Rules

RULE

Department of Agriculture and Forestry
Office of Animal Health Services
Livestock Sanitary Board

Livestock Auction Market Requirements
(LAC 7:XXI.305-311)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., The Department of Agriculture and Forestry, Office of the Commissioner adopts regulations governing livestock auction market requirements. These rules comply with and are enabled by R.S. 3:2093, R.S. 3:2221, and R.S. 3:2228.

Title 7
AGRICULTURE AND ANIMALS
Part XXI. Diseases of Animals

Chapter 3. Cattle

§305. Brucellosis Vaccination and Fee

A. - C. ...

D. All heifer calves between 4 and 12 months of age not vaccinated for brucellosis which are to be sold through an approved livestock auction market must be vaccinated with USDA approved brucellosis vaccine prior to being sold. There shall be a fee to be paid by the seller of $2 for each heifer calf required to be vaccinated for brucellosis, which fee shall be known as the brucellosis vaccination fee. The brucellosis vaccination fee shall be collected on the date of the sale from the seller by the approved livestock auction market and forwarded to the Louisiana Department of Agriculture and Forestry no later that the tenth day of the month following the month in which the fee was collected.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2221 and R.S. 3:2223.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 15:75 (February 1989), amended LR 22:960 (October 1996), LR 25:1083 (June 1999).

§307. Livestock Auction Market Requirements

A. - A.1.c.iv. ...

d. All heifer calves, between 4 and 12 months of age not vaccinated for brucellosis must be vaccinated with USDA approved Brucellosis vaccine prior to being sold. Failure to accomplish this vaccination shall be a violation of this regulation and violators shall be subject to penalties which may be imposed by the Louisiana Livestock Sanitary Board as granted in R.S. 3:2093.

d.i. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2093, R.S. 3:2221, and R.S. 3:2228.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Livestock Sanitary Board, LR 11:237 (March 1985), amended LR 11:615 (June 1985), amended LR 12:501 (August 1986), LR 12:598 (September 1986), LR 13:556 (October 1987), LR 14:220 (April 1988), LR 14:695(October 1988), LR 15:813 (October 1989), LR 17:30 (January 1991), LR 18:837 (August 1992), amended LR 22:960 (October 1996), LR 25:1083 (June 1999).

§309. Governing the Sale of Cattle in Louisiana by Livestock Dealers

A. - 2.b.ii. ...

3.a. All heifer calves between 4 and 12 months of age must be vaccinated with USDA approved Brucellosis vaccine prior to being sold. Failure to accomplish this vaccination shall be a violation of this regulation and violators shall be subject to penalties which may be imposed by the Louisiana Livestock Sanitary Board as granted in R.S. 3:2093.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:562, R.S. 3:2221 and R.S. 3:2228.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Livestock Sanitary Board, LR 11:237 (March 1985), LR 11:651 (June 1985), amended LR 12:502 (August 1986), LR 13:558 (October 1987), LR 14:221 (April 1988), LR 17:31 (January 1991), LR 18:838 (August 1992), LR 22:960 (October 1996), LR 25:1083 (June 1999).

§311. Governing the Sale of Purchases, within Louisiana, of All Livestock not Governed by Other Regulations (Brucellosis Requirements)

A. ...

1. Heifer calves 4 to 12 months of age, must be official brucellosis calfhood vaccinates to be eligible to be sold other than to slaughter or to a quarantined feedlot.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2093, R.S. 2221 and R.S. 3:2228.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Livestock Sanitary Board, LR 11:238 (March 1985), LR 11:615 (June 1985), amended 12:502 (August 1986), LR 13:559 (October 1987), LR 17:31 (January 1991), LR 18:837 (August 1992), LR 25:1083 (June 1999).

Bob Odom
Commissioner

9906#021

RULE

Department of Economic Development
Office of the Secretary
Division of Economically Disadvantaged Business Development

Economically Disadvantaged Business Development Program—Eligibility Requirements (LAC 19:II.107)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Department of Economic Development, Office of the Secretary, Division of Economically Disadvantaged Business Development, hereby promulgates amendments of changes to its rules relative to the

Economically Disadvantaged Business Development Program.

Title 19
CORPORATIONS AND BUSINESS
Part II. Economically Disadvantaged Business Development Program
Chapter 1. General Provisions
§107. Eligibility Requirements for Certification

A. - B. ...

1. - 2. ...

3. Net Worth. Each individual owner's net worth may not exceed $200,000. The market value of individual owner's personal residence will be excluded from the networth calculation.

4. ...

C.1. - 6. ...

7. Diminished Capital and Credit

a. A firm will be considered to have diminished capital and credit if its ability to compete in the free enterprise system has been impaired due to diminished capital and credit opportunities as compared to other firms in the same or similar line of business, and whose diminished opportunities have precluded, or are likely to preclude, such firm from successfully competing in the open market. Examples of diminished capital and credit are lack of access to long-term financing or credit, working capital financing, equipment trade credit, raw materials, supplier trade credit, and bonding. The applicant must furnish documentation that credit was denied. An applicant firm that scores poorly on all financial measurements published by the Robert Morris Associates for liquidity, leverage, operating efficiency, and profitability is considered to be economically disadvantaged. Factors to be considered are:

7.a.i. - D.6 ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:1751,1752, and 1754.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, Division of Economically Disadvantaged Business Development, LR 23:50 (January 1997), amended LR 24:430 (March 1998), LR 25:1084 (June 1999).

Henry J. Stamper
Executive Director

9906#029

RULE

Board of Elementary and Secondary Education

Bulletin 741—Accountability System (LAC 28:I.901)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education adopted an amendment to Bulletin 741, referenced in LAC 28:I.901.A, promulgated by the Board of Elementary and Secondary Education in LR l:483 (November 1975). The amendment adds the School Accountability System as a part of Bulletin 741.

Title 28
EDUCATION
Part I. Board of Elementary and Secondary Education
Chapter 9. Bulletins, Regulations, and State Plans
Subchapter A. Bulletins and Regulations
§901. School Approval Standards and Regulations

A. Bulletin 741

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education LR 1:483 (November 1975), amended by the Board of Elementary and Secondary Education LR 24:1085 (June 1998), LR 25:1084 (June 1999).

Bulletin 741
Louisiana Handbook for School Administrators

I. Preface

A. The Louisiana Public Education Accountability system is intended to drive fundamental changes in classroom teaching by helping schools and communities focus on improved student achievement. The system is designed to encourage and support school improvement by:

1. clearly establishing the state's goals for schools and students;

2. creating an easy way to communicate to schools and the public how well a school is performing;

3. recognizing schools for their effectiveness in demonstrating growth in student achievement; and

4. focusing attention, energy, and resources on those schools that need help improving student achievement.

B. The accountability system is based on the concept of continuous growth. Every school can improve. Every school is expected to show academic growth. Every school is compared to itself.

1. The underlying beliefs of the accountability system are:

a. all students can and must learn at significantly higher levels;

b. the need to improve student achievement is urgent;

c. continuous growth in student achievement must occur in all schools;

d. the focus must be on measurable student achievement results;

e. poverty impacts student learning; however, it does not prevent students from achieving;

f. low-performing schools must receive technical assistance and necessary resources to improve;

g. rewards and corrective actions can motivate educators, communities, and students to improve student learning;

h. parents, educators, and community members should be involved in the ongoing development and revision of school and district improvement plans;

i. districts and school sites must have the flexibility to improve learning in schools;

j. the general public must be kept involved in and informed about the accountability process;

k. it is essential that all stakeholders (i.e., students, parents, educators, and community) work together to reach the state education goals;

l. the accountability system must be kept simple;

m. the State must provide adequate funding to support the accountability system and not back down on funding or standards once instituted.

2.006.00 Every School shall participate in a school accountability system based on student achievement as approved by the State Board of Elementary and Secondary Education.

Refer to R.S. 17:10.1

Indicators for School Performance Scores

2.006.01 A school's School Performance Score shall be determined using a weighted composite index derived from three or four indicators: criterion-referenced tests (CRT), norm-referenced tests (NRT), and student attendance for grades K-12, and dropout rates for grades 7-12.

Louisiana's 10- and 20-Year Education Goals

2.006.02 Each school shall be expected to reach 10- and 20-Year Goals that depict minimum educational performances.

Indicators	Grades Administered	10-Year Goal	20-Year Goal
CRT Tests (60 percent K-12)	Grades 4, 8, 10, 11	Average student score at BASIC	Average student score at PROFICIENT
NRT Tests (30 percent K-12)	Grades 3, 5, 6, 7, 9	Average composite standard score corresponding to the 55th percentile rank in the tested grade level	Average composite standard score corresponding to the 75th percentile rank in the tested grade level
Attendance (10 percent K-6; 5 percent 7-12)		95 percent (grades K-8) 93 percent (grades 9-12)	98 percent (grades K-8) 96 percent (grades 9-12)
Dropout Rate (5 percent 7-12)		4 percent (grades 7-8) 8 percent (grades 9-12)	2 percent (grades 7-8) 4 percent (grades 9-12)

School Performance Scores

2.006.03 A School Performance Score (SPS) shall be calculated for each school. This score shall range from 0-100 and beyond, with a score of 100 indicating a school has reached the 10-Year Goal and a score of 150 indicating a school has reached the 20-Year Goal. The lowest score that a given school can receive for each individual indicator index and/or for the SPS as a whole is "0."

Every year of student data shall be used as part of a school's SPS. The initial school's SPS shall be calculated using the most recent year's NRT and CRT test data and the prior year's attendance and dropout rates. Subsequent calculations of the SPS shall use the most recent two years' test data and attendance and dropout rates from the two years prior to the last year of test data used.

A baseline School Performance Score shall be calculated in Spring 1999 for Grades K-8 and in Spring 2001 for Grades 9-12.

During the summer of 1999 for K-8 schools and summer of 2001 for 9-12 schools, each school shall receive two School Performance Scores as follows:

- A score for regular education students, including gifted, talented, speech or language impaired, and 504 students.
- A score including regular education students AND students with disabilities eligible to participate in the CRT and/or NRT tests.
- For the purpose of determining Academically Unacceptable Schools, during the summer of 1999 for K-8 schools and during the summer of 2001 for 9-12 schools, the School Performance Score that includes only regular education students shall be used.

Formula for Calculating an SPS

The SPS for a sample school is calculated by multiplying the index values for each indicator by the weight given to that indicator and adding the total scores. In the example, [(66.0 * 60 percent) + (75.0 * 30 percent) + (50.0 * 10 percent)] = 67.1

Indicator	*Index Value*	*Weight*	*Indicator Score*
CRT	66.0	60 percent	39.6
NRT	75.0	30 percent	22.5
Attendance	50.0	10 percent	5.0
Dropout	N/A	0 percent	0
			SPS = 76.1

Criterion-Referenced Tests (CRT) Index Calculations

A school's CRT Index score equals the sum of the student totals divided by the number of student eligible to participate in state assessments. For the CRT Index, each student who scores within one of the following five levels shall receive the number of points indicated.

Advanced =	200 points
Proficient =	150 points
Basic =	100 points
Approaching Basic =	50 points
Unsatisfactory =	0 points

Formula for Calculating a CRT Index for a School

1. Calculate the total number of points by multiplying the number of students at each performance level times the points for those respective performance levels, for all content areas.
2. Divide by the total number of students eligible to be tested times the number of content area tests.
3. Zero shall be the lowest CRT Index score reported for accountability calculations.

Initial Transition Years

To accommodate the phase-in of Social Studies and Science tests for K-8 schools, the following CRT scores shall be used for each year:

1999 Baseline CRT Score =	1999 Math and English Language Arts (Grades 4 and 8)
2001 Comparison CRT Score =	2000 and 2001 Math and English Language Arts (both years averaged for each subject and each grade)
2001 *New* Baseline CRT Score =	2000 and 2001 Math, English, Social Studies, and Science (both years averaged for each subject and each grade)
2003 Comparison CRT Scores =	2002 and 2003 Math, English, Social Studies, and Science (both years averaged for each subject and each grade)

This re-averaging shall result in a re-calculated baseline to include science and social studies for K-8 schools in 2001. A similar schedule shall be used for 9-12 schools to begin with a 2001 baseline year.

Norm-Referenced Tests (NRT) Index Calculations
For the NRT Index, standard scores shall be used for computing the SPS. Index scores for each student shall be calculated, scores totaled, and then averaged together to get a school's NRT Index score.

NRT Goals and Equivalent Standard Scores

Composite Standard Scores Equivalent to
Louisiana's 10- and 20-Year Goals, by Grade Level *

		Grade				
Goals	Percentile Rank	3	5	6	7	9
10-Year Goal	55th	189	220	232	245	264
20-Year Goal	75th	201	237	252	267	288

* Source of percentile rank-to-standard score conversions: *Iowa Tests of Basic Skills, Norms and Score Conversions, Form M (1996) and Iowa Test of Educational Development, Norms and Score Conversions, with Technical Information, Form M (1996), Chicago, IL: Riverside Publishing Company.*

NRT Formulas Relating Student Standard Scores to NRT Index
Where the 10-year and 20-year goals are the 55th and 75th percentile ranks respectively and where SS = a student's standard score, then the index for that student is calculated as follows:

Grade 3:	Index 3rd grade = (4.167 * SS) - 687.6 SS = (Index 3rd grade + 687.6)/4.167
Grade 5:	Index 5th grade = (2.941 * SS) - 547.0 SS = (Index 5th grade + 547.0)/2.941
Grade 6:	Index 6th grade = (2.500 * SS) - 480.0 SS = (Index 6th grade + 480.0)/2.500
Grade 7:	Index 7th grade = (2.273 * SS) - 456.9 SS = (Index 7th grade + 456.9)/2.273
Grade 9:	Index 9th grade = (2.083 * SS) - 449.9 SS = (Index 9th grade + 449.9)/2.083

Formula for Calculating a School's NRT Index
1. Calculate the index for each student, using the grade-appropriate formula relating standard score to NRT Index.
2. Compute the total number of index points in all grades in the school.
3. Divide the sum of NRT Index points by the total number of students eligible to be tested.
4. Zero shall be the lowest NRT Index score reported for accountability calculations.

Attendance Index Calculations
An Attendance Index score for each school shall be calculated. The initial year's index shall be calculated from the prior year's attendance rates. Subsequent years' indices shall be calculated using the prior two years' average attendance rates as compared to the state goals.

Attendance Goals

	10-Year Goal	20-Year Goal
Grades K-8	95 percent	98 percent
Grades 9-12	93 percent	96 percent

Attendance Index Formulas
Grades K-8
Indicator (ATT K-8) = (16.667 * ATT) - 1483.4
Grades 9-12
Indicator (ATT 9-12) = (16.667 * ATT) - 1450.0
Where ATT is the attendance percentage, using the definition of attendance established by the State Department of Education

Lowest Attendance Index Score
Zero shall be the lowest Attendance Index score reported for accountability calculations.

Dropout Index Calculations
A Dropout Index score for each school shall be calculated. The initial year's index shall be calculated from the prior year's dropout rates. Subsequent years' indices shall be calculated using the prior two year's average dropout rates as compared to the state goals.

Dropout Goals

	10-Year Goal	*20-Year Goal*
Grades 7 and 8	4 percent	2 percent
Grades 9-12	8 percent	4 percent

Dropout Index Formulas
Non-Dropout Rate (NDO) = 100 - Dropout Rate (DO) (expressed as a percentage)

Grades 7 and 8	Dropout Index (7-8) = Indicator (DO Gr 7-8) = (25 * NDO) - 2300.0 NDO = (Indicator DO Gr 7-8 + 2300.0) /25
Grades 9-12	Dropout Index (9-12) = Indicator (DO Gr 9-12) = (12.5 * NDO) - 1050.0 NDO = (Indicator DO Gr 9-12 + 1050.0) /12.5

Lowest Dropout Index Score
Zero shall be the lowest Dropout Index score reported for accountability calculations.

Data Collection

2.006.04 A test score shall be entered for all eligible students within a given school. For any eligible student who does not take the test, including those who are absent, a score of "0" on the CRT and NRT shall be calculated in the school's SPS. To assist a school in dealing with absent students, the State Department of Education shall provide an extended testing period for test administration. The only exception to this policy is a student who was sick during the test and re-testing periods AND who has formal medical documentation for that period.

Growth Targets

2.006.05 Each school shall receive a Growth Target that represents the amount of progress it must make every two years to reach the state 10- and 20-Year Goals.

In establishing each school's Growth Target, the SPS inclusive of students with disabilities shall be used as the baseline. However, the percentage of students with disabilities varies significantly across schools and the rate of growth for such students, when compared to regular education students, may be different. Therefore, the proportion of students with disabilities eligible to participate in the CRT or NRT test in each school will be a factor in determining the Growth Target for each school.

Growth Targets
During the first ten years, the formula is the following:
[PropRE * (100 - SPS)/N] + [PropSE * (100 - SPS)/2N], or 5 points, *whichever is greater*
where
PropSE = the number of special education students in the school who are eligible to participate in the NRT or CRT tests, divided by the total number of students in the school who are eligible to participate in the NRT or CRT tests. For purposes of this calculation, gifted, talented, speech or language impaired, and 504 students shall not be counted as special education students, but shall be included in the calculations as regular education students.
PropRE = 1-PropSE. PropRE is the proportion of students not in special education.
SPS = School Performance Score
N = Number of remaining accountability cycles in the 10-Year Goal period
During the second ten years, the formula is the following:
[PropRE * (150 - SPS)/N] + [PropSE * (150 - SPS)/2N], or 5 points, *whichever is greater*

Growth Labels

2.006.06 A school shall receive a label based on its success in attaining its Growth Target.

Growth Labels
A school exceeding its Growth Target by 5 points or more shall receive a label of *Exemplary Academic Growth.*
A school exceeding its Growth Target by fewer than 5 points shall receive a label of *Recognized Academic Growth.*
A school improving, but not meeting its Growth Target, shall receive a label of *Minimal Academic Growth.*
A school with a flat or declining SPS shall receive a label of *School in Decline.*

When a school's SPS is greater than or equal to the state goal, "Minimal Academic Growth" and "School in Decline" labels shall no longer apply.

Performance Labels

2.006.07 A Performance Label shall be given to a school that qualifies, in addition to Growth Labels.

A school with an SPS of 30 or below shall be identified as an Academically Unacceptable School. This school immediately enters Corrective Actions.

For purpose of determining Academically Unacceptable Schools, during the summer of 1999 for K-8 schools and during the summer of 2001 for 9-12 schools, the SPS that includes only regular education students shall be used. Any school with an SPS of 30 or less, based on the test scores of regular education students only, shall be deemed an Academically Unacceptable School.

A school with an SPS of 100.0 - 124.9 shall be labeled a *School of Academic Achievement*.
A school with an SPS of 125.0 - 149.9 shall be labeled a *School of Academic Distinction.*
A school with an SPS of 150.0 or above shall be labeled a *School of Academic Excellence* and shall have no more Growth Targets.
A school with these labels shall no longer be subject to Corrective Actions and shall not receive "negative" growth labels, i.e., School in Decline and Minimal Academic Growth. This school shall continue to meet or exceed Growth Targets to obtain "positive" growth labels, recognition, and possible rewards.

Rewards/Recognition

2.006.08 A school shall receive recognition and possible monetary awards when it meets or surpasses its Growth Targets and when it shows growth in the performance of students who are classified as high poverty.

School personnel shall decide how any monetary awards shall be spent; however, possible monetary rewards shall not be used for salary or stipends. Other forms of recognition shall also be provided for a school that meets or exceeds its Growth Targets.

Corrective Actions

2.006.09 A school that does not meet its Growth Target shall enter into Corrective Actions. A school that enters Corrective Actions shall receive additional support and assistance, with the expectation that extensive efforts shall be made by students, parents, teachers, principals, administrators, and the school board to improve student achievement at the school. There shall be three levels of Corrective Actions.

Corrective Actions Level I: Working with District Assistance Teams, a school shall utilize a state diagnostic process to identify school needs, redevelop school improvement plans, and examine the use of school resources.

Corrective Actions Level II: A highly trained Distinguished Educator (DE) shall be assigned to a school by the state. The DE shall work in an advisory capacity to help the school improve student performance. The DE shall make a public report to the school board of recommendations for school improvement. Districts shall then publicly respond to these recommendations. If a school is labeled as Academically Unacceptable, parents shall have the right to transfer their child to a higher performing public school (See Transfer Policy Standard Number 2.006.11).

Corrective Actions Level III: The DE shall continue to serve the school in an advisory capacity. Parents shall have the right to transfer their child to a higher performing public school (See Transfer Policy, Standard Number 2.006.11). A district must develop a Reconstitution Plan for the school at the beginning of the first year in this level and submit the plan to SBESE for approval.
If a Corrective Actions Level III school has achieved at least 40 percent of its Growth Target or 5 points, whichever is greater, during its first year, then that school may proceed to a second year in Level III. If such minimum growth is not achieved during the first year of Level III, but SBESE has approved its Reconstitution Plan, then the school shall implement the Reconstitution Plan during the beginning of the next school year. If SBESE does not approve the Reconstitution Plan AND a given school does not meet the required minimum growth, the school shall lose state approval and all state funds.
Any reconstituted School's SPS and Growth Target shall be re-calculated utilizing data from the end of its previous year. SBESE shall monitor the implementation of the Reconstitution Plan.

A school initially enters Corrective Actions Level I if it has an SPS of 30 or less or if it has an SPS of less than 100 and fails to reach its Growth Target.

A school moves into a more intensive level of Corrective Actions when adequate growth is not demonstrated during each 2-year cycle.
A school with an SPS of 30 or less, i.e., Academically Unacceptable School, shall move to the next level of Corrective Actions as long as its score is 30 or less.
A school with an SPS of 30.1 to 50.0 shall move to the next level of Corrective Actions if it grows fewer than 5 points. If it grows 5 points or more each cycle, but less than its Growth Target, a school may remain in Corrective Actions Level I for two cycles and Corrective Actions Level II for one cycle.
A school with an SPS of 50.1 to 99.9 shall remain in Corrective Actions Level I as long as its growth is at least its Growth Target minus 5 points, but not less than 0.1 points. During the first 10-year cycle, there is no maximum number of cycles that such a school can stay in Level I as long as this minimum growth is shown each cycle.

A school exits Corrective Actions if its School Performance Score is above 30 and the school achieves its Growth Target.

Corrective Actions Summary Chart

School Level Tasks

Level I

1) Utilize state diagnostic process to identify needs; and
2) Develop/implement a consolidated improvement plan, including an integrated budget; process must include: a) opportunities for significant parent and community involvement, b) public hearings, and c) at least two-thirds teacher approval

Level II

1) Work with advisory Distinguished Educator, teachers, parents, and others to implement revised School Improvement Plan; and
2) Distinguished Educator works with principals to develop capacity for change

Level III

1) Distinguished Educator continues to assist with improvement efforts and the design of that school's Reconstitution Plan

Reconstitution or No State Approval/No Funding

1) If Reconstitution Plan is approved by SBESE: a) implement Reconstitution Plan, and b) utilize data from the end of the previous year to re-calculate school performance goals and Growth Targets. If Reconstitution Plan is not approved, no state approval/no state funding

District Level Tasks

Level I

1) Create District Assistance Teams to assist schools;
2) Publicly identify existing and additional assistance being provided by districts, such as funding, policy changes, and greater flexibility;
3) As allowed by law, reassign or remove school personnel as necessary; and
4) For Academically Unacceptable schools, ensure schools receive at least their proportional share of applicable state, local, and federal funding.

Level II

1) District Assistance Teams continue to help schools;
2) Hold public hearing and respond to Distinguished Educators' written recommendations;
3) As allowed by law, local boards reassign or remove personnel as necessary; and
4) For Academically Unacceptable Schools, authorize parents to send their children to other public schools

Level III

1) District Assistance Teams shall continue to help schools;
2) Authorize parents to send their children to other public schools;
3) Design Reconstitution Plan; and
4) At the end of year one, one of the following must occur: a) schools must make adequate growth of at least 40 percent of the Growth Target or 5 points, whichever is greater; b) District shall develop Reconstitution Plan to be approved by SBESE; and c) SBESE grants non-school approval status

Reconstitution or No State Approval/Funding

1) If Recommendation Plan is approved by SBESE, provide implementation support. If the Reconstitution Plan is not approved, no state approval/no state funding

State Level Tasks

Level I

1) Provide diagnostic process for schools;
2) Provide training for District Assistance Teams;
3) For some Academically Unacceptable Schools only, SBESE assigns advisory Distinguished Educators to schools; and
4) Work to secure new funding and/or redirect existing resources to help schools implement their improvement plans

Level II

1) Assign advisory Distinguished Educator to schools; and
2) Work to secure new funding and/or redirect existing resources to help schools implement their improvement plans

Level III

1) Assign advisory Distinguished Educator to schools for one additional year;
2) At end of Year 1, SBESE approves or disapproves Reconstitution Plans; and
3) Work to secure new funding and/or redirect existing resources to help schools implement their improvement plans

Reconstitution or No State Approval/No Funding

1) If Reconstitution Plan is approved by SBESE, a) monitor implementation of reconstitution plan; and b) provide additional state improvement funds; and
2) If Reconstitution Plan is not approved, no state approval/state funding

Reconstitution Plan

2.006.10 Districts shall develop and submit a Reconstitution Plan to SBESE for approval for any school in Correction Actions Level III during the first year in that level. This Reconstitution Plan indicates how the district shall remedy the school's inadequate growth in student performance. The plan shall specify how and what reorganization shall occur and how/why these proposed changes shall lead to improved student performance.

If a Corrective Actions Level III school has grown at least 40 percent of its Growth Target or 5 points, whichever is greater, during its first year, then that school may continue another year in Level III. If such minimum growth is not achieved during the first year, but SBESE has approved its Reconstitution Plan, then the school shall implement the Reconstitution Plan during the beginning of the next school year. If SBESE does not approve the Reconstitution Plan AND a given school does not meet the required minimum growth, it shall lose state approval and all state funds.

Transfer Policy

2.006.11 Parents shall have the right to transfer their child to another public school when an Academically Unacceptable School begins Correction Actions Level II or any other school begins Correction Actions Level III.

Transfers shall not be made to Academically Unacceptable Schools or any school undergoing Corrective Actions Level II or Level III.

Upon parental request, districts shall transfer the child to the nearest acceptable school prior to the October 1 student membership count.

If no academically acceptable school in the district is available, the student may transfer to a neighboring district. Parents shall provide the transportation to the school. State dollars shall follow the child when such a transfer occurs.

Schools and districts may refuse to accept a student if there is insufficient space, if a desegregation order prevents such a transfer, or if the student has been subjected to disciplinary actions for behavioral problems.

Progress Report

2.006.12 The SBESE shall report annually on the state's progress in reaching its 10- and 20-Year Goals. The State Department of Education shall publish an individual School Report Card to provide information on every school's performance. The School Report Card shall include the following information: School Performance Scores, school progress in reaching Growth Targets, school performance when compared to similar (like) schools, and subgroup performances.

Appeals Procedures

2.006.13 The State Department of Education shall define "appeal" what may be appealed, and the process that the appeal shall take.

Student Mobility

2.006.14 As a general rule, the test score of every eligible student who takes a test at a given school shall be included in that school's performance score regardless of how long that student has been enrolled in that school. A school that has at least 10 percent of its students transferring from outside the district and enrolled in the school after October 1 may request that the State Department of Education calculate what its SPS would have been if such out-of-district enrollees had not been included. If there is at least a 5 point difference between the two School Performance Scores, then the school may appeal any negative accountability action taken by the state, e.g., movement into Corrective Actions, application of growth labels.

Pairing/Sharing of Schools with Insufficient Test Data

2.006.15 In order to receive an SPS, a given school must have at least one grade level of CRT testing and at least one grade level of NRT testing. A school that does not meet this requirement must either be "paired or shared" with another school in the district as described below. For the purpose of the State Accountability System, such a school shall be defined as a "non-standard school."

A school with a grade-level configuration such that it participates in neither the CRT test nor in the NRT test (e.g., a K, K-1, K-2 school) must be "paired" with another school that has at least one grade level of CRT testing and one grade level of NRT testing. This "pairing" means that a single SPS shall be calculated for both schools by averaging both schools' attendance and/or dropout data and using the test score data derived from the school that has at least two grade levels of testing.

A school with a grade-level configuration where students participate in either CRT or NRT testing, but not both (e.g., a K-3, 5-6 school), must "share" with another school that has at least one grade level of the type of testing missing. Both schools shall "share" the missing grade level of test data. This shared test data must come from the grade level closest to the last grade level in the non-standard school. The non-standard school's SPS shall be calculated by using the school's own attendance, dropout, and testing data AND the test scores for just one grade from the other school.

A district must identify the school where each of its non-standard schools shall be either "paired or shared." The "paired or shared" school must be the one that receives by promotion the largest percentage of students from the non-standard school. In other words, the "paired or shared" school must be the school into which the largest percentage of students "feed." If two schools receive an identical percentage of students from a non-standard school, the district shall select the "paired or shared" school.

Once the identification of "paired or shared" schools has been made, this decision is binding for 10 years. An appeal to SBESE may be made to change this decision prior to the end of 10 years, only if a redistricting or other significant attendance change occurs.

New Schools and/or Significantly Reconfigured Schools

2.006.16 For a newly formed school, the school district may petition SBESE, following existing procedures, to have a new site code assigned to that school. Once the site code is assigned, the school shall receive its initial baseline SPS the summer following its second year of operation, since it shall need two years of testing data and one year of attendance and/or dropout data.

The district may also petition SBESE for a new SPS for a school with significant reconfiguration from the previous year, where such significant reconfiguration varies at least 50 percent from the previous year's grade structure and/or size. For example, a K-4 school changes to a K-8 school, or a given school's population decreases in half or doubles in size from one year to the next. If SBESE grants a new SPS and agrees that this is a significant reconfiguration, this school would receive a new baseline SPS during the summer following its second year of operation.

A school that has population and/or grade configuration change from the previous year of less than 50 percent, but more than 25 percent, is not eligible for a new SPS. Instead, such school may appeal any state accountability decisions made as a result of not meeting its Growth Targets, e.g., movement into Corrective Actions.

Inclusion of Alternative Education Students

2.006.17 Each superintendent, in conjunction with the alternative school director, shall choose from one of two options for including alternative education students in the State Accountability System for the system's alternative education schools.

Option I The score for every alternative education student at a given alternative school shall be returned to ("sent back") and included in the home-based school's SPS. The alternative school itself shall receive a "diagnostic" SPS, not to be used for rewards or Corrective Actions, if a statistically valid number of students were enrolled in the school at the time of testing.

Option II The score for every alternative education student shall remain at the alternative school. The alternative school shall be given its own SPS and Growth Target, which makes the alternative school eligible for rewards and Corrective Actions.

In order to be eligible for Option II, an alternative school shall meet all of the following requirements:

- The alternative school must have its own site code and operate as a school;
- The alternative school must have a required minimum number of students in the tested grade levels. The definition of "required minimum" is to be determined; and
- At least fifty percent (50 percent) of the total school population must have been enrolled in the school for the entire school year, October 1 - May 1.

Once an option is selected for an alternative school, it shall remain in that option for at least 10 years. An appeal to SBESE may be made to change the option status prior to the end of 10 years if a school's purpose and/or student eligibility changes.

An alternative school that chooses Option II shall receive an initial baseline SPS during summer of 1999 if the majority of its students are in grades K-8. If the majority of its students are in grades 9-12, an alternative school shall receive its baseline SPS during the summer of 2001.

All students pursuing a regular high school diploma, working in curriculum developed from Louisiana Content Standards, shall be included in the state-testing program, with those scores included in an SPS.

Students 16 years of age and older who are enrolled in a Pre-GED program, not pursuing a regular high school diploma, shall not be included in the state-testing program nor in an SPS. Information on these students, e.g., number receiving a GED, shall be reported in the school's report card as a sub-report.

An alternative school in Corrective Actions II may request some flexibility in obtaining assistance from either a Distinguished Educator (DE) or a team designed to address the special needs of the alternative school population, as long as the total costs for the team do not exceed that for the DE. Sample team members could include the following: social workers, psychologists, educational diagnosticians, and counselors, etc.

Inclusion of Lab Schools and Charter Schools

Such schools shall be included in the State Accountability System following the same rules that apply to traditional and/or alternative schools. The only exceptions are that Lab Schools and Type 1, 2, and 3 Charter Schools are "independent" schools and cannot be "paired" or "shared" with another school if they do not have at least one CRT and one NRT grade level, and/or if there is no "home-based" district school to which a given student's scores can be returned if all three conditions for Option II cannot be met. Therefore, if they do not have the required grade levels and/or required minimum number of students, such schools cannot receive an SPS. Instead, the state shall publish the results from pre- and post-test student achievement results, as well as other relevant accountability data, as part of that school's report card. This policy is to be revisited during the year 2001.

For the 1999-2000 academic school year, detention and Department of Corrections facilities shall NOT receive an SPS.

Inclusion of Students with Disabilities

2.006.18 All students, including those with disabilities, shall participate in Louisiana's new testing program. The scores of all students who are eligible to take the CRT and the NRT tests shall be included in the calculation of the SPS. Most students with disabilities, approximately 80 percent of students with disabilities, shall take the CRT and the NRT tests with accommodations, if required by their Individualized Education Plan (IEP). A small percentage of students with very significant disabilities, approximately 20 percent of students with disabilities, shall take an alternate assessment, as required by their IEP.

Weegie Peabody
Executive Director

9906#065

RULE

Board of Elementary and Secondary Education

Bulletin 746—Alternative Process Issuance of Permanent Regular Teacher Certificate Non-Public Schools
(LAC 28:I.903)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education adopted an amendment to Bulletin 746, Louisiana Standards for State Certification of School Personnel, referenced in LAC 28:I.903.A. The amendment adds an alternative process for the issuance of a permanent regular teacher certificate for non-public school teachers.

Title 28
EDUCATION
Part I. Board of Elementary and Secondary Education
Chapter 9. Bulletins, Regulations, and State Plans
Subchapter A. Bulletins and Regulations
§903. Teacher Certification Standards and Regulations

A. Bulletin 746

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A) (10) (11) (15); R.S. 17:7 (6); R.S. 17:10, R.S. 17:22 (6) R.S. 17:391.1-391.10; R.S. 17:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education in LR 1:183, 311, 399, 435, 541 (April, July, September, October, December 1975), amended LR 24:283 (February 1998), LR 24:1091 (June 1998), LR 24:2078 (November 1998), LR 25:1090 (June 1999).

Bulletin 746—Teacher Certification Standards and Regulations

* * *

HIGHER CERTIFICATES FOR TEACHERS IN NON-PUBLIC SCHOOLS WHO HAVE NOT COMPLETED THE STATE TEACHER ASSESSMENT PROGRAM

I. Louisiana state certified teachers teaching in any approved non-public school shall be awarded a permanent teaching certificate provided they have successfully:

1. taught for three (3) years in the teacher's area of certification;

2. completed a teacher assessment program for three consecutive years at the same non-public school. This assessment shall be performed by the non-public school principal and shall, as a minimum, include satisfactory assessment of the teacher's performance in the following areas: planning, management, instruction and professional development.

The three years of teaching in the area of certification and the three consecutive years of teacher assessment may be

accomplished concurrently or during different school years. The principal of the non-public school shall certify when the above criteria have been met.

Teachers in a non-public school who have taught three consecutive years in the same non-public school and who have completed the school based teacher assessment program successfully are eligible for a "B*" certificate which is valid in non-public schools only. The asterisk behind the "B" would refer to a statement at the bottom of the certificate which reads:

> If this teacher enters a public school system in Louisiana, he/she will be required to successfully complete the state teacher assessment program.

The same asterisk would appear on the "A" certificate. The accumulation of the required three (3) years of experience begins with the 1998-99 school year.

II. Any non-public school that would like for its teachers to participate in state teacher assessment will be allowed to do so.

* * *

Weegie Peabody
Executive Director

9906#063

RULE

Student Financial Assistance Commission
Office of Student Financial Assistance

Commission Bylaws (LAC 28:V.113)

The Louisiana Student Financial Assistance Commission (LASFAC), the statutory body created by R.S. 17:3021 et seq., in compliance with §952 of the Administrative Procedure Act, hereby revises its governing bylaws, as follows.

Title 28
EDUCATION
Part V. Student Financial Assistance—Higher Education Loan Program
Chapter 1. Student Financial Assistance Commission Bylaws
§113. Rights Duties and Responsibilities of the Executive Staff of the Commission

A. - B.6. ...

7. Annually, on or before September 30, an evaluation of the executive director's job performance and compensation shall be conducted by the commission. These evaluations shall be conducted using a format adopted by the commission for these purposes. Changes to the compensation structure adopted by the commission shall be effective on July 1 of the year in which the evaluation is performed.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:321.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:810 (September 1996), amended LR 24:1265 (July 1998), LR 25:1091 (June 1999).

Jack L. Guinn
Executive Director

9906#006

RULE

Student Financial Assistance Commission
Office of Student Financial Assistance

Tuition Opportunity Program for Students (TOPS)
Maintaining Eligibility (LAC 28:IV.705, 805, 907)

The Louisiana Student Financial Assistance Commission (LASFAC) hereby revises the provisions of the Tuition Opportunity Program for Students (TOPS), effective for TOPS recipients beginning with the spring semester, 1999.

Title 28
EDUCATION
Part IV. Student Financial Assistance—Higher Education Scholarship and Grant Programs
Chapter 7. Tuition Opportunity Program for Students (TOPS) Opportunity; Performance and Honors Award
§705. Maintaining Eligibility

A.1. - 5. ...

6. continue to enroll and accept the TOPS award as a full-time undergraduate student in an eligible postsecondary institution, as defined in §1901, and maintain an enrolled status throughout the academic term, unless granted an exception for cause by LASFAC; and

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:642 (April 1998), amended LR 24:1911 (October 1998), LR 25:1091 (June 1999).

Chapter 8. TOPS-TECH Award
§805. Maintaining Eligibility

A.1. - 5. ...

6. continue to enroll and accept the TECH award as a full-time student in an eligible postsecondary institution, as defined in §1901, and maintain an enrolled status throughout the school term, unless granted an exception for cause by LASFAC; and

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:642 (April 1998), amended LR 24:1911 (October 1998), LR 25:1091 (June 1999).

Chapter 9. TOPS Teacher Award

§907. Maintaining Eligibility

A.1. - 4. ...

5. continue to enroll each subsequent semester or quarter as a full-time student in a degree program or course of study leading to a degree in education or alternative program leading to regular certification as a teacher at the elementary or secondary level, and maintain an enrolled status throughout the academic term, unless granted an exception for cause by LASFAC; or

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 24:642 (April 1998), amended LR 24:1911 (October 1998), LR 25:1092 (June 1999).

Jack L. Guinn
Executive Director

9906#005

RULE

Tuition Trust Authority
Office of Student Financial Assistance

Recording Secretary (LAC 28:VI.213)

The Louisiana Tuition Trust Authority (LATTA), the statutory body created by R.S. 17:3093 et seq., in compliance with the Administrative Procedure Act, R.S. 49:950 et seq., hereby revises its governing bylaws, as follows.

Title 28
EDUCATION
Part VI. Student Tuition Trust Authority

Chapter 2. Bylaws

§213. Rights, Duties and Responsibilities of Executive Staff of the Authority

A. - E. ...

F. Recording Secretary. The executive director shall appoint a recording secretary whose duties shall include giving or causing to be given notice of all meetings of the authority and its committees as required by the Administrative Procedure Act or these Bylaws, to record and prepare the minutes of all authority meetings and meetings of its committees and to maintain and provide for the safekeeping of all minutes and other official documents of the authority. The recording secretary shall have the authority to provide copies of the official records of the authority as required by the public records laws of the State of Louisiana or as otherwise directed by the authority or the executive director and to certify the authenticity of such records and the signatures of members of the authority, the executive directors or others acting in their official capacity on behalf of the authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3093 et seq.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:1657 (December 1997), amended LR 25:1092 (June1999).

Jack L. Guinn
Executive Director

9906#007

RULE

Department of Environmental Quality
Office of Water Resources
Water Pollution Control Division

Procedures for Modifying Approved
POTW Pretreatment Programs
(LAC 33:IX.2715, 2721 and 2735)(WP031*)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Water Quality regulations, LAC 33:IX.2715, 2721, and 2735 (WP031*).

This rule is identical to a federal regulation found in 62 FR 38405-38415, Number 137, July 17, 1997, which is applicable in Louisiana. For more information regarding the federal requirement, contact the Investigations and Regulation Development Division at the address or phone number given below. No fiscal or economic impact will result from the rule; therefore, the rule will be promulgated in accordance with R.S. 49:953(F)(3) and (4).

This rule corrects typographical errors and omissions made in WP030*, which was a final rule in November 1998. These changes will equate Louisiana regulations for streamlined procedures for modifying approved pretreatment programs to the EPA federal regulations. The basis and rationale for this rule are to mirror the federal regulations.

This rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33
ENVIRONMENTAL QUALITY
Part IX. Water Quality Regulations

Chapter 23. The Louisiana Pollutant Discharge Elimination System (LPDES) Program

Subchapter T. General Pretreatment Regulations for Existing and New Sources of Pollution

§2715. Pretreatment Program Requirements: Development and Implementation by POTW

* * *

[See Prior Text in A - F.5.d]

6. The POTW shall prepare and maintain a list of its industrial users meeting the criteria in LAC 33:IX.2705.*Significant Industrial User*.a. The list shall identify the criteria in LAC 33:IX.2705.*Significant Industrial User*.a applicable to each industrial user and, for industrial users meeting the criteria in LAC

33:IX.2705.*Significant Industrial User*.a.ii shall also indicate whether the POTW has made a determination in accordance with LAC 33:IX.2705.*Significant Industrial User*.b that such industrial user should not be considered a significant industrial user. The initial list shall be submitted to the approval authority in accordance with LAC 33:IX.2717 as a nonsubstantial program modification in accordance with LAC 33:IX.2735.D. Modifications to the list shall be submitted to the approval authority in accordance with LAC 33:IX.2723.I.1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 24:2122 (November 1998), LR 25:1092 (June 1999).

§2721. Approval Procedures for POTW Pretreatment Programs and POTW Granting of Removal Credits

The following procedures shall be adopted in approving or denying requests for approval of POTW Pretreatment Programs and applications for removal credit authorization.

* * *

[See Prior Text in A - B.1.a]

i. mailing notices of the request for approval of the submission to designated 208 planning agencies, federal and state fish, shellfish, and wildlife resource agencies (unless such agencies have asked not to be sent the notices); and to any other person or group who has requested individual notice, including those on appropriate mailing lists; and

ii. publication of a notice of request for approval of the submission in a newspaper(s) of general circulation within the jurisdiction(s) served by the POTW that provides meaningful public notice.

* * *

[See Prior Text in B.1.b - F]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 25:1093 (June 1999).

§2735. Modification of POTW Pretreatment Programs

* * *

[See Prior Text in A - B.1]

a. modifications that relax POTW legal authorities (as described in LAC 33:IX.2715.F.1), except for modifications that directly reflect revision to the general pretreatment regulations, LAC 33:IX.Chapter 23.Subchapter T or Subchapter N, and reported in accordance with Subsection D of this Section;

b. modifications that relax local limits, except for the modifications to local limits for pH and reallocations of the Maximum Allowable Industrial Loading of a pollutant that do not increase the total industrial loadings for the pollutant, which are reported in accordance with Subsection D of this Section. Maximum Allowable Industrial Loadings mean the total mass of a pollutant that all industrial users of a POTW (or a subgroup of industrial users identified by the POTW) may discharge in accordance with limits developed under LAC 33:IX.2709.C;

* * *

[See Prior Text in B.1.c - B.1.g]

C. Approval Procedures for Substantial Modifications

* * *

[See Prior Text in C.1 - C.2]

3. The approval authority need not publish a notice of decision under LAC 33:IX.2721.E, provided the notice of request for approval under LAC 33:IX.2721.B.1 states that the request will be approved if no comments are received by a date specified in the notice, no substantial comments are received, and the request is approved without change.

* * *

[See Prior Text in C.4 - D.3]

E. Incorporation in the Permit. All modifications shall be incorporated into the POTW's LPDES permit upon approval. The permit will be modified to incorporate the approved modification in accordance with LAC 33:IX.2385.A.7.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 24:2122 (November 1998), LR 25:1093 (June 1999).

Linda Korn Levy
Assistant Secretary

9906#015

RULE

Office of the Governor
Office of Elderly Affairs

FY 1998-99 State Plan on Aging
(LAC 4:VII.1317)

In accordance with Louisiana Revised Statutes 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Governor's Office of Elderly Affairs (GOEA) hereby amends LAC 4:VII.1317, the FY 1998-1999 Louisiana State Plan on Aging, effective July 1, 1999. This rule change is in accordance with the Code of Federal Regulation, 45 CFR 1321.19 "Amendments to the State Plan," and 45 CFR 1321.35 "Withdrawal of area agency designation" (Vol. 53. Number 169 pages 33769 and 33770). The purposes of this rule change are: (1) to reverse the designation of the Governor's Office of Elderly Affairs as the Area Agency on Aging for the Planning and Service Area (PSA) of Calcasieu parish; (2) to designate Calcasieu parish as the Planning and Service Area; and (3) to designate Calcasieu Council on Aging, Inc. as the Area Agency on Aging for the Calcasieu PSA.

The FY 1998-1999 Louisiana State Plan on Aging was adopted and published by reference in the September 20, 1997 issue of the *Louisiana Register*, Volume 23, Number 9. The full text of the State Plan may be obtained from the Office of the State Register at 1051 North Third Street, Room 512, Baton Rouge, LA 70802.

Title 4
ADMINISTRATION
Part VII. Governor s Office
Chapter 13. State Plan on Aging
§1317. Area Agencies on Aging

Area Agency on Aging	Planning and Service Area (Parishes Served)
Allen COA	Allen
Beauregard COA	Beauregard
Bienville COA	Bienville
Bossier COA	Bossier
Caddo COA	Caddo
CAJUN Area Agency on Aging (AAA)	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, St. Mary, Vermilion
Calcasieu COA	Calcasieu
Caldwell COA	Caldwell
Cameron COA	Cameron
Capital Area Agency on Aging (AAA)	Ascension, Assumption, East Feliciana, Iberville, Pointe Coupee, St. Helena, Tangipahoa, Washington, West Baton Rouge, West Feliciana
CENLA Area Agency on Aging (AAA)	Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Winn
Claiborne COA	Claiborne
DeSoto COA	DeSoto
East Baton Rouge COA	East Baton Rouge
Jefferson COA	Jefferson
Jefferson Davis COA	Jefferson Davis
Lafourche COA	Lafourche
Lincoln COA	Lincoln
Livingston COA	Livingston
Madison COA	Madison
Morehouse COA	Morehouse
Natchitoches COA	Natchitoches
North Delta (AAA)	East Carroll, Franklin, Jackson, Richland, Tensas, Union
New Orleans COA	Orleans
Ouachita COA	Ouachita
Plaquemines COA	Plaquemines
Red River COA	Red River
Sabine COA	Sabine
St. Bernard COA	St. Bernard
St. Charles COA	St. Charles
St. James AAA	St. James
St. John COA	St. John
St. Tammany COA	St. Tammany
Terrebonne COA	Terrebonne
Vernon COA	Vernon
Webster COA	Webster
West Carroll COA	West Carroll

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:932(8).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Office of Elderly Affairs, LR 19:1317 (October 1993), repealed and promulgated LR 23:1146 (September 1997), amended LR 24:1110 (June 1998), LR 25:1094 (June 1999).

Paul F. "Pete" Arceneaux, Jr.
Executive Director

9906#020

RULE

Department of Health and Hospitals
Board of Examiners in Dietetics and Nutrition

Dietetics and Nutrition
(LAC 46:LXIX.Chapter 1)

The Louisiana Board of Examiners in Dietetics and Nutrition adopts the following rules into the Board's General Rules.

The rules define and clarify terms that are currently included in the Louisiana Dietetic/Nutrition Practice Act. Further, the rules outline in accordance with the Administrative Procedure Act and the Disciplinary Manual for Occupational Licensing Boards, the procedures that the Board will use in the investigation of complaints, the process for holding compliance and disciplinary hearings, and a list of the disciplinary options available to the Board for sanctioned licensees.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LXIX. Registered Dietitians
Chapter 1. Dietitians/Nutritionists
§101. Definitions

* * *

Application—any person who has applied to the board for a license or permit to engage in the practice of dietetics/nutrition in the state of Louisiana.

* * *

Diet Instruction—the process of imparting knowledge related to a specific nutrition plan. It does not include the dynamics of interpretation of the nutrition assessment, deliberation, development or change in a nutrition plan, all of which are within the scope of *Dietetics/Nutrition Practice*.

Dietetic Nutrition Practice and Medical Nutrition Therapy—may be used interchangeably.

* * *

Incidental to the Practice of Their Profession—as specified in that profession's practice act or licensure law in

the State of Louisiana as interpreted by that profession's regulatory board or agency.

* * *

Nutrition Counseling—the provision of individualized guidance on appropriate food and nutrient intake for those with special needs, taking into consideration health, cultural, socioeconomic, functional and psychological facts from the nutrition assessment. Nutrition counseling may include advice to increase or decrease nutrients in the diet; to change the timing, size of composition of meals; to modify food textures; and in extreme instances, to change the route of administration.

Nutrition Education—imparts information about food and nutrients, diet lifestyle factors, community nutrition resources and services to people to improve their nutrition.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:435 (July 1988), amended LR 25:1094 (June 1999).

§113. Rules for Professional Conduct

Licensees, under the act shall perform their professional duties using the following Code of Ethics which reflect the ethical principles of the dietetic/nutrition professional and outline obligations of the licensee to self, client, society and the profession.

A. - C. ...

D. The licensee will not be negligent in his practice and assumes responsibility and accountability for personal competence in practice through continuing education and recognition of the limits of his ability and adherence to accepted standards of practice.

E. - G. ...

H. The licensee shall not be addicted to or dependent upon alcohol or other habit-forming drugs or be a habitual user of narcotics, barbiturates, amphetamines, hallucinogenics, or other drugs having similar effects upon the competency of the licensee. When such substances are prescribed by a physician, the licensee will not practice if the medications adversely affects his mental competency.

I. ...

J. A failure to adhere to the above Code of Ethics, or a violation of the above Rules for Professional Conduct constitutes unprofessional conduct and a violation of lawful rules and regulations adopted by the board and further constitutes grounds for disciplinary action specified in R.S. 37:3090 of the Dietitian/Nutritionist Practice Act and these Rules and Regulations and also constitutes grounds for a denial of licensure or a renewal of licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:437 (July 1988), amended LR 25:1095 (June 1999).

§115. Denial, Suspension or Revocation of License

A. Certificate denial, suspension or revocation shall be accomplished in accordance with Section 3090(A) of R.S. 37:3081-3093, the State Administrative Procedure Act, and the Procedural Rules provided in 46:LXIX.Chapter 5.

B. The board may refuse to issue a license or provisional license, or suspend, revoke or impose probationary conditions and restrictions on the license or provisional license of a person on a finding of any of the causes provided by §3090.A and B of the Dietitian/Nutritionist Practice Act.

C. A suspended license shall be subject to expiration and may be renewed as provided in §115, but such renewal shall not entitle the licensee, while the license remains suspended and until he is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order of judgment by which the license was suspended. If a license is revoked on disciplinary grounds and is reinstated, the licensee, as a condition of reinstatement, shall pay the renewal fee and any late fee that may be applicable.

D. Disciplinary Options Available to the Board. In accordance with R.S. 37:3085; R.S. 37:3088 and R.S. 37:3090, the following disciplinary options are available to the board.

1. Revocation. The involuntary termination of the licensee's license.

2. Suspension. The licensee is not permitted to practice for a specified period of time. Rehabilitative conditions may be imposed to run concurrently with the suspension period.

3. Probation. The licensee is permitted to practice, but the board has imposed conditions upon the practice or the practitioner including, but not limited to, rehabilitation. Once the time period has elapsed, and the licensee has complied with the terms of probation and/or rehabilitation, the board will allow the practitioner to resume practice unconditionally.

4. Restriction of License. A reduction in the scope of practice.

5. Censure. The board makes an official statement of censure ship concerning the individual.

6. Reprimand. Similar to censure. The board reproves the licensee. There may be public or private reprimands.

7. Restitution. Requirement imposed upon the licensee that he make financial or other restitution to a client or other injured party.

E. Publication of Disciplinary Action. The board will notify the professional community within 30 days of any disciplinary action, including the disciplined licensee's name, location, offense and sanction imposed. A notice of disciplinary action will also be published in the board's newsletter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 14:438 (July 1988), amended LR 25:1095 (June 1999).

Chapter 5. Procedural Rules

§501. Authority

A. Consistent with the legislative purpose enumerated in R.S. 37:3081-3093, and to further protect the safety and welfare of the public of this state against unauthorized, unqualified and improper practice of dietetics and nutrition,

the following rules of procedure are established under this board's specific rulemaking authority of R.S. 37:3085 and R.S. 49:952 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1095 (June 1999).

§503. Investigation of Complaints

A. The board is authorized to receive complaints against licensees or applicants from any person.

B. Any complaint bearing on a licensee's professional competence, conviction of a crime, unauthorized practice, violation of provisions of the Dietitian/Nutritionist Practice Act or Board Rules and Regulations, mental competence, neglect of practice or violation of the state law or ethical standards where applicable to the practice of dietetics and nutrition, should be submitted to the board.

C. Once a written and signed complaint is received, the board will initiate a review of the allegations. The board may dispose of the complaint informally through correspondence or conference with the licensee and/or the complainant which may result in a consent order agreeable to both parties. If the licensee stipulates to the complaint and waives his right to formal hearing, the board may impose appropriate sanctions without delay. If the board finds that a complaint cannot be resolved informally, the written complaint will be forwarded to the board's designated Complaint Investigation Officer (hereinafter referred to as the CIO) for investigation.

D. The board's CIO shall have authority to investigate the nature of the complaint through conference and correspondence directed to those parties or witnesses involved. The officer shall send the involved licensee notice of the investigation, containing a short summary of the complaint and any questions the officer may direct to the licensee relative to the complaint. All letters to the involved licensee, the complainant, or any other witness, shall be sent by registered mail, with the designation "Personal and Confidential" clearly marked on the outside of the envelope.

E. The CIO shall conclude the investigation as quickly as possible without compromising thoroughness. Unless good cause is shown by the CIO satisfactory to the board, which may extend the time for the investigation, the investigation and recommended action shall be completed within 60 days of the date the CIO first receives the complaint.

F. The CIO shall make a recommendation to the board for disposition by informal hearing, formal hearing or dismissal of the complaint. When the CIO's recommended action might lead to denial, suspension, or revocation of the certificate, the board shall immediately convene a formal adjudication hearing, pursuant to R.S. 37:3090.B. The officer may determine that the licensee's explanation satisfactorily answers the complaint and may recommend to the Board that the matter be dropped. The recommended remedial action or dismissal of the complaint shall be forwarded to the involved complainant and licensee.

G. The CIO may also resolve the complaint through a consent order entered into by the licensee and the complainant. If the order contains any agreement by the licensee to some remedial course of action, the agreement must be signed by the complainant, the licensee and the board. The CIO will make note of any settlement arrived at between the complainant and the licensee, but such a settlement does not necessarily preclude further disciplinary action by the board.

H. If the CIO's recommendation for informal hearing is accepted by the board, the officer shall notify the licensee of the time and place of the conference and of the issues to be discussed. The licensee shall appear on a voluntary basis. The licensee shall be advised that the hearing will be informal, no lawyers will be utilized and no transcript of the hearing made. Any witnesses used will not be placed under oath, and no subpoenas will be issued. The licensee shall be informed that any statements made at the informal hearing may not be used or introduced at a formal hearing, unless all parties consent, in the event the complaint cannot be resolved informally. If the licensee notifies the CIO that he does not wish such an informal hearing, none shall be held. In that event, the CIO shall recommend to the board the initiation of a formal disciplinary hearing.

I. If the investigation disclosed any of the following:

1. that the complaint is sufficiently serious to require formal adjudication;

2. the licensee fails to respond to the CIO's correspondence concerning the complaint;

3. the licensee's response to the CIO's letter discloses that further action is necessary; an informal hearing is held but does not resolve all the issues; or the licensee refuses to comply with the recommended remedial action, the CIO shall recommend to the board the initiation of a formal disciplinary hearing.

J. In any recommended action submitted to the board by the CIO, the recommended action should be submitted in brief, concise language, without any reference to the particulars of the investigation, or any findings of fact or conclusions of law arrived at during the investigative process.

K. The board shall also have authority to delegate to the CIO the investigation of any alleged violations of R.S. 37:3090.A, prior to board action on such alleged violations. In that event, the CIO shall submit to the board the complete details of the investigation, including all facts and the complete investigation file, if requested by the board. Final authority for appropriate action rests solely with the board.

L. At no time shall the CIO investigate any case as authorized by the board or §503 where said officer has any personal or economic interest in the outcome of the investigation, or is personally related to or close friends with the complainant, the licensee, or any of the involved witnesses. In such event, the officer shall immediately contact the board, who shall have authority to appoint a CIO ad hoc for disposition of that case.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12

(January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1096 (June 1999).

§505. Conduct of Hearing

A. The board shall be authorized to conduct two types of hearings: compliance hearings and formal disciplinary hearings.

1. Compliance Hearing

a. The board will provide a compliance hearing to an applicant for a regular or provisional license whose application was disapproved by the board pursuant to §111.G of these Rules and Regulations, providing such applicant requests a compliance hearing in writing within thirty (30) days after the receipt of the notice of the disapproval, in which request the applicant shall state the opposition to the disapproved application.

b. A licensee, whose license is deemed expired because of a failure to timely renew, under R.S. 37:3088, shall be entitled to a compliance hearing, provided the licensee requests same in writing, within ten days after the receipt of the notice of the expired license; or in the event the licensee did not receive notice of the expired license within 30 days of the date upon which the license would have expired by operation of law.

c. Whenever possible, the board shall schedule a compliance hearing on a disapproved application in such a manner that the applicant is given an opportunity to present evidence of compliance and the board to rule thereon in sufficient time to allow the applicant to take the next scheduled examination, if the board decides in favor of the applicant. If this is not possible, and the board has reason to believe that the applicant's opposition has merit, the applicant shall be allowed to take the examination provisionally, pending the hearing and determination of the board. In no event shall the compliance hearing be conducted later than 30 days after requested. This time limitation applies to rejected applicants, as well as licensees with lapsed certificates.

d. The purpose and intent of the compliance hearing is to provide a forum for the applicant or licensee to present documentary evidence in the form of affidavits, court records, official records, letters, etc., along with under-oath testimony to establish that they do, in fact, meet the lawful requirements for the application or the retention of the license. The board shall have the authority to administer oaths, hear the testimony and conduct the hearing. No transcript of the hearing is required. The applicant or licensee may be represented by counsel, or may represent themselves in proper person.

e. In any compliance hearing, the burden shall be on the applicant or licensee to establish that he meets the criteria for licensure or that his certificate was timely renewed.

f. Within 30 days after the compliance hearing, the board will forward its final decision, including findings of fact and conclusions of law, by certified mail, to unsuccessful applicant or licensee.

g. Thereafter, the unsuccessful applicant or licensee may apply for a rehearing, as provided in R.S. 49:959, subject to further judicial review, pursuant to R.S. 49:964, 965.

2. Formal Disciplinary Hearing

a. The board shall also be authorized to conduct formal disciplinary hearings pursuant to R.S. 37:3090.B. The board shall promptly notify the Attorney General, who is authorized and requested to appear on behalf of the State.

b. The hearing shall be held before the board only after the involved licensee is given at least 30 days notice by certified mail. The content of the notice, as well as the conduct of the hearing, shall be governed by R.S. 49:955, being further provided that the licensee be advised of his right to be represented by legal counsel; and that the board shall arrange for a court reporter to make an accurate recording of all testimony presented at the hearing. By bringing a complaint, the client waives the privilege of confidentiality for the purposes of the hearing.

c. The rules of evidence, notice, authority to administer oaths, issue subpoenas, conduct depositions and control confidential or privileged information, will apply to the formal adjudication hearing in the form specified by R.S. 49:956.

d. It is the licensee's continuing obligation to keep the board informed of his whereabouts. Accordingly, if notice of the hearing cannot be delivered by mail because of a change of address and the new address is not provided to the board, the board may hold the hearing in the licensee's absence, after making reasonable efforts to obtain the licensee's new address.

e. When the licensee receives notice, he may file an answer to the notice denying some or all of the charges, or offering any explanation or assert whatever defense is deemed applicable.

f. For good cause shown, the board has discretion to extend or continue the time set for the hearing for such reasons as ill health, inability to obtain counsel, the complexities of the case, or such other matters deemed by the board to present good cause.

g. The board shall elect from its membership a person to act as Presiding Officer at the hearing, to make rulings on objections, the admissibility of evidence, and to insure that the conduct of the hearing proceeds without delay and pursuant to law. The other board members may not delegate their decision-making and fact-finding duties to the Presiding Officer; nor shall the Presiding Officer have any greater weight in the decision-making process. The board's findings of fact and conclusions of law shall be signed by the majority of the board finding those findings of fact and conclusions of law. Any board member disagreeing with those findings of fact and conclusions of law may also file in the record a dissent.

h. Any board member having reason to believe that he or she is biased or prejudiced against one of the parties to the proceeding or has a personal interest in the outcome shall immediately notify the remaining board members and request to be disqualified. Likewise, any party to such a hearing may file with the board an affidavit requesting a disqualification because of bias or personal interest. As soon as possible, but not later than the beginning of the hearing, the majority of the board must pass upon the requests for disqualification. The concerned board member shall not participate in the action to disqualify and shall not vote on

the issue. If the board is quite certain that there is no merit to the requests for disqualification, the board will proceed with the hearing. However, any doubt should be resolved in favor of disqualification. In that event, the board should immediately contact the Governor to appoint a board member pro tem to replace the disqualified member for the hearing in progress only.

i. The parties to the hearing are urged to confer prior to the hearing through their respective counsel, or personally to attempt to reduce or simplify the issues to be heard. This procedure is not required. The board will, however, honor any stipulations arrived at between the parties as proven fact at the hearing. The purpose of the prehearing conference is to insure that the hearing is not unusually delayed by receiving testimony or other evidence on matters which are not seriously in dispute.

j. The board shall have discretion to consolidate one or more cases for hearing involving the same or related parties, or substantially the same questions of law or fact. The board may also grant separate hearings if such a joint hearing would be prejudicial to one or more of the parties. If hearings are to be consolidated, notice must be given to all parties in advance of the hearing.

k. The Presiding Officer shall consider a motion to modify or quash any subpoena issued in connection with the hearing, provided that such motion is filed, by registered mail, with the board not later than three days prior to the hearing date, or the date scheduled for the deposition. Possible grounds to quash or limit the subpoena include, but are not limited to, testimony or material protected by privilege of statute, regulation, or other law; burdensomeness that would not be justified in light of the evidence's importance to the case, undue hardship on a witness; vagueness; and immateriality.

l. The procedures to be followed in conducting the hearing governing the order of proceedings, rulings on evidence, and the board's decision are contained in Chapters 11 through 14, respectively, of the Disciplinary Action Manual for Occupational Licensing Boards, prepared by the Louisiana Department of Justice, 1979, through the office of the Attorney General. A copy of these pertinent chapters will be provided to an interested party involved with a hearing, by written request submitted to the board.

m. The burden of proof rests upon the Attorney General who is bringing the charge before the board. No sanctions shall be imposed or order be issued, except upon consideration of the whole record, as supported by and in accordance with reliable, probative and substantial evidence as cited in R.S. 49:957.

n. Any party or person deemed to be governed by or under the jurisdiction of R.S. 37:3081-3093, may apply to the board for a declaratory order or ruling in order to determine the applicability of a statutory provision or rule of this board to said party or person. The board shall issue the declaratory order or ruling in connection with the request by majority vote of the board, signed and mailed to the requesting party within 30 days of the request, except that the board may seek legal counsel or an Attorney General's opinion in connection with the request, in which case the declaratory order or ruling may be issued within 60 days of its request.

o. Judicial review and appeal of any decision or order of the board shall be governed by R.S. 49:964, 965.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3081-3093; R.S. 36:259(Q).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 10:12 (January 1984), promulgated by the Department of Health and Hospitals, Board of Examiners in Dietetics and Nutrition, LR 25:1097 (June 1999).

JoAnn M. Puls, LDN, RD
Chairperson

9906#004

RULE

Department of Health and Hospitals
Board of Examiners of Psychologists

Acceptable Sponsorship, Offerings and Activities
(LAC 46:LXIII.805)

In accordance with R.S. 49:950 et seq., the Board of Examiners of Psychologists amends §§805 and 807, its continuing education rule, as follows.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LXIII. Psychologists
Chapter 8. Continuing Education
§805. Acceptable Sponsorship, Offerings and Activities

A. - G. ...

H. Licensees can earn CE hours equal to six times the credit hours granted students for the preparation and teaching of a graduate level psychology course in an accredited institution of higher education. This CE credit may be claimed only once for a course. Subsequent teaching of the same course will not qualify for CE credit.

I. Licensees can earn CE hours equal to four times the CE hours given participants for the preparation and presentation of a workshop which has an acceptable sponsor and otherwise meets the criteria for acceptable continuing education. This CE credit may be claimed only once for the initial presentation of a workshop. Repeated presentations of the same or similar workshops will not qualify for CE credit.

J. If continuing education is taught by more than one person, the number of hours earned by each shall be equal to the number that would be earned if taught by a sole presenter divided by the number of presenters.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2354.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 16:770 (September 1990), amended LR 19:46 (January 1993), LR 22:1131 (November 1996), LR 25:1098 (June 1999).

§807. Unacceptable Offerings and/or Activities

A. - B. Repealed.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2354.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR

6:489 (August 1980), amended LR 10:795 (October 1984), LR 25:1098 (June 1999).

C. Gary Pettigrew, Ph.D.
Chairman

9906#069

RULE

Department of Health and Hospitals
Office of Public Health

Sanitary Code—Eating and Drinking Establishments
(Chapter XXIII)

Sanitary Code
Chapter XXIII. Eating and Drinking Establishments

* * *

23:002 Interpretation/Certification
23:002-1 Interpretation:

* * *

23:002-2 Food Safety Certification:

(1) It shall be required that the owner or a designated employee of a food service establishment hold a "food safety certificate" on behalf of the food service establishment.

(2) This shall not apply to establishments with food sales of less than one hundred and twenty-five thousand dollars annually.

(3) The Office of Public Health shall approve all training programs. These programs shall include but not be limited to the standards set forth in the Applied Food Service Sanitation Program established by the Education Foundation of the National Restaurant Association, or other programs recognized by the food service industry and the Office of Public Health. The Office of Public Health shall maintain a list of these training programs.

(4) Instructors/trainers shall meet the criteria established by the Educational Foundation of the National Restaurant Association or other instructor/trainer requirements established by the food service industry and the Office of Public Health.

(5) The Office of Public Health shall approve training programs administered or approved by another state, political subdivision, or other jurisdiction with standards that meet or exceed those established in this Code.

(6) Testing: a person must pass a written exam approved by the Office of Public Health before qualifying for the certificate. This test will meet the standards as described in section three.

(7) Certificate: a food safety certificate shall be issued by the Office of Public Health to any individual who files an application with satisfactory evidence that he/she has completed an approved training program which includes passing a written examination.

(8) Fees: a fee of twenty-five dollars will be collected from each individual or food service establishment for each certificate.

(9) Certificate renewal: certificates from the Office of Public Health shall be required to be renewed every five years for a twenty-five dollar fee. A person shall pass another written exam as described in section six before the certificate is renewed.

(10) Display of certificate: a certificate issued by the Office of Public Health shall be displayed in each food service establishment where required.

(11) No parish or municipality in Louisiana shall enforce any ordinance or regulation requiring a food service establishment or any of its employees to complete a Food Safety training program or test.

(12) This section shall be enforced in accordance with Chapter 1 of this Code.

David Hood
Secretary

9906#055

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Private Hospital—Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the following rule in the Medical Assistance Program as authorized by LA. R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Bureau of Health Services Financing amends the reimbursement methodology for private hospitals contained in the June 20, 1994 rule to discontinue the practice of automatically applying an inflationary adjustment to the current reimbursement rates for non-fixed costs in those years when the rates are not rebased. The subsequent application of the inflationary adjustment to the reimbursement rates for private hospitals shall be contingent on the allocation of funds by the Legislature in the Appropriation Bill.

David W. Hood
Secretary

9906#058

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Private Intermediate Care Facilities for the Mentally Retarded—Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the following rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Bureau of Health Services Financing amends the reimbursement methodology contained in the October 20, 1989 rule for private intermediate care facilities for the mentally retarded to discontinue the practice of automatically applying an inflationary adjustment to the current reimbursement rates for non-fixed costs in those years when the rates are not rebased. Subsequent application of an inflationary adjustment to the reimbursement rates for private intermediate facilities for the mentally retarded shall be contingent on the allocation of funds by the Legislature in the Appropriation Bill.

David W. Hood
Secretary

9906#059

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Private Nursing Facilities—Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the following rule in the Medical Assistance Program as authorized by LA. R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the reimbursement methodology for private nursing facilities contained in the June 20, 1984 rule to discontinue the practice of automatically applying an inflationary adjustment to the current reimbursement rates for non-fixed costs in those years when the rates are not rebased. The subsequent application of an inflationary adjustment to the reimbursement rates for private nursing facilities shall be contingent on the allocation of funds by the Legislature in the Appropriation Bill.

David W. Hood
Secretary

9906#060

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Standards for Payment for Adult Day Health Care (ADHC) Services (LAC 50:II.10905 and 10907)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts the following rule in the Medicaid Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. The rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing amends §10905 entitled Definitions and §10907 entitled Licensure as follows.

Title 50
PUBLIC HEALTH - MEDICAL ASSISTANCE
Part II. Medical Assistance Program
Subpart 3. Standards for Payment
Chapter 109. Standards for Payment—Adult Day Health Care Services

§10905. Definitions

* * *

DHCBSW—Division of Home and Community-Based Services Waivers of the Bureau of Health Services Financing.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1100 (June 1999).

§10907. Licensure

A. Enrolled Title XIX Adult Day Health Care Centers shall be licensed by the Department of Health and Hospitals.

B. A Provider Agreement must be executed wherein the applicant agrees to comply with the Standards for Payment for Adult Day Health Care Centers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary LR 14:793 (November 1988), repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1150 (September 1997), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1099 (June 1999).

David W. Hood
Secretary

9906#057

RULE

Department of Insurance
Office of the Commissioner

Regulation 33—Medicare Supplement Insurance Minimum Standards (LAC 37:XIII.Chapter 5)

Pursuant to the provisions of R.S. 49:951 et seq. and R.S. 22:224, the Commissioner of Insurance gives notice of his intent to amend Regulation 33. This action is necessary to bring the Medicare Supplement Insurance Minimum Standards Regulation in line with the requirements of the

Social Security Act, mandated by the Balanced Budget Act of 1997.

Title 37
INSURANCE
Part XIII. Regulations
Chapter 5. Regulation 33—Medicare Supplement Insurance Minimum Standards

§501. Purpose

A. The purpose of this regulation is:

1. to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

2. to facilitate public understanding and comparison of such policies;

3. to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and

4. to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999).

§502. Applicability and Scope

A. Except as otherwise specifically provided in §§510, 540, 545, 560 and 585, this Regulation shall apply to:

1. all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

2. all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999).

§503. Definitions

A. For purpose of this regulation:

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 certificate holder.

Bankruptcy—means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

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—

a. means with respect to an individual, coverage of the individual provided under any of the following:

i. a group health plan;

ii. health insurance coverage;

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

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

v. Chapter 55 of Title 10 United States Code (CHAMPUS);

vi. a medical care program of the Indian Health Service or of a tribal organization;

vii. a State health benefits risk pool;

viii. a health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

ix. a public health plan as defined in federal regulation; and

x. a health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

b. creditable coverage shall not include one or more, or any combination of, the following:

i. coverage only for accident or disability income insurance, or any combination thereof;

ii. coverage issued as a supplement to liability insurance;

iii. liability insurance, including general liability insurance and automobile liability insurance;

iv. workers' compensation or similar insurance;

v. automobile medical payment insurance;

vi. credit-only insurance;

vii. coverage for on-site medical clinics; and

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

c. 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:

i. limited scope dental or vision benefits;

ii. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

iii. such other similar, limited benefits as are specified in federal regulations.

d. creditable coverage shall not include the following benefits if offered as independent, noncoordinated benefits:

i. coverage only for a specified disease or illness; and

ii. hospital indemnity or other fixed indemnity insurance.

e. creditable coverage shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

i. Medicare supplemental health insurance as defined under section 1882 (g)(1) of the Social Security Act;

ii. coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

iii. 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 the inability to pay its obligations when they are due, or a condition when its admitted assets do not exceed its liabilities plus the greater of:

a. any capital and surplus required by law for its organization; and

b. the total par or stated value of its authorized and issued capital stock.

c. for purposes of this subsection, liabilities shall include but not be limited to reserves required by statute, by general regulations of the Department of Insurance or by specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto.

Issuer—includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity authorized to deliver or issue 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+Choice Plan—means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, 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. medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

c. Medicare+Choice private fee-for-service plans.

Medicare Supplement Policy—means a group or individual policy of health insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. § 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. Also, it includes those plans commonly known as health care prepayment plans (HCPPs).

Policy Form—means the form on which the policy is delivered or issued for delivery by the issuer.

Qualified Actuary—means an actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

Secretary—means the Secretary of the United States Department of Health and Human Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 43 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1101 (June 1999).

§504. Policy Definitions and Terms

A. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

Accident, Accidental Injury, or Accidental Means—shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words or description or characterization.

a. The definition shall not be more restrictive than the following:

> "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

b. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

Benefit Period or *Medicare Benefit Period*—shall not be defined more restrictively than as defined in the Medicare program.

Convalescent Nursing Home, *Extended Care Facility*, or *Skilled Nursing Facility*—shall not be defined more restrictively than as defined in the Medicare program.

Health Care Expenses—means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Expenses shall not include:

a. home office and overhead costs;
b. advertising costs;
c. commissions and other acquisition costs;
d. taxes;
e. capital costs;
f. administrative costs; and
g. claims processing costs.

Hospital—may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

Medicare—shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

Medicare Eligible Expenses—shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

Physician—shall not be defined more restrictively than as defined in the Medicare program.

Sickness—shall not be defined to be more restrictive than the following.

a. Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

b. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999).

§505. Policy Provisions

A. Except for permitted preexisting condition clauses as described in §510.A.1. and §515.A.1. of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1102 (June 1999).

§506. Reserved.

§507. Reserved.

§508. Reserved.

§509. Reserved.

§510. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 20, 1992

A. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. 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.

d. A noncancellable, guaranteed renewable, or noncancellable and guaranteed renewable Medicare supplement policy shall not:

i. provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

ii. be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e.i. Except as authorized by the Commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

ii. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in §510.A.1.e.iv., the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(a). an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(b). an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in §515.A.2. of this regulation.

(c). Group contracts in force prior to the effective date of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may have existing contractual obligations to continue benefits contained in the group contract. This section is not intended to impair those obligations.

iii. If membership in a group is terminated, the issuer shall:

(a). offer the certificate holder the conversion opportunities described in §510.A.1.e.ii; or

(b). at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

iv. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the

policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

2. Minimum Benefit Standards

a. 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;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1103 (June 1999).

§511. Reserved.

§512. Reserved.

§513. Reserved.

§514. Reserved.

§515. Benefit Standards for Policies or Certificates Issued or Delivered on or After July 20, 1992

A. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 20, 1992. 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.

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

a. 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.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. 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.

d. 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.

e. Each Medicare supplement policy shall be guaranteed renewable.

i. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;

ii. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under §515. A.5.e.v, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

(a). provides for continuation of the benefits contained in the group policy; or

(b). provides for benefits that otherwise meet the requirements of this subsection.

iv. if an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(a). offer the certificate holder the conversion opportunity described in §515.A.1.e.iii; or

(b). at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

v. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. 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.

g.i. 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 certificate holder for the period (not to exceed twenty-four (24) months), or upon discovering thereof by the insurer in which the policyholder or certificate

holder 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 certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

ii. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of entitlement if the policyholder or certificate holder 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.

iii. Reinstitution of coverages:

(a). shall not provide for any waiting period with respect to treatment of preexisting conditions;

(b). shall provide for coverage which is substantially equivalent to coverage in effect before the date of suspension; and

(c). shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

2. Standards for Basic (Core) Benefits Common to All Benefit Plans. Every issuer shall make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

a. 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;

b. 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;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

d. 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;

e. 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;

3. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by §520 of this regulation.

Medicare Part A Deductible—coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

Skilled Nursing Facility Care—coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

Medicare Part B Deductible—coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

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.

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.

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.

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.

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.

Preventive Medical Care Benefit—coverage for the following preventive health services:

i. an annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;

ii. any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(a). fecal occult blood test or digital rectal examination, or both;

(b). mammogram;

(c). dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(d). pure tone (air only) hearing screening test, administered or ordered by a physician;

(e). serum cholesterol screening (every five (5) years);

(f). thyroid function test;

(g). diabetes screening.

iii. influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster (every ten (10) years);

iv. any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

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.

i. For purposes of this benefit, the following definitions shall apply:

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.

Care Provider—means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

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.

At-Home Recovery Visit—means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four-hour period of services provided by a care provider is one visit.

ii. Coverage Requirements and Limitations

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

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

(c). 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.

iii. Coverage is excluded for:

(a). home care visits paid for by Medicare or other government programs; and

(b). care provided by family members, unpaid volunteers, or providers who are not care providers.

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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1104 (June 1999).

§516. Reserved.

§517. Reserved.

§518. Reserved.

§519. Reserved.

§520. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in §515.A.2. of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in §515.A.3.*New and Innovative Benefits* and in §525 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in §503 of this regulation. Each benefit shall be structured in accordance with the format provided in §515.A.2. and §515.A.3 and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-up of Benefit Plans

1. Standardized Medicare supplement benefit plan "*A*" shall be limited to the basic (core) benefits common to all benefit plans, as defined in §515.A.2. of this regulation.

2. Standardized Medicare supplement benefit plan "*B*" shall include only the following: The core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible as defined in §515.A.3.*Medicare Part A Deductible.*

3. Standardized Medicare supplement benefit plan "*C*" shall include only the following: the core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country, as defined in §515.A.3.*Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible* and *Medically Necessary Emergency Care in a Foreign Country*, respectively.

4. Standardized Medicare supplement benefit plan "*D*" shall include only the following: the core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country, and At-Home Recovery Benefit*, respectively.

5. Standardized Medicare supplement benefit plan "*E*" shall include only the following: the core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country, and Preventive Medical Care Benefit*, respectively.

6. Standardized Medical supplement benefit plan "*F*" shall include only the following: the core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country*, 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 §515.A.2. 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 §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country*, 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 §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in §515.A.3.*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*, respectively.

9. Standardized Medicare supplement benefit plan "*H*" shall consist of only the following: The core benefit as defined in §515.A.2 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country, as defined in §515.A.3. *Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Outpatient Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country*, respectively.

10. Standardized Medicare supplement benefit plan "*I*" shall consist of only the following: The core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in §515.A.3.*Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Outpatient Prescription Drug Benefit, Medically Necessary Care in a Foreign Country and At-Home Recovery Benefit*, respectively.

11. Standardized Medicare supplement benefit plan "*J*" shall consist of only the following: The core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in §515.A.3.*Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit*, respectively.

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in §515.A.2. of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in §515.A.3.*Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit*, 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1106 (June 1999).

§521. Reserved.

§522. Reserved.

§523. Reserved.

§524. Reserved.

§525. Medicare Select Policies and Certificates

A.1. This section shall apply to Medicare Select policies and certificates, as defined in this Section.

2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.

B. For the purposes of this Section:

Complaint—means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

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.

Medicare Select Issuer—means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

Medicare Select Policy or *Medicare Select Certificate*—means respectively a Medicare supplement policy or certificate that contains restricted network provisions.

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.

Restricted Network Provision—means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

Service Area—means the geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

1. evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

a. services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

b. the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

i. to deliver adequately all services that are subject to a restricted network provision; or

ii. to make appropriate referrals.

c. there are written agreements with network providers describing specific responsibilities.

d. emergency care is available 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 §525.I.

7. any other information requested by the Commissioner.

F.1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved.

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

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

1. the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

2. it is not reasonable to obtain such services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure, in writing, of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1. an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

a. other Medicare supplement policies or certificates offered by the issuer; and

b. other Medicare Select policies or certificates;

2. a description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

3. a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized;

4. a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. a description of limitations on referrals to restricted network providers and to other providers;

6. a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer;

7. a description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M.1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

2. For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

1. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more

significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1108 (June 1999).

§526. Reserved.

§527. Reserved.

§528. Reserved.

§529. Reserved.

§530. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this Subsection without regard to age.

B.1. If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this Subsection.

C. Except as provided in Subsection B and §590, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1110 (June 1999).

§531. Reserved.

§532. Reserved.

§533. Reserved.

§534. Reserved.

§535. 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 or disenrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 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 Person. An eligible person is an individual described in any of the following paragraphs.

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan;

2. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, and any of the following circumstances apply:

a. The organization's or plan's certification [under this part] has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

b. 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. 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. The individual meets such other exceptional conditions as the Secretary may provide.

3.a. The individual is enrolled with:

i. an eligible organization under a contract under Section 1876 (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 §535.B.2.

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

a.i. of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

ii. of other involuntary termination of coverage or enrollment under the policy;

b. the issuer of the policy substantially violated a material provision of the policy; or

c. the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.a. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C of Medicare, any eligible organization under a contract under Section 1876 (Medicare risk or cost), any similar organization operating under demonstration project authority, an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and

b. the subsequent enrollment under subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. the individual, upon first becoming enrolled for benefits under Medicare part B, enrolls in a Medicare+Choice plan under part C of Medicare, and disenrolls from the plan by not later twelve (12) months after the effective date of enrollment.

C. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

1. §535.B.1.2.3 and 4 is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any issuer.

2. §535.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 §535.C.1.

3. §535.B.6 shall include any Medicare supplement policy available by any issuer.

D. Notification provisions

1. At the time of an event described in Subsection B of this Section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in Subsection B of this Section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under §535.A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1110 (June 1999).

§536. Reserved.

§537. Reserved.

§538. Reserved.

§539. Reserved.

§540. Standards for Claims Payment

A. An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

1. accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

2. notifying the participating physician or supplier and the beneficiary of the payment determination;

3. paying the participating physician or supplier directly;

4. furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;

5. paying user fees for claim notices that are transmitted electronically or otherwise; and

6. providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1111 (June 1999).

§541. Reserved.
§542. Reserved.
§543. Reserved.
§544. Reserved.
§545. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards

1.a. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

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

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

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3. For purposes of applying Subsection A.1 of this Section and §550.C.3. only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to January 20, 1991, expected claims in relation to premiums shall meet:

a. the originally filed anticipated loss ratio when combined with the actual experience since inception;

b. the appropriate loss ratio requirement from §545.A.1.a.i. and ii. when combined with actual experience beginning with January 1, 1998 to date; and

c. the appropriate loss ratio requirement from §545.A.1.a.i. and ii. over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation

1. An issuer shall collect and file with the Commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

2. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this Section, policies or certificates issued prior to January 20, 1991, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1998. The first report shall be due by May 31, 2000.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Filing of Rates and Rating Schedules. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

1. Each Medicare supplement policy or certificate form shall be accompanied, upon submission for approval, by an original and one copy of an actuarial memorandum. The memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the information listed in the following subparagraphs:

a. the form number that the actuarial memorandum addresses;

b. a brief description of benefits provided;

c. a schedule of rates to be used;

d. a certification that the anticipated lifetime loss ratio is at least 65% (for individual coverage) or at least 75% (for group coverage);

e. a table of anticipated loss ratio experience for each year from issue over a reasonable number of years;

f. a certification that the premiums are reasonable in relation to the benefits provided; and

g. the memorandum shall be filed in duplicate;

h. any additional information requested by the Commissioner.

2. Subsequent rate adjustments filings, except for those rates filed solely due to a change in the Part A calendar year deductible, shall also provide an original and one copy of an actuarial memorandum, prepared, signed and dated by a qualified actuary, in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the following:

a. the form number addressed by the actuarial memorandum;

b. a brief description of benefits provided;

c. a schedule of rates before and after the rate change;

d. a statement of the reason and basis for the rate change;

e. a demonstration and certification by the qualified actuary showing that the past plus future expected experience after the rate change will result in an aggregate loss ratio equal to, or greater than, the required minimum aggregate loss ratio;

i. this rate change and demonstration shall be based on the experience of the named form in Louisiana only, if that experience is credible.

ii. the rate change and demonstration shall be based on experience of the named form nationwide, if the named form is used nationwide and the Louisiana experience is not credible, but the nationwide experience is credible.

f. for policies or certificates in force less than three years, a demonstration shall be included to show that the third-year loss ratio is expected to be equal to, or greater than, the applicable percentage;

g. a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided;

h. the memorandum shall be filed in duplicate;

i. any additional information requested by the Commissioner.

3.a. An issuer of Medicare supplement policies and certificates issued before or after the effective date of Regulation 33 (Revised, 1992) in this state shall file annually no later than December 31 its rates for the upcoming calendar year. Also, supporting documentation including ratios of incurred losses to earned premiums by policy duration shall be submitted for approval by the Commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

b. The filing for purposes of this subsection shall contain all Medicare supplement plans issued by the issuer and shall not include rate adjustments. An actuarial memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices. The filing shall contain at least the following:

i. the form number for each plan;

ii. plan type designation (for example: Plan A, Plan B, Pre-standardized);

iii. the rates for each plan;

iv. yearly loss ratios for each plan;

v. lifetime expected loss ratios for each plan;

vi. identify filing as "ANNUAL MEDICARE SUPPLEMENT FILING" on the face page of the memorandum.

vii. the memorandum shall be filed in duplicate;

viii. any additional information requested by the Commissioner.

4. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Commissioner, in accordance with the applicable filing procedures of this state:

a.i. appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

ii. an issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

iii. if an issuer fails to make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

b. any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The Commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of Regulation 33 as revised July 20, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the Commissioner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1112 (June 1999).

§546. Reserved.

§547. Reserved.

§548. Reserved.

§549. Reserved.

§550. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance

with the filing requirements and procedures prescribed by the Commissioner.

C.1. Except as provided in C.2 of this Subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the Commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

a. the inclusion of new or innovative benefits;

b. the addition of either direct response or agent marketing methods;

c. the addition of either guaranteed issue or underwritten coverage;

d. the offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this Section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

D.1. Except as provided in D.1.a, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the Commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner, in writing, its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this Subsection.

3. A change in the rating structure or methodology shall be considered a discontinuance under D.1 unless the issuer complies with the following requirements:

a. The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

b. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Commissioner may approve a change to the differential which is in the public interest.

E.1. Except as provided in E.2, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in §545 of this Regulation.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1113 (June 1999).

§551. Reserved.

§552. Reserved.

§553. Reserved.

§554. Reserved.

§555. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers, and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this Section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finders fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1114 (June 1999).

§556. Reserved.

§557. Reserved.

§558. Reserved.

§559. Reserved.

§560. Required Disclosure Provisions

A. General Rules

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare

supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to, in writing, signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6.a. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates, as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application, and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

b. For the purposes of this Section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. The notice shall:

a. include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

b. inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies.

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3.a. The outline of coverage provided to applicants pursuant to this Section consists of four parts:

i. a cover page;

ii. premium information;

iii. disclosure pages, and

iv. charts displaying the features of all benefit plans available by the issuer.

b. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-J shall be shown on the cover page, and each Medicare supplement policy and certificate currently available by an issuer shall be prominently identified. Premium information for plans that are available 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 available to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The following items shall be included in the outline of coverage in the order prescribed below.

[**COMPANY NAME**]

Outline of Medicare Supplement Coverage Cover Page:

Benefit Plan(s)_____[insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (Generally, 20 percent) of Medicare-approved expenses), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayment.

Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	**Basic Benefits**	**Basic Benefits**	**Basic Benefits**	**Basic Benefits**
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care

F	F*	G	H	I	J	J*
Basic Benefits		**Basic Benefits**	**Basic Benefits**	**Basic Benefits**	**Basic Benefits**	
Skilled Nursing Co-Insurance		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	
Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
Part B Deductible					Part B Deductible	
Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
		At-Home Recovery		At-Home Recovery	At-Home Recovery	
			Basic Drugs ($1,250	Basic Drugs ($1,250	Extended Drugs (3,000	
			Limit)	Limit)	Limit)	
					Preventive Care	

*Plan F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plan F and J after one has paid a calendar year [$1500] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but does not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

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 *The Medicare Handbook* 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 §520.D of this Regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.]

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing and miscellaneous services and supplies**			
First 60 days	All but $768	$0	$768 (Part A Deductible)
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $384/day	$384/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.**			
21st thru 100th day	All but $96/day	$0	Up to $96/day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **Available as long as your doctor certifies you are terminally ill and you elect to receive these services**	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN A

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES			

PARTS A and B

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

PLAN B

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
--While using 60 lifetime reserve days	All but $384/day	$384/day	$0
--Once lifetime reserve days are used:			
--Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
--Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $96/day	$0	Up to $96/day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN B

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs

BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and B

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

PLAN C

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing and miscellaneous services and supplies**			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $384/day	$384/day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.**			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $96/day	Up to $96/day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **Available as long as your doctor certifies you are terminally ill and you elect to receive these services**	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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.

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.			
SERVICES	**MEDICARE PAYS**	**PLAN PAYS**	**YOU PAY**
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved	Generally, 80%	Generally, 20%	$0

Amounts			
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and B

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

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN D

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after;			
While using 60 lifetime reserve days	All but $384/day	$384/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 have been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $96/day	Up to $96/day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN D

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges	$0	$0	All Costs

(Above Medicare Approved Amounts)			
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $100 of Medicare Approved Amounts	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN E

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $384/day	$384/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 lea in the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th Daily	All but $96/day	Up to $96/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	All but very limited	$0	Balance

your doctor certifies you are terminally ill and you elect to receive these services	coinsurance for out-patient drugs and inpatient respite care		

PLAN E

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 TREATMENTS, 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 Deduct-ible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deduct-ible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deduct-ible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services, such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

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

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

**This high deductible plan pays the same or offers the same benefits as plan F after one has paid a calendar year [$1500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1500 DEDUCT-IBLE, ** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but	$192/day	$0

	$192/day		
91st day and after:			
While using 60 lifetime reserve days	All but $384/day	$384/day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.**			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $96/day	Up to $96/day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **Available as long as your doctor certifies you are terminally ill and you elect to receive these services**	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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 [$1500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$1500]. 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 $1500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1500 DEDUCT-IBLE, ** YOU PAY
MEDICAL EXPENSES* **in or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.**			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	All Costs	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and B

HOME HEATH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO $1500 DEDUCT-IBLE, ** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE **Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA**			
First $250 each calendar year	$0	$0	$250

Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing and miscellaneous services and supplies**			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $384/day	$384/day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital**			
First 20 days	All Approved amounts	$0	$0
21st thru 100th day	All but $96/day	Up to $96/day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **Available as long as your doctor certifies you are terminally ill and you elect to receive these services**	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN G

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* **in or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.**			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deduct-ible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deduct-ible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	$100	$0	$0

PARTS A and 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 Deduct-ible)
Remainder of	80%	20%	$0

Medicare Approved Amounts			
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN H

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $384 day	$384/day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $96/day	Up to $96/day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN H

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* in or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess	$0	$0	All Costs

Charges (Above Medicare Approved Amounts)			
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and 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 benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%--$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing and miscellaneous services and supplies**			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $384/day	$384/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 the Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital**			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $96/day	Up to $96/day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

PLAN I

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* in or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	All Costs	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	%0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50% $1,250 calendar year	50%

		maximum benefit	
Over $2,500 each calendar year	$0	$0	All Costs

PLAN J or HIGH DEDUCTIBLE PLAN J
MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [$1500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCT-IBLE, ** PLAN PAYS	IN ADDITION TO $1500 DEDUCT-IBLE, ** YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing and miscellaneous services and supplies**			
First 60 days	All but $768	$768 (Part A Deductible)	$0
61st thru 90th day	All but $192/day	$192/day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $384/day	$384/day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.**			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $96/day	Up to $96/day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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 [$1500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* **in or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.**			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	All Costs	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A and B

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCT-IBLE,** PLAN PAYS	IN ADDITI ON TO $1500 DEDUCT -IBLE, ** YOU PAY
HOME HEALTH CARE (contd.) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
Calendar year maximum	$0	$1,600	

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1500 DEDUCT-IBLE, ** PLAN PAYS	IN ADDITI ON TO $1500 DEDUCT -IBLE, ** YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50% $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

***Medicare benefits are subject to change. Please consult the latest *guide to health insurance for people with Medicare.*

D. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. §1395 et seq.), disability income policy; or other policy identified in §502.B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language: *"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."*

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D.1 shall disclose, using the

applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1114 (June 1999).

§561. Reserved.

§562. Reserved.

§563. Reserved.

§564. Reserved.

§565. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

B. An application for a medicare supplement policy shall not be combined with an application for any other type of insurance coverage. The application may not make reference to or include questions regarding other types of insurance coverage except for those questions specifically required under this section.

1. [Statements]

a. You do not need more than one Medicare supplement policy.

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

c. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

d. The benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

e. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

2. [Questions]

a. To the best of your knowledge,

i. Do you have another Medicare supplement policy or certificate in force?

(a). If so, with which company?

(b). If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

ii. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(a). If so, with which company?

(b). What kind of policy?

iii. Are you covered for medical assistance through the state Medicaid program:

(a). As a Specified Low-Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c). For other Medicaid medical benefits?

C. 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.

D. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

E. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice, signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant, at the time of the issuance of the policy, the notice regarding replacement of Medicare supplement coverage.

F. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not

duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefit, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Other. (please specify)

_____
_____
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*

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

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

G. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1130 (June 1999).

§566. Reserved.

§567. Reserved.

§568. Reserved.

§569. Reserved.

§570. Filing Requirements for Advertising

A. An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review and approval by the Commissioner to the extent permitted under the Insurance Code, particularly under R. S. 22:1215.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1131 (June 1999).

§571. Reserved.

§572. Reserved.

§573. Reserved.

§574. Reserved.

§575. Standards for Marketing

A. An issuer, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

2. Establish marketing procedures to assure excessive insurance is not sold or issued;

3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: *"Notice to buyer: This policy may not cover all of your medical expenses."*

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance;

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

B. In addition to the practices prohibited in Louisiana Revised Statutes 22:1211 et seq. the following acts and practices are prohibited:

1. Twisting. Making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms Medicare Supplement, Medigap, Medicare Wrap-Around and words of similar import shall not be used

unless the policy is issued in compliance with this regulation.

D. No insurer providing Medicare supplement insurance in this state shall allow its agent to accept premiums except by check, money order, or bank draft made payable to the insurer. If payment in cash is made, the agent must leave the insurer's official receipt with the insured or the person paying the premium on behalf of the insured. This receipt shall bind the insurer for the monies received by the agent. Under this section, the agent is prohibited from accepting checks, money orders and/or bank drafts payable to the agent or his agency. The agent is not to leave any receipt other than the insurer's for premium paid in cash.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1131 (June 1999).

§576. Reserved.

§577. Reserved.

§578. Reserved.

§579. Reserved.

§580. Appropriateness of Recommended Purchase and Excessive Insurance

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

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§581. Reserved.

§582. Reserved.

§583. Reserved.

§584. Reserved.

§585. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

1. policy and certificate number; and
2. date of issuance.

B. The items set forth above must be grouped by individual policyholder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§586. Reserved.

§587. Reserved.

§588. Reserved.

§589. Reserved.

§590. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§591. Reserved.

§592. Reserved.

§593. Reserved.

§594. Reserved.

§595. Separability

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§596. Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

Type[1] _____ SMSBO[2] _____

For the State of_____

Company Name_____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit_____

Title _____Telephone Number _____

	(a) Earned Premium[3]	(b) Incurred Claims[4]
1 Current Year's Experience		
a. Total (all policy years)		
b. Current year's issues (z)	_____	_____
c. Net (for reporting purposes = 1a - 1b)		
2 Past Years' Experience (All Policy Years)	_____	_____
3 Total Experience (Net Current	_____	_____

Year + Past Years' Experience)

4 Refunds last year (Excluding Interest)_____

5 Previous Since Inception (Excluding Interest)_____

6 Refunds Since Inception (Excluding Interest)_____

7 Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO I)_____

8 Experienced Ratio Since Inception

Total Actual Incurred Claims (line
(line 3, col b) = Ratio 2
Tot. Earned Prem.(line 3, col a) -
Refunds Since Inception (line 6)

9 Life Years Exposed Since Inception
_____

If the Experience Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table)_____

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

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

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

3 Includes Modal Loadings and Fees Charged

4 Excludes Active Life Reserves

5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

Type[1] _____ SMSBOP[2] _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____Telephone Number _____

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

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

If Ratio 3 is less than the benchmark ratio, then proceed.

12. Adjusted Incurred Claims =
[Tot. Earned Premiums (line 3, col a)-Refunds Since Inception (line 6)]
X Ratio 3 (line 11)

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

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

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

_____
Signature

_____
Name - please type

_____
Title

_____
Date

REPORTING FORM FOR THE CALCULATION OF

BENCHMARK RATIO SINCE INCEPTION

FOR GROUP POLICIES

FOR CALENDAR YEAR _____

Type[1]_____ SMSBP[2] _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____Telephone Number_____

(a)[3]	(b)[4]	(c)	(d)	(e)
Year	**Earned Premium**	**Factor**	**(b)x(c)**	**Cumulative Loss Ratio**
1		2.770		0.507
2		4.175		0.567
3		4.175		0.567
4		4.175		0.567
5		4.175		0.567
6		4.175		0.567
7		4.175		0.567
8		4.175		0.567
9		4.175		0.567
10		4.175		0.567
11		4.175		0.567
12		4.175		0.567
13		4.175		0.567
14		4.175		0.567
15		4.175		0.567
Total:			(k):	

(f)	(g)	(h)	(i)	(j)	(o)[5]
(d)x(e)	**Factor**	**(b)x(g)**	**Cumulative Loss Ratio**	**(h)x(i)**	**Policy Year Loss Ratio**
	0.000		0.000		0.46
	0.000		0.000		0.63
	1.194		0.759		0.75
	2.245		0.771		0.77
	3.170		0.782		0.80
	3.998		0.792		0.82
	4.754		0.802		0.84
	5.445		0.811		0.87
	6.075		0.818		0.88
	6.650		0.824		0.88
	7.176		0.828		0.88
	7.655		0.831		0.88
	8.093		0.834		0.89
	8.493		0.837		0.89
	8.684		0.838		0.89
(l):		(m):		(n):	

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

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

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

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

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

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

REPORTING FORM FOR THE CALCULATION OF

BENCHMARK RATIO SINCE INCEPTION

FOR INDIVIDUAL POLICIES

FOR CALENDAR YEAR _____

Type[1] _____ SMSBP[2] _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)
Year	**Earned Premium**	**Factor**	**(b)x(c)**	**Cumulative Loss Ratio**	**(d)x(e)**
1		2.770		0.442	
2		4.175		0.493	
3		4.175		0.493	
4		4.175		0.493	
5		4.175		0.493	
6		4.175		0.493	
7		4.175		0.493	
8		4.175		0.493	
9		4.175		0.493	
10		4.175		0.493	
11		4.175		0.493	
12		4.175		0.493	
13		4.175		0.493	
14		4.175		0.493	
15		4.175		0.493	
Total:			(k):		(l):

(g)	(h)	(i)	(j)	(o)[5]
Factor	**(b)x(g)**	**Cumulative Loss Ratio**	**(h)x(i)**	**Policy Year Loss Ratio**
0.000		0.000		0.40
0.000		0.000		0.55
1.194		0.659		0.65
2.245		0.669		0.67
3.170		0.678		0.69
3.998		0.686		0.71
4.754		0.695		0.73
5.445		0.702		0.75
6.075		0.708		0.76
6.650		0.713		0.76
7.176		0.717		0.76
7.655		0.720		0.77
8.093		0.723		0.77
8.493		0.725		0.77
8.684		0.725		0.77
	(m):		(n):	

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

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

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

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1132 (June 1999).

§597. Appendix B

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES	
Company Name:	
Address:	
Phone Number: Due: March 1, annually	
The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.	
Policy and Certificate #	Date of Issuance
_____ Signature _____ Name and Title (please type) _____ Date	

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1136 (June 1999).

598. Appendix C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for

Health Insurance Policies Sold to Medicare Beneficiaries

that Duplicate Medicare

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

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

other approved items and services

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

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

hospitalization

physician services

other approved items and services

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items and services

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

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

hospitalization

physician services

hospice

other approved items and services

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items and services

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items and services

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items & services

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

other approved items and services

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

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

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

hospitalization

physician services

other approved items and services

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

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items and services

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

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

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

hospitalization

physician services

hospice

other approved items and services

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

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items and services

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

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items and services

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

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

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

Medicare generally pays for most or all of these expenses.

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

hospitalization

physician services

hospice

other approved items & services

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

Before You Buy This Insurance

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

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

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1136 (June 1999).

§599. Effective Date

This regulation shall be effective on June 18, 1999

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:224 and 42 U.S.C. 1395 et seq.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 25:1142 (June 1999).

James H. "Jim" Brown
Commissioner

9906#008

RULE

Department of Labor
Office of Workforce Development

Workforce Development Training Fund
(LAC 40:XVI.101-111)

The Louisiana Department of Labor, pursuant to authority vested in the Department by R.S. 23:1514 and in accordance with applicable provisions of the Administrative Procedure Act, has adopted rules governing the workforce development training account, LAC 40:XVI.101-111, to provide for eligibility and requirements for submission of applications.

Title 40
LABOR AND EMPLOYMENT

Chapter 1. Workforce Development Training Fund

§101. Definitions

Account—the Workforce Development Training Account.

Applicant—the business requesting training assistance from LDOL under this program.

Award—funding approved under this program for eligible training activities.

Awardee—an applicant (and/or company(ies)) receiving a training award under this program.

Contract—a legally enforceable agreement between LDOL, the awardee and a training provider governing the terms and conditions of the training award.

Contractee—the awardee and training provider that are party to a training award contract with LDOL under this program.

LDOL—the Louisiana Department of Labor.

Monitoring Entity—a public entity contracted to monitor the compliance of an awardee with the terms and conditions of a training award contract.

Secretary—the secretary of the Department of Labor.

Training Provider—the entity providing the customized training for the awardee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1142 (June 1999).

§103. Eligibility

A. An applicant shall be eligible for customized training if it is one of the following:

1. an individual employer that seeks to provide customized training for his present employees to prevent job loss caused by obsolete skills, technological change, or national or global competition;

2. an individual employer that seeks to provide customized training to create, update, or retain jobs in a labor demand occupation;

3. an individual employer that seeks to provide customized training to update or retain jobs in an occupation which is not a labor demand occupation, if the administrator determines that the services are necessary to prevent the likely loss of jobs;

4. a labor or community-based organization that seeks to provide customized training for a labor demand occupation;

5. a consortium made up of one or more educational institutions and one or more eligible individual employers, labor, or community-based organizations that seeks to provide customized training in labor demand occupations;

6. A local economic development entity and one or more eligible individual employers that seek to provide customized training in a labor demand occupation.

B. All applications by eligible applicants for customized training shall be submitted in conjunction with the entity selected by the applicant to provide the customized training. All disbursements of funds for the training shall be made to the entity actually providing the customized training. To be eligible, the training provider selected by the applicant must demonstrate a history of:

1. successful training through its placement, retention, and satisfaction rates;

2. collaboration with the targeted industry in the development of the training program curriculum;

3. use of a current industry standard as the basis for programs utilized to train students for employment in the targeted industry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1142 (June 1999).

§105. Criteria

A. Employer(s) must be in full compliance with Louisiana unemployment insurance laws.

B. During the first nine months of a fiscal year, not less than 25 percent of all funds available during a fiscal year shall be available for employers with 150 or fewer Louisiana-based employees. For the final three months of a fiscal year, the remaining available funds will be available to all eligible employers, without size restrictions.

C. No single employer shall receive training funds more than once in a 24-month time period. No single employer shall receive more than 5 percent of the total funds available to the program during a fiscal year.

D. Employers receiving awards must provide evidence satisfactory to LDOL of their long-range commitment to employee training and that funds shall be used to supplement and not supplant existing training efforts.

E. Applicants must request training for at least 15 employees.

F. Special emphasis shall be placed on entry-level/incumbent training programs.

G. Preference will be given to employers that have:

1. selected a public training institution as the training provider;

2. donated materials, equipment, or instructors to public training providers, secondary and postsecondary vocational-technical schools, or community colleges within the state;

3. hired former welfare recipients through participation in the Welfare to Work Partnership.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

§107. Application Procedure

LDOL will provide a standard form which applicants will use to apply for assistance. The application form will contain, but not be limited to, detailed descriptions of the following:

1. an overview of the company, its history, and the business climate in which it operates;

2. the company's overall training plan, including a summary of the types and amounts of training to be provided and a description of how the company determined its need for training;

3. the specific training programs for which LDOL assistance is requested, including descriptions of the methods, providers and costs of the proposed training; and

4. any additional information the secretary may require.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

§109. Submission and Review Procedure

A. Applicants must submit their completed application to LDOL. Submitted applications will be reviewed and evaluated by LDOL staff. Input may be required from the applicant, other divisions of the Department of Labor, and other state agencies as needed, in order to:

1. understand the labor market conditions the proposed training is seeking to mitigate;

2. evaluate the strategic importance of the proposed training to the economic well-being of the state and local communities;

3. determine whether the employer's specific needs are best met by training;

4. identify the availability of existing training programs which could be adapted to meet the employer's needs;

5. identify the resources the business can provide to support the training, including trainers, facilities, materials and equipment;

6. identify or develop appropriate curricula; and

7. determine the most cost effective approach to meet the employer's training needs.

B. Upon determination that an application meets the eligibility criteria for this program and is deemed to be beneficial to the well-being of the state, LDOL staff will then make a recommendation to the secretary of the Department of Labor. The application will then be reviewed and approved by the following entities in the following order:

1. the secretary of the Department of Labor;

2. the governor.

C. A copy of the application shall be sent to the executive director of the Louisiana Workforce Commission. No funds spent on the project prior to the secretary's approval will be considered eligible project costs.

D. The secretary will issue a Letter of Commitment to the applicant within five working days of the application approval by the governor.

E. If any application is rejected by any of the preceding entities, the application shall not be considered by the next succeeding entity unless first reconsidered and approved by the entity which initially rejected the application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

§111. General Award Provisions

A. Award Contract

1. A contract will be executed between LDOL, the awardee (and/or company(ies) receiving training) and the training provider. The contract will specify the performance objectives expected of the company(ies) and the compliance requirements to be enforced in exchange for state assistance, including, but not limited to, time lines for job training.

2. The monitoring entity will monitor the progress of the training.

3. LDOL will reimburse the training provider from invoices submitted by the training provider on a form approved by LDOL and disburse funds from invoices or certificates of work completed.

4. The cost associated with the contract between the monitoring entity and the awardee will be considered part of the total training award, but will not exceed 5 percent of the award amount or $10,000, whichever is less.

5. Funds may be used for training programs extending up to two years in duration.

B. Use of Funds

1. The Louisiana Workforce Development Training Account offers financial assistance in the form of a grant for reimbursement of eligible training costs specified in the award agreement.

2. Eligible training costs may include, inter alia, the following:

a. instruction costs—wages for company trainers and training coordinators, Louisiana public and/or private school tuition, contracts for vendor trainers, training seminars;

b. travel costs (limited to 30 percent of the total training award)—travel for trainers and training coordinators (company and other), and travel for trainees; travel expenses reimbursable under this agreement will comply with State Travel Regulations, PPM 49;

c. materials and supplies costs—training texts and manuals, audio/visual materials, skills assessment (documents or services to determine training needs), raw materials (for manufacturing and new employee on-the-job training), Computer Based Training (CBT) software; and

d. other costs—facility rental, and fees or service costs incurred by the monitoring entity associated with the contract to monitor the training.

3. Training costs ineligible for reimbursement include:

a. trainee wages and fringe benefits;

b. nonconsumable tangible property (e.g., equipment, calculators, furniture, classroom fixtures, non-Computer Based Training (CBT) software), unless owned by a public training provider;

c. out-of-state, publicly supported schools;

d. employee handbooks;

e. scrap produced during training;

f. food, refreshments; and

g. awards.

C. Conditions for Disbursement of Funds

1. Funds will be available on a reimbursement basis following submission of approved invoices to LDOL. Only funds spent on the project after the secretary's approval will be considered eligible for reimbursement.

2. Invoices will be eligible for reimbursement at 90 percent until all contracted performance objectives have been met. After the company has achieved 100 percent of its contracted performance objectives, the remaining 10 percent of the grant award will be made available for reimbursement.

3. All disbursements of funds shall be made to the training provider actually providing the customized training.

D. Compliance Requirements

1. Training providers shall be required to complete quarterly reports describing progress toward the performance objectives specified in their contract with LDOL.

2. In the event the awardee fails to meet its performance objectives specified in its contract with LDOL, LDOL shall retain the rights to withhold award funds, modify the terms and conditions of the award, and to reclaim disbursed funds from the awardee in an amount commensurate with the scope of the unmet performance objectives and the foregone benefits to the state.

3. In the event the awardee or monitoring entity knowingly files a false statement in its application or in a progress report, the awardee or monitoring entity shall be guilty of the offense of filing false public records and shall be subject to the penalty provided for in La. R.S. 14:133.

4. LDOL shall retain the right to require and/or conduct financial and performance audits of a project, including all relevant records and documents of the awardee and the monitoring entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1514.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workforce Development, LR 25:1143 (June 1999).

Garey Forster
Secretary

9906#023

RULE

Department of Social Services
Office of Community Services

Reimbursement Rates for Residential Facilities
(LAC 67:V.3503)

The Department of Social Services, Office of Community Services, has amended the rule entitled "Reimbursement Rates for Residential Facilities." The current rate setting methodology has been changed.

Title 67
SOCIAL SERVICES
Part V. Office of Community Services
Subpart 5. Foster Care
Chapter 35. Payments, Reimbursables and Expenditures
§3503. Reimbursement Rates for Residential Facilities

A.1. The rate setting methodology for residential facilities reimbursed by the Department of Social Services/Office of Community Services consists of four components:

a. administration;

b. basic care;

c. supervision; and

d. intervention.

2. Costs will be reimbursed through cost models with the models based on historical costs, reasonable costs and the level of services the Department wishes to purchase. Administrative costs will be reimbursed through models of reasonable administrative structures which are based on facility size and agency complexity. The costs of basic care will be based on the cost of raising a child as estimated by the United States Department of Agriculture. The model for the supervision component is based on the level of staffing needed to care for the level of care required for the children in the facility. Costs associated with supervision will continue to reflect the cost for direct care workers, and their immediate supervisors, when the supervisors are not included in the administration component. Costs associated with intervention will continue to reflect the cost of professional social workers, psychologists and psychiatrists and related costs. The salary levels in the Administrative, Intervention and Supervision cost models are based on the salaries for equivalent state workers. The rate will be the sum of the four components appropriate to the care being delivered to the client.

B. Facilities receiving reimbursement under this rate methodology will be required to submit audited cost reports to the Office of Community Services every second year,

starting with the first year of implementation. The audit must be conducted by a certified public accountant, must determine whether the cost report conforms to the requirements of the Department of Social Services, Rate Setting for Residential Services Manual, and must contain the opinion of a certified public accountant that the costs shown in the cost report are accurate and allowable. Facilities which submit costs reports after the date specified by the Office of Community Services are subject to progressive penalties including fiscal sanctions, suspension of eligibility for OCS placements and termination of the placement agreement with OCS.

C. Each year the Department will implement a percentage of the calculated rates as the approved budget allows.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:1084.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Community Services, LR 14:542 (August 1988), amended LR 20:898 (August 1994), LR 25:1144 (June 1999).

Madlyn Bagneris
Secretary

9906#062

RULE

Department of Social Services
Office of the Secretary

Drug Testing of Employees (LAC 67:I.101-121)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and in accordance with Executive Order MJF 98-38 and R.S. 49:1001 et seq., the Department of Social Services, Office of the Secretary has adopted rules regarding the implementation of a drug testing program for new and existing employees within the department.

Title 67
SOCIAL SERVICES
Part I. Office of the Secretary
Subpart 1. General Administration
Chapter 1. Drug Testing
§101. Introduction and Purpose

A. The employees of the State of Louisiana are among the state's most valuable resources, and the physical and mental well-being of these employees is necessary for them to properly carry out their responsibilities. Substance abuse causes serious adverse consequences to users, impacting on their productivity, health and safety, dependents and co-workers, as well as the general public. Substance abuse on the job can cause undue risk of harm to the public in general and the children and other clients directly served by and dependent on the services of the Department of Social Services (DSS).

B. The State of Louisiana has a long-standing commitment to working toward a drug-free workplace. In order to curb the use of illegal drugs by employees of the State of Louisiana, the Louisiana Legislature enacted laws which provide for the creation and implementation of drug testing programs for state employees. Further, the Governor of the State of Louisiana issued Executive Order Number MJF 98-38 providing for the promulgation by executive agencies of written policies mandating drug testing of employees, appointees, prospective employees and prospective appointees, pursuant to R.S. 49:1001 et seq.

C. The Department of Social Services fully supports these efforts and is committed to a drug-free workplace.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1145 (June 1999).

§103. Applicability

This policy shall apply to all employees of DSS including appointees and all other persons having any employment relationship with this agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1145 (June 1999).

§105. Definitions

Controlled Substance—a drug, chemical substance or immediate precursor in Schedules I through V of R.S. 40:964 or Section 202 of the Controlled Substances Act (21 U.S.C. 812).

Designer (Synthetic) Drugs—those chemical substances that are made in clandestine laboratories where the molecular structure of both legal and illegal drugs is altered to create a drug that is not explicitly banned by federal law.

Employee—unclassified, classified, and student employees, student interns, both paid and unpaid, and any other person having any employment relationship with the agency, regardless of the appointment type (e.g. full-time, part-time, temporary, etc.).

Illegal Drug—any drug which is not legally obtainable or which has not been legally obtained, to include prescribed drugs not legally obtained and prescribed drugs not being used for prescribed purposes or being used by one other than the person for whom prescribed.

Public Vehicle—any motor vehicle, water craft, air craft or rail vehicle owned or controlled by the state.

Reasonable Suspicion—belief based upon reliable, objective and articulable facts derived from direct observation of specific physical, behavioral, odorous presence, or performance indicators and being of sufficient import and quantity to lead a prudent person to suspect that an employee is in violation of this policy.

Safety-Sensitive or *Security-Sensitive*—a position determined by the appointing authority to contain duties of such nature that the compelling state interest to keep the incumbent drug-free outweighs the employee's privacy interests. Executive Order Number MJF 98-38 sets forth the following non-exclusive list of examples of safety-sensitive and/or security-sensitive positions in state government:

1. positions with duties that may require or authorize the safety inspection of a structure;
2. positions with duties that may require or authorize access to a prison or an incarcerated individual;

3. positions with duties that may require or authorize carrying a firearm;

4. positions with duties that may allow access to controlled substances (drugs);

5. positions with duties that may require or authorized inspecting, handling, or transporting hazardous waste as defined in R.S. 30:2173(2) or hazardous materials as defined in R.S. 32:1502(5);

6. positions with duties that may require or authorize any responsibility over power plant equipment;

7. positions with duties that may require instructing or supervising any person to operate or maintain, or that may require or authorize the operating or maintaining, any heavy equipment or machinery;

8. positions with duties that may require or authorize the operation or maintenance of a public vehicle, or the supervision of such an employee.

Under the Influence—for the purposes of this policy, a drug, chemical substance, or the combination of a drug, chemical substance that affects an employee in any detectable manner. The symptoms or influence are not confined to that consistent with misbehavior, nor to obvious impairment of physical or mental ability, such as slurred speech or difficulty in maintaining balance. A determination of influence can be established by a professional opinion or a scientifically valid test.

Workplace—any location on agency property including all property, offices, facilities, vehicles and equipment, whether owned, leased or otherwise used by the agency or by an employee on behalf of the agency in the conduct of its business, in addition to any location from which an individual conducts agency business while such business is being conducted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1145 (June 1999).

§107. DSS Drug-free Workplace Policy

A. It shall be the policy of DSS to maintain a drug-free workplace and a workforce free of substance abuse (see DSS Policy 8050-89). Employees are prohibited from reporting for work, performing work, or otherwise being on any duty status for DSS with the presence in their bodies of illegal drugs, controlled substances, or designer (synthetic) drugs at or above the initial testing levels and confirmatory testing levels as established in the contract between the State of Louisiana and the official provider of drug testing services. Employees are further prohibited from illegal use, possession, dispensation, distribution, manufacture, or sale of controlled substances, designer (synthetic) drugs, and illegal drugs at the work site and while on official state business, on duty or on call for duty.

B. To assure maintenance of a drug-free workforce, it shall be the policy of DSS to implement a program of drug testing in accordance with Executive Order Number MJF 98-38, R.S. 49:1001 et seq., and all other applicable federal and state laws, as set forth below.

C. DSS will begin drug testing after the Division of Administration (DOA) awards the request for proposal to a drug testing service and provides procedures to the department regarding the use of the drug testing service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1146 (June 1999).

§109. Conditions Requiring Drug Tests

A. DSS shall require drug testing under the following conditions.

1. Reasonable Suspicion. Any employee shall be required to submit to a drug test if there is a reasonable suspicion (as defined in this policy) that the employee is using illegal drugs. At least two supervisors/managers must concur there is reasonable suspicion before an employee is required to submit to a drug test.

2. Post-Accident. Each employee involved in an accident that occurs during the course and scope of employment shall be required to submit to a drug test if the accident:

a. involves circumstances leading to a reasonable suspicion of the employee's drug use;

b. results in a fatality; or

c. results in or causes the release of hazardous waste as defined in R.S. 30:2173(2) or hazardous materials as defined in R.S. 32:1502(5).

3. Rehabilitation Monitoring. Any employee who is participating in a substance abuse after-treatment program or who has a rehabilitation agreement with the agency shall be required to submit to random drug testing.

4. Pre-Employment. Each prospective employee shall be required to submit to drug screening at the time and place designated by the appointing authority or designee following a job offer contingent upon a negative drug-testing result. Pursuant to R.S. 49:1008, a prospective employee who tests positive for the presence of drugs in the initial screening or who fails to cooperate in the testing shall be eliminated from consideration for employment.

5. Safety-Sensitive and Security-Sensitive Positions—Appointments and Promotions. Each employee who is offered a safety-sensitive or security sensitive position (as defined in this policy) shall be required to pass a drug test before being placed in such position, whether through appointment or promotion. (See §119 listing of these positions.)

6. Safety-Sensitive and Security-Sensitive Positions—Random Testing. Every employee in a safety-sensitive or security-sensitive position shall be required to submit to drug testing as required by the appointing authority, who shall periodically call for a sample of such employees, selected at random by a computer-generated random selection process, and require them to report for testing. All such testing shall, if practicable, occur during the selected employee's work schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1146 (June 1999).

§111. Procedure

A. Drug testing pursuant to this policy shall be conducted for the presence of any illegal drugs including, but not limited to, cannabinoids (marijuana metabolites), cocaine metabolites, opiate metabolites, phencyclidine, and amphetamines in accordance with the provisions of R.S. 49:1001 et seq. DSS reserves the right to test employees for

the presence of any other illegal drugs or controlled substance when there is a reasonable suspicion to do so.

B. The human resource director of each Office shall be involved in any determination that one of the above-named conditions requiring drug-testing exists. Upon such determination, the appointing authority or designee for each Office shall notify the supervisor of the employee to be tested, who shall immediately notify the employee where and when to report for the testing.

C. Testing services shall be performed by a provider chosen by the Office of State Purchasing, Division of Administration, pursuant to applicable bid laws. At a minimum, the testing service shall assure the following.

1. All specimen collections will be performed in accordance with applicable federal and state regulations and guidelines to ensure the integrity of the specimens and the privacy of the donors. The appointing authority or designee for each Office shall review and concur in advance with any decision by a collection site person to obtain a specimen under direct observation. All direct observation shall be conducted by a collection site person of the same gender.

2. Chain of custody forms must be provided to ensure the integrity of each urine specimen by tracking its handling and storage from point of collection to final disposition.

3. Testing shall be performed by a SAMSHA-certified (Substance Abuse Mental Services Health Administration) laboratory.

4. The laboratory shall use a cut-off of 50 ng/ml for a positive finding in testing for cannabinoids.

5. All positives reported by the laboratory must be confirmed by gas/chromatography/mass spectrometry.

6. All initial positive results of drug-testing shall be reported by the laboratory to a qualified medical review officer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1146 (June 1999).

§113. Confidentiality

All information, interviews, reports, statements, memoranda, and/or test results received by DSS through its drug testing program are confidential communications, pursuant to R.S. 49:1012, and may not be used or received in evidence, obtained in discovery, or disclosed in any public or private proceedings, except in an administrative or disciplinary proceeding or hearing, or civil litigation where drug use by the tested individual is relevant. These records will be kept in a locked confidential file just as any other medical records are retained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1147 (June 1999).

§115. Responsibilities

A. The Secretary of DSS is responsible for the overall compliance with this policy and shall submit to the Office of the Governor, through the Commissioner of Administration, a report on this policy and drug testing program; describing the process, the number of employees affected, the categories of testing being conducted, the associated costs of testing, and the effectiveness of the program by November 1 of each year.

B. The appointing authority or designee is responsible for administering the drug testing program; determining when drug testing is appropriate; receiving, acting on, and holding confidential all information received from the testing services provider and from the medical review officer; and collecting appropriate information necessary to agency defense in the event of legal challenge.

C. All supervisory personnel are responsible for assuring that each employee under their supervision receives a copy of this policy, signs a receipt form, and understands or is given the opportunity to understand and have questions answered about its contents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1147 (June 1999).

§117. Violation of the Policy

A. Positive Test Result. Any employee reported with a confirmed positive test will be subject to the following disciplinary action, up to and including termination at the Secretary's discretion. Post-accident or return to duty tests which are positive will result in the employee's termination. At a minimum the following actions will be taken in the instance of a first positive test.

1. The safety-sensitive employee will be suspended without pay for a period of time determined by the appointing authority but not less than one week.

2. The employee must meet with an approved chemical abuse counselor for a substance abuse evaluation. The employee must release the substance abuse evaluation prior to returning to duty. The evaluation will become part of the follow-up plan for that employee to continue employment with the department.

3. The employee shall be screened on a random basis for not less than 12 months nor more than 60 months. Follow-up testing, return to duty testing, counseling and any other recommended treatment will be at the cost of the employee and not the department.

B. Refusal to Test. Any employee refusing to submit to a drug test will be subject to the consequences of a positive test. A refusal is defined as a verbal refusal, abusive language to the supervisor or personnel performing the test, or tampering of any sample, container, equipment or documentation of the sampling process. If a test is determined to be invalid, it is not considered a refusal and no disciplinary action will be taken. Inability to perform the testing procedures must be documented by a medical physician and recorded in the employee's personnel file.

C. Challenging Test Results. All initial screening tests must be confirmed by a second more accurate test with the results reviewed by a medical review officer. If a current or prospective employee receives a confirmed positive test result, he/she may challenge the test results within 72 hours of actual notification, with the understanding that he/she might be placed on suspension pending investigation, until the challenge is resolved. A written explanation of the reason for the positive test result may be submitted to the medical review officer. Employees who are on legally prescribed and obtained medication for a documented illness, injury or ailment will be eligible for continued employment upon receiving clearance from the medical review officer.

D. Other Violations. Each violation and alleged violation of this policy will be handled on an individual basis, taking into account all data, including the risk to self, fellow employees, clients, and the general public.

E. Failure to comply with provision of the policy, including but not limited to, the following, will be grounds for disciplinary action:

1. possession of controlled substances without a prescription or sale of controlled substances will be cause for immediate discharge;

2. refusal or failure to report to an approved counseling or rehabilitation program after voluntarily requesting help for drug addiction;

3. refusal or failure to report to an approved counseling or rehabilitation program, if advised by the department to do so, after a confirmed positive test for any substance prohibited by this policy;

4. leaving a treatment program prior to completion and not being properly released to return to work.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1147 (June 1999).

§119. Attachment A—Safety-Sensitive and Security-Sensitive Positions Within DSS

A candidate for one of the following positions will be required to pass a drug test before being placed in such a position, whether through appointment or promotion:

Louisiana Rehabilitation Services	Registered Nurse Licensed Practical Nurse Psychiatric Aide Supervisor Psychiatric Aide Rehabilitation Facility Supervisor Rehabilitation Aide Maintenance Repairer Maintenance Repairer Master Administrative Specialist 3 (Position 060871)
Office of Family Support	Support Enforcement Specialist I Support Enforcement Regional Administrator Support Enforcement District Manager Support Enforcement Specialist II Support Enforcement Supervisor
Office of Community Services	Social Service Counselor I Social Service Counselor II Social Service Counselor Supervisor Social Service Counselor/Adoption Social Service Specialist Intern Social Service Specialist I Social Service Specialist II Social Service Specialist III Social Service Supervisor Client Service Worker
Office of the Secretary/Office of Management and Finance	Licensing Specialist External Auditor Mailroom Courier

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1148 (June 1999).

§121. Attachment B—Procedures for Scheduling Drug Testing

A. On a yearly basis a percentage of all DSS employees in safety-sensitive or security-sensitive positions will be randomly drug-tested. One-twelfth of that number will be scheduled each month.

1. Information services will set up a computerized system which will randomly select a designated number of employees by social security numbers.

2. Each month the appropriate managers will be notified by human resources of the names of employees in their office location randomly selected to be drug-tested. The names of employees to be tested must be kept confidential at all times.

3. Based on each individual employee's schedule, at the earliest possible date within the designated month, the appropriate manager will notify the employee in writing first thing in the morning that they must report to a designated lab for testing. Human resources must be notified if an employee is on extended leave.

4. Each employee must go to the designated lab within 24 hours of being notified.

5. The office human resources personnel will be notified of the results of the tests. All test results must be kept confidential and retained in a locked file cabinet.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:1001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of the Secretary, LR 25:1148 (June 1999).

Madlyn B. Bagneris
Secretary

9906#061

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