoked, or issue a public notice that the preparation of an EIS will be required;
- (iii) issue an amendment to a FNSI, or revoke a FNSI and issue a public notice that the preparation of an EIS will be required, or
- (iv) issue a supplement to a record of decision, or revoke a record of decision and issue a public notice that financial assistance will not be provided.

(B) When five (5) or more years have elapsed between the last environmental determination and the submittal of an application to the Fund, the Board will re-evaluate the project, environmental conditions and public views, and prior to the approval of application, proceed in accordance with 785:50-9-60(2)(A).

(3) Other determinations that are available to the Board.

(A) An applicant may request advance authority to construct part of the proposed wastewater treatment project prior to completion of the necessary environmental review when the part of the project will:

- (i) immediately remedy a severe public health, water quality or environmental problem;
- (ii) not preclude any reasonable alternatives identified for the complete system;
- (iii) not cause significant or indirect environmental impacts including those which cannot be acceptably mitigated without completing the entire project; and
- (iv) not be highly controversial.

(B) Based upon the review of the information required by Section 785:50-9-61, the Board will issue a FNSI so conditioned as to prohibit construction of the remainder of the project until a complete environmental review has been performed and a subsequent environmental determination has been issued.

(C) The Board may choose to accept determinations made by a federal agency in a previously issued environmental decision in lieu of conducting a formal environmental review when the proposed project will not cause adverse impacts to the environment and is not highly controversial.

(4) Projects exempt from environmental review. The Board is not required to perform an environmental review of the following projects:

- (A) Nonpoint source projects that
 - (i) cannot be defined as Section 212 projects; and
 - (ii) are not funded with funds directly made from a capitalization grant

(B) Projects that consist of design and planning fees only.

785:50-9-61. Environmental information required by the Board

Documentation required in this subsection will be submitted to the Board.

(1) ~~Applicants~~ Except as otherwise provided in OAC 785:50-9-60(1)(A)(iii), applicants seeking a categorical exclusion will provide the Board with sufficient documentation to demonstrate compliance with the criteria of Section 785:50-9-60(1)(i) of this ~~regulation~~ Chapter and shall satisfy the provisions of 40 C.F.R. Section 6.204. At a minimum, this will consist of:

- (A) a brief, complete description of the proposed project and its costs;
- (B) a statement indicating that the project is cost-effective and that the applicant is financially capable of constructing, operating and maintaining the facilities; and
- (C) a plan map or maps of the proposed project showing:
 - (i) the location of all construction areas,
 - (ii) the planning area boundaries, and
 - (iii) any known environmentally sensitive areas.

(2) An EID must be submitted by those applicants whose proposed projects do not meet the criteria for a categorical exclusion and for which the Board has made a preliminary determination that an EIS will not be required. The Board will provide guidance on both the format and contents of the EID to potential applicants prior to initiation of planning.

(A) At a minimum, the contents of an EID will include:

- (i) the purpose and need for the project;
- (ii) the environmental setting of the project and the future of the environment without the project;
- (iii) the alternatives to the project as proposed and their potential environmental impacts;
- (iv) a description of the proposed project;
- (v) the potential environmental impacts of the project as proposed including those which cannot be avoided;
- (vi) the relationship between the short term uses of man's environment and the maintenance and enhancement of long term productivity;
- (vii) any irreversible and irretrievable commitments of resources to the proposed project;
- (viii) a description of public participation activities conducted, issues raised, and changes to the project which may be made as a result of public participation process; and
- (ix) documentation of coordination with appropriate governmental agencies.

(B) Prior to the applicant's adoption of the planning document, the applicant will hold a public hearing on the proposed project and the EID, and provide the

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Board with a transcript of the hearing. The Board will provide guidance to the applicant regarding the contents of the hearing notice and of the hearing. The hearing will generally be advertised at least thirty (30) days in advance in a local newspaper of general circulation. Concurrent with the advertisement, a notice of the public hearing and availability of the documents will be sent to all local, state, and federal agencies and public and private parties that may have an interest in the proposed project. Included with the transcript will be a list of attenders, and written testimony, and the applicant's responses to the issues raised.

(C) The applicant will make copies of the EID available to all federal, state, and local agencies and others with an interest in the project. The Board will provide guidance to the applicant regarding coordination requirements.

(3) The format of an EIS will encourage sound analysis and clear presentation of alternatives, including the no action alternative and the selected alternative, and their environmental, economic and social impacts. The following format must be followed by the applicant unless the Board determines there are compelling reasons to do otherwise.

(A) A cover sheet identifying the applicant, the project(s), the program through which financial assistance is requested, and the date of publication.

(B) An executive summary of the critical issues of the EIS in sufficient detail that the reader may become familiar with the proposed project and its cumulative effects. The summary will include:

- (i) a description of the existing problem;
- (ii) a description of each alternative;
- (iii) a listing of each alternative's potential environmental impacts, mitigative measures and any areas of controversy; and
- (iv) any major conclusions.

(C) The body of the EIS, which will contain the following information.

(i) A complete and clear description of the purpose and need for the proposed project that clearly identifies its goals and objectives.

(ii) A balanced description of each alternative considered by the applicant. The description will include the size and location of the facilities and pipelines, land requirements, and construction schedules. The alternative of no action will be discussed and the applicant's preferred alternative(s) will be identified. Alternatives that are eliminated from examinations will be presented with the reasons for their elimination.

(iii) A description of the alternatives available to the Board including:

- (I) providing financial assistance to the proposed project;
- (II) requiring that the proposed project be modified prior to providing financial assistance to reduce adverse impacts, or providing

assistance with conditions requiring the implementation of mitigative measures; and

(III) not providing financial assistance.

(iv) A description of the alternatives available to other local, state, and federal agencies which may have the ability to issue or deny a permit, provide financial assistance or otherwise affect or have an interest in any of the alternatives.

(v) A description of the affected environment and environmental consequences of each alternative. The affected environment on which the evaluation of each alternative will be based includes, as a partial listing, hydrology, geology, air quality, noise, biology, socioeconomic, land use, and cultural resources of the facilities planning area. The Board will provide guidance, as necessary, to the applicant regarding the evaluation of the affected environment. The discussion will present the total impacts of each alternative in manner that will facilitate comparison. The effects of the no action alternative must be included to serve as a baseline for comparison of the adverse and beneficial impacts of the other alternatives. A description of the existing environment will be included in the no action section to provide background information. The detail in which the affected environment is described will be commensurate with the complexity of the situation and the significance of the anticipated impacts.

(D) The draft EIS will be provided to all local, state and federal agencies and public groups with an interest in the proposed project and be made available to the public for review. The final EIS will include all objections and suggestions made before and during the draft EIS review process, along with the issues of public concern expressed by individuals or interested groups. The final EIS must include discussions of any such comments pertinent to the project or the EIS. All commentors will be identified. If a comment has led to a change in either the project or the EIS, the reason should be given. The Board will always endeavor to resolve any conflicts that may have arisen, particularly among permitting agencies, prior to the issuance of the final EIS. In all cases, the comment period will be no less than 45 days.

(E) Material incorporated into an EIS by reference will be organized to the extent possible into a Supplemental Information Document and be made available for public review upon request. No material may be incorporated by reference unless it is reasonably available for inspection by interested persons within the comment periods specified in 785:50-9-61(3)(D) and 785:50-9-61(3)(G)(ii) and (iii).

(F) When an EIS is prepared by contractors, either in the service of the applicant or the Board, the Board will independently evaluate the EIS prior to issuance of the Record of Decision (ROD) and take responsibility for its scope and contents. The Board staff who

undertake this evaluation will be identified under the list of preparers along with those of the contractor and any other parties responsible for the content of the EIS.

(G) The public participation required for an EIS is extensive; but should, depending upon the nature and scope of the proposed project, be supplemented by the applicant. The following requirements represent the minimum allowable to the applicant and the Board.

(i) Upon making the determination that an EIS will be required of a proposed project, the Board will publish in the Oklahoma Register and distribute a notice of intent to prepare an EIS.

(ii) As soon as possible after the notice of intent has been issued, the Board will convene a meeting of the affected federal, state and local agencies, the applicant, and other interested parties to determine the scope of the EIS. A notice of this scoping meeting may be incorporated into the Notice of Intent or prepared as in (2)(B) of this subsection except that in no case will the notification period be less than forty-five (45) days. As part of the scoping meeting the Board will, at a minimum:

(I) determine the significance of issues for and the scope of those significant issues to be analyzed in depth in the EIS;

(II) identify the preliminary range of alternatives to be considered;

(III) identify potential cooperating agencies and determine the information or analyses that may be needed from cooperating agencies or other parties;

(IV) discuss the method for EIS preparation and the public participation strategy;

(V) identify consultation requirement of other laws and regulations;

(VI) determine the relationship between the preparation of the EIS and the completion of the facilities plan and any necessary arrangements for coordination of the preparation of both documents.

(iii) Following the scoping process the Board will begin the identification and evaluation of all potentially viable alternatives to adequately address the range of issues developed in the scoping. A summary of this including a list of the significant issues identified will be provided to the applicant and other interested parties. Preparation of the EIS will be done, at the discretion of the Board: directly, by its own staff; by consultants to the Board; or by a consultant, contracted by the applicant subject to approval by the Board. In the latter two cases, the consultant will be required to execute a disclosure statement prepared by the Board signifying they have no financial or other conflicting interest in the outcome of the project. Both the draft EIS and final EIS will be distributed and made available for public review in a fashion

consistent with the requirements of (2)(B) of this section except that the advertisement and comment period for the public participation will be no less than forty-five (45) days. The Board will publish, in the Daily Oklahoman and a newspaper(s) of general circulation in the project area, a notice of availability of the EIS giving locations at which it will be available for public review at least forty-five (45) days prior to making any environmental determination.

785:50-9-62. Environmental review by the Board

(a) When the Board has determined that an applicant's proposed project may be excluded from a formal environmental review or has determined that a categorical exclusion is to be rescinded, the Board will prepare a public notice of the determination to categorically exclude the project and stating the availability of supporting documentation for public inspection. The notice will be published in a local newspaper of community-wide circulation by the applicant. The Board, concurrent with the publication, will distribute the notice to all interested parties.

(b) An environmental review of the proposed project, supported by the applicant's EID, will be conducted by the Board to determine whether any significant impacts are anticipated and whether any changes may be made in the proposed project to eliminate significant adverse impacts. As part of this review, the Board may require the applicant to submit additional information or undertake additional public participation and coordination to support its environmental determination. Based on the environmental review, the Board will prepare an environmental assessment, describing:

- (1) the purpose and need for the proposed project;
- (2) the proposed project, including its costs;
- (3) the alternatives considered and the reasons for their rejection or acceptance;
- (4) the existing environment;
- (5) any potential adverse impacts and mitigative measures; and
- (6) any proposed conditions to the provision of financial assistance and any means provided for the monitoring of compliance with the conditions.

(c) Based upon this environmental assessment, the Board will issue a FNSI or a notice of intent to prepare an EIS. The FNSI will include a brief description of the proposed project, its costs, any mitigative measures required of the applicant as a condition of its receipt of financial assistance, and a statement to the effect that comments supporting or disagreeing with the FNSI may be submitted for consideration by the Board. The environmental assessment will be attached when mitigative measures are specified by conditions of the financial assistance. The FNSI will be distributed to all parties, governmental entities, and agencies that may have an interest in the proposed project. No action regarding approval of the facilities plan or the provision of financial assistance will be taken by the Board for at least thirty (30) days after the issuance of a FNSI.

(d) Following the comment period and public hearings on the final EIS and at the time of the decision to approve the

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facilities plan or to provide or deny financial assistance to the proposed project, the Board will prepare a concise public record of decision. The record of decision will describe those mitigative measures to be taken which will make the selected alternative environmentally acceptable.

(e) In accordance with this Part, the Board will conduct environmental reviews and issue public notices or amended determinations, as appropriate.

SUBCHAPTER 13. OKLAHOMA WATER CONSERVATION GRANT PROGRAM

785:50-13-1. Purpose

The purpose of these rules is to implement the provisions of 82 O.S. Section 1088.1, enacted as part of House Bill 3135 approved in May 2008, that creates a new financial assistance grant program specifically for water conservation.

785:50-13-2. Definitions

In addition to the definitions contained in Section 785:50-1-2 of this chapter 50, the following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Communities" means *entire cities or towns, combined cities or towns, part of cities or towns, or schools, groups or entities located within a community* [82:1088.1].

"Groups or entities" means non-profit corporations who hold charitable non-profit status certifications from the Internal Revenue Service pursuant to the Internal Revenue Code and non-profit rural water districts formed under Title 82, O.S.

"Water conservation grant" means a written contract between the Board and a recipient whereby the recipient agrees to provide described goods or services for a public purpose under terms and conditions specified in the agreement.

785:50-13-3. Eligible entities

(a) Communities are eligible to become water conservation grant recipients.

(b) For purposes of qualifying for and obtaining the financial assistance contemplated in this subchapter, communities shall submit appropriate proof of eligibility.

785:50-13-4. Eligible projects

(a) The Board shall make grants for the establishment of pilot projects which will implement water conservation projects or plans in communities in the state;

(b) Pilot projects shall be innovative programs that will serve as models for other communities in the state.

(c) Pilot projects may include, but are not limited to, community conservation demonstration projects, water use accounting programs, retrofit projects, school education projects, Xeriscape demonstration gardens, and information campaigns on capturing and using harvested rainwater and graywater.

785:50-13-5. Pilot project criteria

The Board will consider the following in determining whether to approve a water conservation grant:

(1) Unless otherwise determined by the Board in a notice of funding availability, the total grant requested may not exceed Seven Thousand Dollars (\$7,000);

(2) Percentage of water efficiency improvement or water savings that may be realized by implementation of the pilot project;

(3) Ability of the applicant community to monitor benefits of project proposed;

(4) Amount of matching funds and/or inkind contributions to be provided;

(5) Potential to serve as model for other communities in the state; and

(6) Number of communities, groups or entities collaborating in the proposed project.

785:50-13-6. Process for consideration of proposals

(a) The Board will solicit applications by placing a notice of availability of funds for the water conservation grant program on the Oklahoma Water Resources Board website. The notice will contain a cutoff date for submission of applications.

(b) Applications for water conservation grants shall be submitted on forms provided by the Board.

(c) Staff will prioritize applications using the following formula:

(1) Estimated percentage of water efficiency improvement or water savings that may be realized by the implementation of the pilot project:

(A) one to ten percent = 5 points

(B) 11 to 20 percent = 10 points

(C) 21 percent or more = 20 points

(2) Applicant will monitor actual savings/benefits resulting from the proposed project:

(A) No - 0 points

(B) Yes - 15 points

(3) Amount of matching funds and/or inkind contributions to be provided:

(A) 10 to 20% - 5 points

(B) 21 to 30% - 10 points

(C) 31 to 40% - 15 points

(D) 41% or greater - 20 points

(4) Adaptability of proposed project to other communities:

(A) No - 0 points

(B) Yes - 15 points

(5) Number of communities, groups or entities collaborating on water conservation project:

(A) two = 10 points

(B) three = 20 points

(C) four or more = 30 points

785:50-13-7. Requirements for operation of projects

(a) In addition to other terms and conditions stated therein, the water conservation grant recipient shall monitor and evaluate actual water conservation realized from implementation

of the project or provide documentation regarding the potential for improvements to water use efficiency. Such monitoring may include week-to-week or month-to-month comparisons and changes in consumption based on total meter readings from the targeted area.

(b) Approved projects that require construction of infrastructure such as pipes and meters shall be constructed and operated in accordance with all applicable state laws and maintained in good working order by the grant recipient.

785:50-13-8. Funding availability

(a) Contingent upon the availability of funding, the Board may award grants each year in an amount not to exceed Twenty-five Thousand Dollars (\$25,000.00) for each grant, with total amount of grants awarded each year not to exceed Fifty Thousand Dollars (\$50,000.00).

(b) The notice of availability of funding shall specify the funding limitation for each grant and the total funding amount of grants to be awarded based upon the availability of funding.

785:50-13-9. Funding disbursement and limitations

(a) Water conservation grant recipients receiving \$1,000.00 or less:

- (1) Must complete projects within one (1) year;
- (2) Will be funded on a reimbursable basis upon submittal of invoices, receipts or other proof of expenditures as approved by the Board;

(3) Must submit a final report at the end of the project describing how the terms and conditions of the water conservation grant agreement were accomplished.

(b) Water conservation grant recipients receiving more than \$1,000.00:

- (1) Must complete projects within two years;
- (2) Will be funded on a reimbursable basis upon submittal of invoices, receipts or other proof of expenditures as approved by the Board.
- (3) Will provide status reports at intervals prescribed by the Board and a final report at the end of the project describing how the terms and conditions of the water conservation grant agreement were accomplished.

785:50-13-10. General terms and conditions for grants

(a) Funds must be used for purposes described in the application and in accordance with the water conservation grant agreement;

(b) Projects must be completed in time frame specified in the grant agreement, but not to exceed two years.

(c) Funds are not to be used for travel, salaries, overhead, current or completed projects or other general operating expenses of grant recipient.

[OAR Docket #09-781; filed 4-27-09]

Executive Orders

As required by 75 O.S., Sections 255 and 256, Executive Orders issued by the Governor of Oklahoma are published in both the *Oklahoma Register* and the *Oklahoma Administrative Code*. Executive Orders are codified in Title 1 of the *Oklahoma Administrative Code*.

Pursuant to 75 O.S., Section 256(B)(3), "Executive Orders of previous gubernatorial administrations shall terminate ninety (90) calendar days following the inauguration of the next Governor unless otherwise terminated or continued during that time by Executive Order."

TITLE 1. EXECUTIVE ORDERS

1:2009-20a.

AMENDED EXECUTIVE ORDER 2009-20

I, Brad Henry, Governor of the State of Oklahoma, pursuant to the authority vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution, hereby direct and order as follows:

In 2008, the State Legislature adopted House Concurrent Resolution 1047, directing the Oklahoma Historical Society to conduct a competition to select the official Oklahoma State Rock and Roll Song. Oklahomans nominated 454 songs which an expert panel then narrowed to 10 finalists.

The 10 finalists were "Heartbreak Hotel," co-written by Oklahoma school teacher Mae Boren Axton and recorded by Elvis Presley; "Let's Have a Party," recorded by Oklahoman Wanda Jackson; "Walk, Don't Run," recorded by the Ventures, which included Oklahoman Nokie Edwards; "After Midnight," written and recorded by Oklahoman J.J. Cale and re-released by Eric Clapton; "Never Been to Spain," by Oklahoman Hoyt Axton and made famous by Three Dog Night; "Home Sweet Oklahoma," written and recorded by Oklahoman Leon Russell; "Oklahoma," by the Call, including Oklahomans Michael Been and Scott Musick; "Move Along," by Oklahoma band the All-American Rejects; "Endless Oklahoma Sky," by John Moreland and the Black Gold Band, also from Oklahoma; and "Do You Realize??" written and recorded by the Oklahoma band the Flaming Lips.

Oklahomans were encouraged to vote online to choose the Official Oklahoma Rock and Roll Song. "Do You Realize??" by the Flaming Lips received 10,738 votes, or nearly 51 percent of the 21,061 votes cast.

"Do You Realize??" from the 2002 gold-certified album *Yoshimi Battles the Pink Robots*, displays an optimism and love

of humanity that are reflective of the Oklahoma spirit. Family being central to the Oklahoma way of life, "Do You Realize??" encourages each of us to make the most of scarce moments we have with our families and loved ones.

Pursuant to the procedure set forth in House Concurrent Resolution 1047 (2008) and the resulting vote of the people of this state, I hereby declare, direct and order that the official Oklahoma State Rock and Roll Song shall be the words and music of the song "Do You Realize??" by The Flaming Lips, composed and written by Wayne Coyne, Steven Drozd, Michael Ivins and Dave Fridmann.

This Executive Order shall be forwarded to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, the Secretary of Commerce and Tourism, the Director of the Oklahoma Film and Music Commission and the Executive Director of the Oklahoma History Center who shall cause the provisions of this Order to be implemented by all appropriate agencies of state government, and to Wayne Coyne, Steven Drozd, Michael Ivins, Kliph Scurlock, Dave Fridmann and Scott Booker.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City this 28th day of April, 2009.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Brad Henry

ATTEST:
M. Susan Savage
Secretary of State

[OAR Docket #09-830; filed 5-4-09]

