Colorado Register

38 CR 9

Volume 38 , No. 9

May 10, 2015

Introduction

The *Colorado Register* is published pursuant to C.R.S. 24-4-103(11) and is the sole official publication for state agency notices of rule-making, proposed rules, attorney general's opinions relating to such rules, and adopted rules. The register may also include other public notices including annual departmental regulatory agendas submitted by principal departments to the secretary of state.

"Rule" means the whole or any part of every agency statement of general applicability and future effect implementing, interpreting, or declaring law or policy or setting forth the procedure or practice requirements of any agency. "Rule" includes "regulation". C.R.S. 24-4-102(15). Adopted rules are effective twenty days after the publication date of this issue unless otherwise specified.

The *Colorado Register* is published by the office of the Colorado Secretary of State twice monthly on the tenth and the twenty-fifth. Notices of rule-making and adopted rules that are filed from the first through the fifteenth are published on the twenty-fifth of the same month, and those that are filed from the sixteenth through the last day of the month are published on the tenth of the following month. All filings are submitted through the secretary of state's electronic filing system.

For questions regarding the content and application of a particular rule, please contact the state agency responsible for promulgating the rule. For questions about this publication, please contact the Administrative Rules Program at rules@sos.state.co.us.

Notice of Proposed Rulemaking

Tracking number

2015-00219

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

TITLES AND REGISTRATIONS

Rulemaking Hearing

Date

06/01/2015

Time

10:00 AM

Location

1881 Pierce Street, Lakewood, CO. 80214, Rm 110 Boards/Commissions Mtg Room

Subjects and issues involved

The following rules and regulations are promulgated to establish a process for the cancellation of vehicle registration and the reinstatement of vehicle registration subsequent to cancellation.

Statutory authority

The statutory bases for this regulation are sections 42-1-204, 42-3-120, 42-4-235 (2)(d) C.R.S.

Contact information

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DEPARTMENT OF REVENUE

Division of Motor Vehicles – Title and Registration Section

1 CCR 204-10

RULE 3. CANCELLATION OF VEHICLE REGISTRATION FOR FAILURE TO PAY CIVIL PENALTIES

Basis: The statutory bases for this regulation are sections 42-1-204, 42-3-120, 42-4-235 (2)(d) C.R.S.

Purpose: The following rules and regulations are promulgated to establish a process for the cancellation of vehicle registration and the reinstatement of vehicle registration subsequent to cancellation.

1.0 Definition

1.1 "Cancellation" means to remove the registration information from the motor vehicle record located in the Department's motor vehicle database which would denote that the license plates have been cancelled and no further registration transactions shall be conducted for that vehicle until further notice.

2.0 Process

2.1 Upon notification from the Colorado State Patrol, the Department shall cancel the vehicle registration per C.R.S. 42-3-120 or 42-4-235.

2.2 Upon notification from the Colorado State Patrol that the registration record may be re-registered, the Department will reactivate the record to allow the vehicle to be re-registered and license plates to be issued to the vehicle.

2.3 At the time of re-registration, the registered owner will be required to pay all registration fees for the 12 month cycle beginning with the month of re-registration.

2.4 Credit of registration fees and ownership taxes paid for the registration which was cancelled will be allowed to the extent of any unexpired time remaining on the cancelled registration at the time of re-registration.

2.5 All applicable registration fees, material fees, and prior ownership tax shall be collected prior to re-registration of the vehicle.

Notice of Proposed Rulemaking

Tracking number

2015-00223

Department

500,1008,2500 - Department of Human Services

Agency

502 - Behavioral Health

CCR number

2 CCR 502-5

Rule title

Behavioral Health Executive Director Rules

Rulemaking Hearing

Date

06/05/2015

Time

11:30 AM

Location

Colorado Department of Human Services, 1575 Sherman Street, 8th Floor C-Stat Room, Denver, CO 80203

Subjects and issues involved

#15-4-10-1: Procedures for Applying for and Awarding of Gambling Addiction Grants

Statutory authority

12-47.1-1601(4)(a.5)(I); 26-1-105(2)(a); 26-1-108; 26-1-109; 26-1-111; 27-61-101, C.R.S. (2014)

Contact information

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Title of Proposed Rule: Procedures for Applying for and Awarding of Gambling Addiction Grants

Rule-making#: 15-4-10-1

Office/Division or Program: Office of Behavioral Health/ Community Programs

Rule Author: Ryan Templeton

Phone: 303-866-7405

E-Mail: ryan.templeton@state.co.us

STATEMENT OF BASIS AND PURPOSE

Summary of the basis and purpose for the rule or rule change. *(State what the rule says or does, explain why the rule or rule change is necessary and what the program hopes to accomplish through this rule. How do these rule changes align with the outcomes that we are trying to achieve, such as those measured in C-Stat?)*

These proposed rules establish the procedures for applying for and awarding of grants for gambling addiction counseling, required by executive director rule-making authority. Gambling addiction can affect all areas of an individual's life. These rules outline how grants are applied for and awarded to provide counseling for Colorado residents assessed to be problem gamblers, as well as others who have been affected by problem gambling.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

☐ to comply with state/federal law and/or

☐ to preserve public health, safety and welfare

Explain:

Authority for Rule:

Executive Director Authority: 26-1-108, C.R.S. (2014) – powers and duties of the executive director, including rule-making;
26-1-109, C.R.S. (2014) – state department rules to coordinate with federal programs;
26-1-111, C.R.S. (2014) - state department to promulgate rules for public assistance and welfare activities.

Program Authority:
12-47.1-1601(4)(a.5)(I), C.R.S. (2014) - executive director shall adopt rules establishing the procedure for applying for and awarding a gambling addiction grant;
26-1-105(2)(a), C.R.S. (2014) – executive director may establishing such division, sections and other units within the state department as are necessary for the proper and efficient discharge of its power, duties, and function;
27-61-101, C.R.S. (2014) – creating the office of behavioral health

Initial Review	05/08/2015	Final Adoption	06/05/2015
Proposed Effective Date	08/01/2015	EMERGENCY Adoption	N/A

[Note: "Strikethrough" indicates deletion from existing rules and "all caps" indicates addition of new rules.]

Title of Proposed Rule: Procedures for Applying for and Awarding of Gambling Addiction Grants

Rule-making#: 15-4-10-1

Office/Division or Program: Office of Behavioral Health/ Community Programs

Rule Author: Ryan Templeton

Phone: 303-866-7405

E-Mail: ryan.templeton@state.co.us

STATEMENT OF BASIS AND PURPOSE (continued)

Does the rule incorporate material by reference?		Yes	X	No
Does this rule repeat language found in statute?		Yes	X	No
If yes, please explain.				

The program has sent this proposed rule-making package to which stakeholders?

Stakeholders who will be contacted include: a representative from the Colorado Department of Public Health and Environment, a Managed Service Organization, a substance use program that provides gambling addiction counseling, and the Problem Gambling Coalition of Colorado.

Attachments:
Regulatory Analysis
Overview of Proposed Rule
Stakeholder Comment Summary

Title of Proposed Rule: Procedures for Applying for and Awarding of Gambling Addiction Grants

Rule-making#: 15-4-10-1

Office/Division or Program: Office of Behavioral Health/ Community Programs

Rule Author: Ryan Templeton

Phone: 303-866-7405

REGULATORY ANALYSIS

1. List of groups impacted by this rule:
Which groups of persons will benefit, bear the burdens or be adversely impacted by this rule?

All Colorado residents will benefit from having more gambling counseling services available.

The groups of persons who will benefit from this rule are the Colorado residents in need of gambling addiction counseling, due to having grant moneys available for gambling addiction counseling, including prevention and education.

2. Describe the qualitative and quantitative impact:
How will this rule-making impact those groups listed above? How many people will be impacted? What are the short-term and long-term consequences of this rule?

Short-term consequences of this rule are that more moneys, in the form of grants, will be available for gambling addiction counseling.

Long-term consequences of this rule are that more and more Colorado residents in need of gambling addiction counseling will receive counseling services, which will create a more informed society regarding prevention and education around gambling addiction.

3. Fiscal Impact:
For each of the categories listed below explain the distribution of dollars; please identify the costs, revenues, matches or any changes in the distribution of funds even if such change has a total zero effect for any entity that falls within the category. If this rule-making requires one of the categories listed below to devote resources without receiving additional funding, please explain why the rule-making is required and what consultation has occurred with those who will need to devote resources.

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

Since the gambling addiction counseling grants will be awarded to existing programs that provide gambling addiction counseling services, either local public or private entities, there will be no State Fiscal Impact.

Pursuant to Section 12-47.1-701(2)(a)(III), C.R.S., of the moneys transferred to the limited gaming impact account and the gambling addiction account, two percent shall be used to award grants from the provision of gambling addiction counseling, including prevention and education, to Colorado residents.

County Fiscal Impact

Since the gambling addiction counseling grants will be awarded to existing programs that provide gambling addiction counseling services, either local public or private entities, there will be no County Fiscal Impact.

REGULATORY ANALYSIS (continued**)**

Federal Fiscal Impact

Since the gambling addiction counseling grants will be awarded to existing programs that provide gambling addiction counseling services, either local public or private entities, there will be no Federal Fiscal Impact.

No federal moneys are involved, only state moneys from the local government limited gaming impact fund are awarded as gambling addiction counseling grants.

Other Fiscal Impact *(such as providers, local governments, etc.)*

Since the gambling addiction counseling grants will be awarded to existing programs that provide gambling addiction counseling services, either local public or private entities, there will be no Other Fiscal Impact.

Pursuant to Section 12-47.1-701(2)(a)(III), C.R.S., of the moneys transferred to the limited gaming impact account and the gambling addiction account, two percent shall be used to award grants from the provision of gambling addiction counseling, including prevention and education, to Colorado residents.

4. Data Description:
List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

No data was used in development of this rule.

5. Alternatives to this Rule-making:
Describe any alternatives that were seriously considered. Are there any less costly or less intrusive ways to accomplish the purpose(s) of this rule? Explain why the program chose this rule-making rather than taking no action or using another alternative.

No alternatives were considered. Section 12-47.1-1601(4)(a.5)(I), C.R.S., requires the executive director of the department of human services to promulgate rules.

Title of Proposed Rule: Procedures for Applying for and Awarding of Gambling Addiction Grants

Rule-making#: 15-4-10-1

Office/Division or Program: Office of Behavioral Health/ Community Programs

Rule Author: Ryan Templeton

Phone: 303-866-7405

OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Section Numbers	Current Regulation	Proposed Change	Stakeholder Comment			
20.000	New	Executive Director rules for applying for and awarding of gambling addiction grants	__	Yes	X	No
20.100	New	General authority for grant awards	__	Yes	X	No
20.200	New	Grants will be awarded to local public or private programs that provide gambling addiction counseling services	__	Yes	X	No
20.300	New	Application procedure and criteria for grant awardees	__	Yes	X	No
20.400	New	A quarterly report is required	__	Yes	X	No

Title of Proposed Rule: Procedures for Applying for and Awarding of Gambling Addiction Grants

Rule-making#: 15-4-10-1

Office/Division or Program: Office of Behavioral Health/ Community Programs

Rule Author: Ryan Templeton

Phone: 303-866-7405

STAKEHOLDER COMMENT SUMMARY

DEVELOPMENT

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

No other individuals and/or entities were included in the development of these proposed rules.

THIS RULE-MAKING PACKAGE

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

Stakeholders who will be contacted include: a representative from the Colorado Department of Public Health and Environment, a Managed Service Organization, a substance use program that provides gambling addiction counseling, and the Problem Gambling Coalition of Colorado.

Are other State Agencies (such as Colorado Department of Health Care Policy and Financing) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

[ ] Yes [X] No

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[ ] Yes [X] No

Date presented _____. Were there any issues raised? ____ Yes ____ No

If not, why. Since the gambling addiction counseling grants will be awarded to existing programs that provide gambling addiction counseling services, either local public or private entities, there will be no county impact.

Comments were received from stakeholders on the proposed rules:

[ ] Yes [X] No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

20.000 EXECUTIVE DIRECTOR RULES CONCERNING THE PROCEDURE FOR AWARDING GAMBLING ADDICTION GRANTS

20.100 GENERAL PROVISIONS

PURSUANT TO SECTION 12-47.1-701(2)(a)(III), C.R.S., OF THE MONEYS TRANSFERRED TO THE LIMITED GAMING IMPACT ACCOUNT AND THE GAMBLING ADDICTION ACCOUNT, TWO PERCENT SHALL BE USED TO AWARD GRANTS FOR THE PROVISION OF GAMBLING ADDICTION COUNSELING, INCLUDING PREVENTION AND EDUCATION, TO COLORADO RESIDENTS.

20.200 APPLICATION AND AWARDING PROCEDURE AND CRITERIA FOR FISCAL AGENTS

PURSUANT TO SECTION 12-102-201, C.R.S., AN ORGANIZATION WILL BE SELECTED TO BE A FISCAL AGENT FOR THE GRANT AWARD PROCESS IN ACCORDANCE WITH THE COLORADO PROCUREMENTS CODE AS FOUND IN THE COLORADO DEPARTMENT OF PERSONNEL AND ADMINISTRATION (1 CCR 101-9).

20.300 GRANT APPLICATION AND AWARDING PROCEDURE, AND CRITERIA FOR GRANT AWARDEES

A. GRANTS SHALL BE AWARDED TO:

1. LOCAL PUBLIC OR PRIVATE ENTITIES.

2. PROGRAMS OR INDIVIDUALS THAT PROVIDE GAMBLING ADDICTION COUNSELING SERVICES AND HAVE OR ARE SEEKING NATIONALLY ACCREDITED GAMBLING ADDICTION COUNSELORS.

B. A MAJORITY OF THE MONEYS IN THE GAMBLING ADDICTION ACCOUNT SHALL BE AWARDED, AS GRANTS, FOLLOWING GRANT PROCEDURES IDENTIFIED IN SECTION A, ABOVE, TO BEHAVIORAL HEALTH PROFESSIONALS AND ADDICTION COUNSELORS PURSUING NATIONAL CERTIFICATION AS A GAMBLING COUNSELOR.

C. IN ORDER TO ENSURE THAT QUALIFIED AND COMPETENT PROFESSIONALS WILL PROVIDE TREATMENT SERVICES TO THOSE INDIVIDUALS WHO ARE ASSESSED TO BE PROBLEM GAMBLERS AS WELL AS OTHERS WHO HAVE BEEN AFFECTED BY THE PROBLEM GAMBLER, APPLICANTS SHALL PROVIDE PROOF THAT HE OR SHE HAS COMPLETED AT LEAST HALF OF THE COUNSELING HOURS REQUIRED FOR NATIONAL ACCREDITATION.

D. THE FISCAL AGENT SHALL ENSURE THAT THE APPLICANTS MEET THE FOLLOWING REQUIREMENTS:

1. BACHELOR'S DEGREE IN A BEHAVIORAL HEALTH FIELD;

2. A MINIMUM OF FIFTEEN (15) HOURS OF APPROVED GAMBLING SPECIFIC TRAINING OR EDUCATION WITH APPROPRIATE SUPPORTING DOCUMENTATION;

3. A MINIMUM OF FIFTY (50) HOURS AS A GAMBLING COUNSELOR DELIVERING DIRECT TREATMENT TO PROBLEM/PATHOLOGICAL GAMBLERS AND SIGNIFICANT OTHERS; AND,

4. A MINIMUM OF TWO (2) ONE-HOUR SESSIONS OF APPROVED SUPERVISION/CONSULTATION WITH AN INTERNATIONAL GAMBLING COUNSELOR BOARD APPROVED CLINICAL CONSULTANT (BACC).

E. FISCAL AGENTS SHALL OBTAIN VERIFICATION THAT THE GRANT AWARDEES MAINTAINED OR OBTAINED THEIR NATIONAL CERTIFICATION AS A GAMBLING COUNSELOR.

20.400 REPORTING

THE FISCAL AGENT SELECTED SHALL SUBMIT A QUARTERLY REPORT TO THE COLORADO DEPARTMENT OF HUMAN SERVICES WITHIN THIRTY (30) DAYS OF THE END OF EACH QUARTER. THESE REPORTS SHALL DETAIL:

A. THE NUMBER OF GRANT APPLICATIONS RECEIVED;

B. THE AMOUNT OF MONEY REQUESTED;,

C. THE TOTAL AMOUNT OF MONEY AWARDED

D. THE PERSONS RECEIVING THE GRANTS; AND,

E. THE DOLLAR AMOUNTS AWARDED TO EACH PERSON.

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Notice of Proposed Rulemaking

Tracking number

2015-00221

Department

700 - Department of Regulatory Agencies

Agency

701 - Division of Banking

CCR number

3 CCR 701-1

Rule title

COMMERCIAL BANKS

Rulemaking Hearing

Date

06/18/2015

Time

10:00 AM

Location

Division of Banking, 975 Conference Room, 1560 Broadway, Suite 975, Denver, CO 80202

Subjects and issues involved

Proposed repeal of CB101.57 to eliminate requirement for paper submission of Suspicious Activity Reports to the State Bank Commissioner.

Statutory authority

11-102-104(1), C.R.S.

Contact information

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Banking Board Secretary

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CB101.57 Suspicious Activity Reports [Section 11-102-104, C.R.S.]

A. A federally insured state chartered institution shall file with the State Bank Commissioner (Commissioner) a copy of the form filed to report apparent criminal violations, FFIEC Form-Suspicious Activity Report, with the U.S. Department of the Treasury's Financial Crimes Enforcement Network (FinCEN) pursuant to 12 U.S.C. 324, 334, et.al. The form shall be filed with the Commissioner within three (3) business days of the filing of said form with the FinCEN. The fact that a report is required by this Rule should not in any case deter the institution from first informing the Commissioner by telephone or other expeditious means of an apparent violation when such is deemed fitting.

B. Failure to comply with this Rule may result in a levy by the Banking Board of a penalty of up to $25.00 per day for each day the report is not filed.

C. Reference:

1. 12 U.S.C. 324, 334 and 12 U.S.C. 93a are federal statutes granting authority to the Board of Governors of the Federal Reserve System and the Federal Deposit Insurance Corporation.
2. This Rule does not include amendments to or editions of the referenced material later than March 2, 2006. Copies of 12 U.S.C. 324, 334 and 12 U.S.C. 93a may be examined at any State Publications Depository.
3. For more detailed information pertaining to this Rule, please contact the Secretary to the Colorado State Banking Board at 1560 Broadway, Suite 1175, Denver, CO 80202, 303-894-7584.

COLORADO
Department of
Regulatory Agencies
Division of Banking

1560 Broadway, Suite 975
Denver, CO 80202

April 17, 2015

BEFORE THE
COLORADO STATE BANKING BOARD

IN THE MATTER OF	)	
	)	**NOTICE OF PROPOSED RULEMAKING**
RULE REPEAL	)	

I. Notice of hearing

PLEASE BE ADVISED THAT, as required by Section 24-4-103, C.R.S., of the State Administrative Procedures Act, the Colorado State Banking Board (Banking Board) hereby gives notice of proposed rulemaking. A hearing is scheduled for June 18, 2015, commencing at 10:00 a.m., at the Division of Banking (Division), DORA 975 Conference Room, 1560 Broadway, Suite 975, Denver, Colorado.

II. Purpose of the proposed rulemaking

The purpose of the hearing is to hear comments concerning the proposed repeal of Banking Board Rule **CB101.57 – Suspicious Activity Reports**, which requires Colorado state-chartered banks to provide a copy of the Suspicious Activity Report (SAR) to the Commissioner. The reports are now accessible to regulators online; therefore, paper submissions are no longer necessary.

III. Statutory authority for proposed rulemaking

The proposed repeal of the rule is being held under the authority given the Banking Board by the Colorado Banking Code in accordance with Section 11-102-104(1), C.R.S., which states "the banking board is the policy-making and rule-making authority for the division of banking and has the power to: (a) make, modify, reverse, and vacate rules for the proper enforcement and administration of this code…"

IV. Opportunity to testify and submit written comments

Any interested person(s) has the right to submit written comments or data, view, or argument. Written information should be filed with the Division no later than June 8, 2015. To submit written comments, please contact Diana Gutierrez, Banking Board Secretary, at diana.gutierrez@state.co.us. In addition, any interested person(s) has the right to make an oral presentation at the Hearing, unless the Banking Board deems any oral presentation unnecessary.

SUBMITTED ON BEHALF OF THE
COLORADO STATE BANKING BOARD

Kenneth Boldt

Kenneth Boldt
Acting State Bank Commissioner

COLORADO
Department of
Regulatory Agencies
Division of Banking

1560 Broadway, Suite 975
Denver, CO 80202

April 16, 2015

STATE BANKING BOARD
RULE CB101.57
PERTAINING TO TITLE 11, ARTICLE 102, SECTION 104
COLORADO REVISED STATUTES

STATEMENT OF BASIS, PURPOSE AND SPECIFIC AUTHORITY

Statutory Basis

A federally insured state-chartered institution is required to file a Suspicious Activity Report (SAR) with the United States Department of the Treasury's Financial Crimes Enforcement Network (FinCEN) when it suspects criminal violations, money laundering, or other illegal activities. Banking Board Rule CB101.57 – Suspicious Activity Report, requires a copy of the SAR to be filed with the Commissioner within three (3) business days of the filing with FinCEN.

Beginning in 2012, FinCEN required the electronic filing of SARs and other reports related to the Bank Secrecy Act/Anti-Money Laundering (BSA/AML) regulations. Financial institutions complete the filing electronically, but then must print a copy of the form and send it to the attention of the Commissioner. The Division of Banking (Division) has the ability to access SARs through FinCEN's SAR database. The Division no longer needs a copy of the SAR to complete its compliance review of a financial institution's BSA/AML compliance program.

Specific Purpose of this Rulemaking

The purpose of this rulemaking is to repeal Banking Board Rule CB101.57 – Suspicious Activity Report, which requires Colorado state-chartered banks to provide a copy of the SAR to the Commissioner.

Rulemaking Authority

Sections 11-101-102 and 11-102-104(1)(a), C.R.S.

Notice of Proposed Rulemaking

Tracking number

2015-00229

Department

700 - Department of Regulatory Agencies

Agency

702 - Division of Insurance

CCR number

3 CCR 702-4 Series 4-2

Rule title

LIFE, ACCIDENT AND HEALTH, Series 4-2

Rulemaking Hearing

Date

06/02/2015

Time

01:30 PM

Location

1560 Broadway, Ste 850, Denver CO 80202

Subjects and issues involved

4-2-51 CARRIER DISCONTINUANCE OF A HEALTH BENEFIT PLAN AND A STUDENT HEALTH PLAN

Statutory authority

10-1-109, 10-16-105.1(6)(a), 10-16-105.7(3)(c), and 10-16-109

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed Amended Regulation 4-2-51

CARRIER DISCONTINUANCE OF A HEALTH BENEFIT PLAN AND A STUDENT HEALTH PLAN

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109, 10-16-105.1(6)(a), 10-16-105.7(3)(c), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards for carriers in discontinuing health benefit plans pursuant to the requirements of Colorado law.

Section 3 Applicability

This regulation shall apply to individual ~~and~~, small group, and large group health benefit plans and student health insurance coverage plans subject to the ~~individual and group~~ health insurance laws of Colorado.

Section 4 Definitions

A. "Carrier" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Creditable coverage" shall, for purposes of this regulation, have the same meaning as found at § 10-16-102(16), C.R.S.

C. "Exchange" shall, for the purposes of this regulation, have the same meaning as set forth in § 10-16-102(26), C.R.S.

D. "Health benefit plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(32), C.R.S.

E. "Grandfathered health benefit plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(31), C.R.S.

~~E~~ F. "SERFF" shall ~~means~~, for the purposes of this regulation, mean System for Electronic Rate and Form Filings.

G. "Small group plan" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(63), C.R.S.

H. "Student health insurance coverage" shall, for the purposes of this regulation, have the same meaning as found at § 10-16-102(65), C.R.S.

I. "Transition plan" shall, for the purposes of this regulation, mean non-compliant non-grandfathered health benefit plans that a carrier elected to continue into 2015, but that cannot continue beyond December 31, 2015.

Section 5 ~~Rules~~Discontinuance of Individual and Small Group Health Benefit Plans

A. Prior to discontinuing any grandfathered or non-grandfathered individual or small group health benefit plans, a carrier must notify the Division of Insurance (Division) of such discontinuance by submitting a filing to the Division. All filings shall be submitted electronically via SERFF by a licensed entity. Failure to supply the required information specified in this regulation will render the filing incomplete, and such a filing may be rejected. A separate filing must be sent for each Line of Business being discontinued. The SERFF filing should be submitted as:

1. Type of Filing "Other"; and

2. Type of Insurance (TOI) code H21, or for HMO's code HOrg03.

B. Until an individual or small group health benefit plan becomes subject to the provisions of HB13-1266, carriers electing to discontinue individual or small group plans must do so in accordance with the requirements found at § 10-16-201.5, C.R.S. (2012).

C. For plans issued after January 1, 2014, carriers that elect to non-renew or discontinue individual or small group health benefit plans must do so in accordance with the requirements found at § 10-16-105.1(2)(g), C.R.S. The carrier shall offer policyholders the option of purchasing any other health benefit plan currently being offered by the carrier for which they qualify.

D. The carrier shall provide notice of the decision not to renew or continue coverage to each policyholder at least ninety (90) days prior to the date of nonrenewal or discontinuance.

E. Carriers shall include notice to the policyholder of eligibility for special enrollment periods, as established pursuant to § 10-16-105.7, C.R.S., with the nonrenewal or discontinuance notice.

F. Carriers must use the notification language provided in Attachment A in order to provide sufficient notification to policyholders.

G. Carrier discontinuance of a health benefit plan qualifies the policyholder for a special enrollment period pursuant to § 10-16-105.7(3), C.R.S. as an involuntary loss of creditable coverage.

~~H. Carriers shall provide the following information in SERFF to the Division when discontinuing plans:~~

~~1. The Form Schedule Tab in SERFF must be completed with the form name, form number, edition date, form type, and action for each policy form that is being discontinued. Listing the readability score and attaching the actual forms is not required.~~

~~2. Copies of all proposed policyholder notices for Division review.~~

~~3. A letter addressed to the Commissioner that contains a summary of the carrier's discontinuance actions must be attached as a supporting document and must contain the following information:~~

~~a. Effective date of the discontinuance and/or exit from the market;~~

~~b. The reason for the carrier's action;~~

~~c. The market segment being discontinued;~~

~~d. Number of people affected (by county); and~~

~~e. Grandfathered/Non-Grandfathered status.~~

~~4. The form found in Appendix B of this regulation shall be completed and included with this filing.~~

~~5. The form found in Appendix C of this regulation shall be completed and included with this filing.~~

Section 6 **Discontinuance of Large Group Health Benefit Plans and Student Health Insurance Coverage**

Large group carriers and student health insurance carriers must use the following guidelines when discontinuing large group health benefit plans or student health insurance coverage plans to ensure adequate consumer protection.

A. When a large group or student health coverage carrier is discontinuing a particular plan, but is remaining in the large group market or student health insurance market, the carrier must provide notice of the decision to discontinue to each policyholder, certificate holder, participant, and beneficiary covered by the plan, no less than ninety (90) days prior to discontinuation.

B. Large group and student health coverage carriers must offer policyholders the option to purchase any other large group or student health benefit plan(s), respectively, currently offered by the carrier.

C. The large group or student health coverage carrier must act uniformly without regard to the claims experience of the policyholders or any health status-related factor relating to any policyholder, certificate holder, participant, or beneficiary covered, or new participants or beneficiaries that may become eligible for such coverage.

D. With respect to the discontinuance of a particular large group plan(s), the carrier must notify the Insurance Commissioner before providing the notification required in subsection A. above.

E. A carrier discontinuing all of its large group health benefit plans or student health insurance coverage plans as part of an exit from that particular market segment shall comply with the requirements found at § 10-16-105.1(2)(h), C.R.S.

Section 7 Required SERFF Submissions

Carriers shall provide the following information via SERFF to the Division when discontinuing plans:

A. The Form Schedule Tab in SERFF must be completed with the form name, form number, edition date, form type, and action for each policy form that is being discontinued. Listing the readability score and attaching the actual forms is not required.

B. Copies of all proposed policyholder notices for Division review.

C. A letter addressed to the Commissioner that contains a summary of the carrier's discontinuance actions must be attached as a supporting document and must contain the following information:

1. Effective date of the discontinuance and/or exit from the market;

2. The reason for the carrier's action;

3. The market segment being exited or discontinued;

4. Number of people affected (by county);

5. Grandfathered/Non-Grandfathered status; and

6. A statement as to whether or not the plan is a transition plan.

D. The form found in Appendix B of this regulation shall be completed and included with this filing.

E. The form found in Appendix C of this regulation shall be completed and included with this filing.

Section 68 Severability

If any provisions of this regulation or the application thereof to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section ~~7~~9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 810 Effective Date

This regulation ~~is~~ shall become effective August 1~~4~~5, 201~~4~~5.

Section 911 History

New ~~R~~regulation effective August 15, 2014.
Amended regulation effective August 1, 2015.

Appendix A – Carrier Discontinuance Notice

Notice to Consumers for Carrier Discontinuance (Pursuant to § 10-16-201.5, C.R.S. (2012) and § 10-16-105.1, C.R.S.)

"We would like to notify you that your current policy will be discontinued or not renewed ninety (90) days from now, on [{Month, Day, Year}] because [{company name}] will no longer offer your current health plan in the State of Colorado.

This discontinuance triggers a special enrollment period which allows you to select a new health plan. You will have ~~thirty~~ sixty (~~36~~0) days before your plan ends and sixty (60) days after the date your plan ends to enroll in a new plan.

You may begin shopping for a new health benefit plan immediately to replace the plan that is ending, and you can enroll in a new health benefit plan up to ~~thirty~~ sixty (~~36~~0) days before your current plan ends, but you will need to be able to provide proof that your current plan is ending to the carrier of the plan you want to enroll in.

This notice can serve as the proof required for enrollment in a new plan. Knowing your plan is ending gives you the ability to enroll in a new plan with coverage beginning no earlier than the day this coverage ends so that you may avoid a gap in coverage.

[If carrier is offering new ~~individual~~ plans, use:

Your options include:

- Purchasing another [individual/small group/large group] health plan from us;
- Purchasing a plan from another carrier; or
- Purchasing a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance (www.connectforhealthco.com).]

[If carrier does not offer new ~~individual~~ plans, use:

We are not going to be selling new [individual/small group/large group] plans so you won't be able to buy a new plan from us. Your options include:

- Purchasing a new plan from another carrier.
- Purchasing a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance (www.connectforhealthco.com).

You should schedule the start date of your new plan to match the end date of this plan to avoid a gap in coverage.

You can contact us, your insurance advisor, or Connect for Health Colorado for assistance and additional information. [Insert Connect for Health Colorado's contact information and ~~Carrier~~ company contact information]

[If student health insurance coverage is involved, use:

If you are in need of a new student health insurance coverage plan, please contact your [school/college/university] directly to determine what plans are available.]

APPENDIX B – HEALTH BENEFIT PLAN DISCONTINUANCES SUMMARY DATA TEMPLATE (WITH EXAMPLES):

Health Benefit Plan Discontinuances Summary [Insert Carrier Name]					
Effective Date	Market Segment	People Affected	Reason for Action	Grandfathered Status	Comments
6/30/14	Individual	6	Discontinuance of Specific Health Benefit Plan §10-16-105.1(2)(g)	Non-grandfathered	
7/1/14	Small Group	29	~~Leaving the State~~ Exiting the Market §10-16-105.1(2)(h)	Grandfathered	
8/1/14	Individual	1,256	Exiting the Market §10-16-105.1(2)(h)	Non-grandfathered	
7/13/15	Large Group	214	Discontinuance of Specific Health Benefit Plan §10-16-105.1(2)(g)	Grandfathered	
1/1/16	Student Health Insurance Coverage	1,823	Exiting the Market §10-16-105.1(2)(h)	Non-grandfathered	

APPENDIX C – HEALTH BENEFIT PLAN DISCONTINUANCES BY COUNTY DATA TEMPLATE (WITH EXAMPLES):

~~CANCELLATIONS~~DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:					
SERFF FILING #:		111111	222222	333333	
NAIC #:		44444	55555	66666	
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z	**COUNTY TOTAL**:
ADAMS COUNTY			2	3	5
ALAMOSA COUNTY					
APAPAHOE COUNTY			3	6	9
ARCHULETA COUNTY					
BACA COUNTY					
BENT COUNTY					
BOULDER COUNTY			6	100	106
BROOMFIELD COUNTY			2	43	45
CHAFFEE COUNTY		1			1
CHEYENNE COUNTY					
CLEAR CREEK COUNTY				1	1
CONEJOS COUNTY					
COSTILLA COUNTY					
CROWLEY COUNTY				1	1
CUSTER COUNTY					
DELTA COUNTY					
DENVER COUNTY			8	200	208
DOLORES COUNTY				1	1
DOUGLAS COUNTY				50	50
EAGLE COUNTY				1	1
EL PASO COUNTY				3	3
ELBERT COUNTY					

APPENDIX C – HEALTH BENEFIT PLAN DISCONTINUANCES DATA TEMPLATE BY COUNTY (WITH EXAMPLES) CONTINUED:

~~CANCELLATIONS~~DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:					
SERFF FILING #:		111111	222222	333333	
NAIC #:		44444	55555	66666	
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z	**COUNTY TOTAL**:
FREMONT COUNTY			2	9	11
GARFIELD COUNTY					
GILPIN COUNTY					
GRAND COUNTY			3	150	153
GUNNISON COUNTY					
HINSDALE COUNTY					
HUERFANO COUNTY			6	40	46
JACKSON COUNTY			2	30	32
JEFFERSON COUNTY		1			1
KIOWA COUNTY					
KIT CARSON COUNTY				1	1
LA PLATA COUNTY					
LAKE COUNTY					
LARIMER COUNTY				1	1
LAS ANIMAS COUNTY					
LINCOLN COUNTY					
LOGAN COUNTY			8	125	133
MESA COUNTY				1	1
MINERAL COUNTY				60	60
MOFFAT COUNTY				1	1
MONTEZUMA COUNTY				3	3
MONTROSE COUNTY					
MORGAN OOUNTY					

APPENDIX C – HEALTH BENEFIT PLAN DISCONTINUANCES DATA TEMPLATE BY COUNTY (WITH EXAMPLES) CONTINUED:

~~CANCELLATIONS~~DISCONTINUANCES BY COUNTY FOR [CARRIER NAME] FOR [MONTH], [YEAR]:					
SERFF FILING #:		111111	222222	333333	
NAIC #:		44444	55555	66666	
PLAN/PRODUCT NAME:		Plan X	Plan Y	Plan Z	**COUNTY TOTAL**:
OTERO COUNTY			2	12	14
OURAY COUNTY					
PARK COUNTY			3	45	48
PHILLIPS COUNTY					
PITKIN COUNTY					
PROWERS COUNTY			6	150	156
PUEBLO COUNTY			2	11	13
RIO BLANCO COUNTY		1			1
RIO GRAND COUNTY					
ROUTT COUNTY				1	1
SAGUACHE COUNTY					
SAN JUAN COUNTY					
SAN MIGUEL COUNTY				1	1
SEDGWICK COUNTY					
SUMMIT COUNTY					
TELLER COUNTY			8	120	128
WASHINGTON COUNTY				1	1
WELD COUNTY				75	75
YUMA COUNTY				1	1
OUT OF STATE				3	3
TOTAL:		**3**	**63**		**1616**

Notice of Proposed Rulemaking

Tracking number

2015-00228

Department

700 - Department of Regulatory Agencies

Agency

702 - Division of Insurance

CCR number

3 CCR 702-4 Series 4-2

Rule title

LIFE, ACCIDENT AND HEALTH, Series 4-2

Rulemaking Hearing

Date

06/02/2015

Time

01:30 PM

Location

1560 Broadway, Ste 850, Denver CO 80202

Subjects and issues involved

4-2-31 ANNUAL HEALTH REPORTING AND DATA RETENTION REQUIREMENTS

Statutory authority

10-1-109, 10-3-109, 10-16-111(4), 10-16-119(3) and 10-16-134

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed Amended Regulation 4-2-31

ANNUAL HEALTH REPORTING AND DATA RETENTION REQUIREMENTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-3-109, 10-16-111(4), 10-16-119(3) and 10-16-134, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to define uniform reporting, filing and data retention requirements for the hospital reimbursement rate report and the Annual Cost Report.

Section 3 Applicability

This regulation applies to all carriers, as defined in Section 4~~(~~.B~~)~~. of this regulation, operating in the state of Colorado with written health premium in the data year. This includes, but is not limited to carriers operating with the following types of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage, supplemental health, limited service licensed provider network business, long-term care, disability income, accident-only, specified or dread disease, hospital indemnity, vision only, dental only, other limited-medical payment plans, Medicare supplement and excess loss insurance (pursuant to §§ 10-16-119 and 10-16-119.5, C.R.S.).

Reporting of information is waived as shown for each report:

A. Hospital Reimbursement Rate Report

The following types of business are waived: Limited medical-payment plans (including disability income, accident only, specified or dread disease, hospital indemnity, vision only, and dental only), Medicare, Medicaid, long term care, and Medicare supplement insurance.

B. Annual Cost Report

~~Third party administration for fully self-funded plans, undeveloped rates that involve Medicare and Medicaid and Medicare Part D.~~ The Division has been granted authority to waive the reporting requirement for carriers responding to the Colorado Health Cost Report so long as at least those representing the top ninety-two percent (92%) of earned premium market share respond. Companies required to respond will be contacted through email sent to the Market Conduct Contact on file with the National Association of Insurance Commissioners (NAIC).

The calculation determining which carriers are waived from being required to report will utilize Colorado-specific data in exhibits from the most recently-filed NAIC Annual Statement for carriers required to report to the NAIC at the time of each Annual Cost Report. Specific information on the annual waiver methodology can be found in Colorado Insurance Bulletin No. B-4.58.

C. Annual Excess Loss Report

The following types of business are waived: Comprehensive health insurance, Health Maintenance Organization (HMO) coverage, supplemental health, limited service licensed provider network business, long-term care, disability income, accident-only, specified or dread disease, hospital indemnity, vision only, dental only, other limited-medical payment plans, and Medicare supplement insurance.

Section 4 Definitions

A. "Average ~~R~~reimbursement ~~R~~rate" means, for the purposes of this regulation, ~~is~~ the average of all reimbursement rates that a carrier paid, by MS-DRG code, to only hospitals/facilities reporting to the Colorado Hospital Association during the previous calendar year including both in-network and out-of-network facilities.

B. “Carrier” , for the purpose of this regulation, shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. "Diagnos~~tic~~is Related Group" means, for purposes of this regulation, the classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status.

D. “Dividends” means, for purposes of this regulation, both policyholder and stockholder dividends.

E. "Exchange" shall have the same meaning as found at § 10-16-102(26), C.R.S.

~~E~~F. MS-DRG" (Medicare Severity Diagnosis Related Group) is a code within a system developed for Medicare as part of ~~their~~ its payment system to classify each hospital case into one of approximately 500 groups that is published ~~in the Federal Register Vol. 77, No. 92, by the~~ Centers for Medicare and Medicaid Services in the FY 2014 Final Rule Tables, Table 5.

~~F~~G. “Premium” means, for purposes of this regulation, the amount of money paid on behalf of the insured as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier’s expectation of the insured’s future claim costs and the insured’s share of the carrier’s claims settlement, operational and administrative expenses, and the carrier’s cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.

~~G~~H. “Reimbursement rate” means, for the purposes of this regulation, the amount, by MS-DRG code, that a carrier paid for a procedure at a facility or hospital, plus any expected deductible, copayment, and/or coinsurance. It is important that only the entire hospital/facility reimbursement be included in this rate, not just the carrier’s portion. Provider reimbursement charges should be

excluded from this total. Private room, personal item and other charges that are generally the responsibility of the policyholder should also be excluded.

~~H~~I. "Trend," means, for the purposes of this regulation, ~~means~~ the rate of increase in costs for the reporting period.

~~I~~J. "Excess ~~L~~loss" means, for the purposes of this regulation, ~~i~~individual or group policies providing coverage to a ~~health plan~~ carrier, a self-insured employer plan, or a medical provider providing coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.

Section 5 Hospital Reimbursement Rate Record Retention and Report

A. The Division will annually publish on its website or communicate directly to carriers the list of MS-DRG codes associated with the twenty-five (25) most common inpatient procedures performed in Colorado for the previous reporting year. This will include more than twenty-five (25) MS-DRG codes, as there are multiple codes for different levels of severity in many of the identified procedures.

B. Pursuant to the Health Care Transparency Act, § 10-16-134, C.R.S., each carrier shall report to the Division the average reimbursement rates and number of procedures on a statewide basis for the twenty-five (25) most common inpatient procedures performed in Colorado at hospitals/facilities reporting to the Colorado Hospital Association. This information shall be filed electronically using the Division of Insurance website in a format made available by the Division.

C. Timing and Submission: The required data shall be filed on or before March 1 of each year. Pursuant to § 10-3-109, C.R.S., failure to file this report by March 1 may result in a late penalty not to exceed $100 per day and any applicable surcharges. Reports not containing all of the information specified in this section may be subject to the assessment of a penalty ~~a fine~~ for an incomplete report.

D. Each entity subject to the Health Care Transparency Act shall:

1. Maintain its books, records, and documents in a manner that ensures the necessary data can be readily ascertained and reported to the Division.

2. Format records for ~~E~~each Diagnosis Related Group to be recorded and classified using the MS-DRG coding format and procedures at the time of discharge.

3. Ensure that reimbursement/claim records shall:

   a. B~~b~~e maintained ~~so as to show clearly~~ to clearly identify the MS-DRG code assigned and reimbursement rate of each procedure~~.~~;

   b. B~~b~~e sufficiently clear and specific so that the pertinent dates, locations, cases and charges of these events can be reconstructed~~.~~; and

   c. ~~i~~include and, if necessary, calculate the complete reimbursement rate, hospital/facility, and MS-DRG Code for each inpatient procedure.

Section 6 Annual Cost Report

A. Pursuant to § 10-16-111(4)(a), C.R.S., ~~companies~~ carriers subject to this regulation shall file an Annual Cost Report as described in this section. This report must comply with the requirements of this section and must contain the information specified in S~~s~~ubsection C, of this section and shall

be filed electronically via a form provided on the Division of Insurance website. www.dora.colorado.gov/insurance.

B. Timing and Submission: All Annual Cost Reports shall be filed electronically in a format made available by the Division of Insurance via the Division's website on or before June 1 of each year. Failure to file this report by June 1 will result in a late penalty not to exceed $100 per day. Reports not containing complete and accurate information specified in Ssubsection C. of this section may be subject to the assessment of a penalty ~~a fine~~ for an incomplete report.

C. Annual Cost Reports filed by ~~companies~~ carriers identified in Section 3 must contain, where applicable, all of the information in this subsection. For every ~~company~~ each carrier the report shall include the following information from the previous calendar year.

1. The information required in this report identified in paragraph 2 of this Ssubsection C. ~~2 of this section~~ must be itemized in the following categories by:

   a. Market group size: individual, small group, and large group; and

   b. Lines of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage, long term care, disability income, accident, specified or dread disease, hospital indemnity, vision, dental, Medicare supplement, and "other".

2. The following information ~~referred to below~~ is to be reported from the carrier's financial annual financial statement or provided using the allocation method detailed in Ssubsection D.:

   a. Earned premium, not reduced by dividends.;

   b. Written premium, not reduced by dividends.;

   c. Net reinsurance premiums.;

   d. Dividends.;

   e. Reserves on hand.;

   f. Net investment income.;

   g. The amount of surplus and the amount of surplus relative to the carrier's risk-based capital requirement.;.

   h. Net ~~i~~Income.

   i. The cost of providing or arranging health care services.;

   j. Net reinsurance recoveries.;

   k. Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses.;

   l. Insurance producer commissions.;

   m. Payments to legal counsel.;

n. Advertising and marketing expenditures.;

o. General administrative expenses, including expenses that are not otherwise mentioned in this subsections.; and

p. Staff salaries not reported in the annual financial statement's Supplemental Compensation Exhibit.

3. The following information may not be available ~~o~~in the annual financial statement and must be reported:

a. The number of policyholders covered. This represents the number of actual policies issued for a product. For group coverage, this represents the number of primary subscribers to the groups and not the number of groups.;

b. The number of groups covered.;

c. The number of lives covered. This represents the number of individuals, including dependents that are covered under the policies or groups covered under a product type.;

d. Paid lobbying expenditures.;

e. Charitable contributions.;

f. Healthcare cost trend must be itemized by product type as follows:

(1) Major Medical: This subsection shall be applicable for product types that provide comprehensive medical coverage, including but not limited to covering basic healthcare services and prescription drugs.

(a) Medical trend, excluding pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology;

(b) Pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting and new brand and generic drugs.

(2) All other products: This subsection shall be applicable for all other product types not described in ~~Subsection 3(f)(1) of this section~~ sub-subparagraph f.(1) of this paragraph 3. For each product type, the ~~company~~ carrier shall report the trend applicable to the product for the prior year.

g. Provision for profit and contingencies.;

h. Taxes itemized by category.; and

i. Intermediaries. A list of each intermediary with whom the carrier has a contractual relationship, or a statement that ~~their company~~ it does not have any intermediaries. Include entity/individual name, business address, and business phone number.

4. Executive salaries~~,~~ is defined to include~~,~~ but is not limited to~~,~~ base salary, bonuses and stock options ~~are to be~~ reported ~~from~~ on the carrier's Supplemental Compensation Exhibit of the annual financial statement. Carriers must provide~~:~~:

   a. ~~t~~The Supplemental Compensation Exhibit of the carrier's annual financial statement; and

   b. ~~t~~The percentage of executive salaries that should be allocated to Colorado health business.

D. The information provided in ~~S~~subsection C~~.~~ of this section shall be provided on a Colorado~~-~~only basis, with the exception of executive salaries ~~which is~~ as defined in ~~Subsection~~ subparagraph C~~.(~~4~~).(~~a~~).~~ of this section. A carrier licensed in multiple jurisdictions may satisfy the requirements of ~~S~~subsection C~~.~~ of this section by filing the Colorado-allocated portion of national data if the actual Colorado~~-~~only data is not otherwise available. The methods of allocation that should be used, if necessary, will be provided by the Division prior to the release of the report for completion.

E. If any of the items listed in ~~S~~subsection C~~.~~ of this section are not applicable to the carrier, the carrier shall indicate in the filing which items are not applicable and the reason why such items are not applicable.

F. The information provided to the Division of Insurance in ~~S~~subsection C~~.~~ of this section will be aggregated for all carriers and will be published on the Division of Insurance's website, www.dora.colorado.gov/insurance.

Section 7 Annual Excess Loss Report

A. Pursuant to § 10-16-119(3), C.R.S., ~~companies~~ carriers subject to this regulation shall file an Annual Excess Loss Report as described in this section for each calendar year~~s~~ ~~2013~~ through 2018. This report must comply with the requirements of this section and must contain the information specified in ~~S~~subsection C~~.~~ of this section and shall be filed electronically via a form provided on the Division of Insurance website~~.~~ www.dora.colorado.gov/insurance.

B. Timing and Submission: All Annual Excess Loss Reports shall be filed electronically in a format made available by the Division of Insurance via the Division's website on or before March 1 of each year. Failure to file this report by March 1 will result in the assessment of a late penalty not to exceed $100 per day. Reports not containing complete and accurate information specified in ~~S~~subsection C~~.~~ of this section may be subject to the assessment of a penalty ~~a fine~~ for an incomplete report.

C. Annual Excess Loss Reports filed by ~~companies~~ carriers identified in Section 3 must contain, where applicable, all of the information ~~in~~ required by this subsection. For every ~~company~~ carrier the report shall include the following information from the previous calendar year.

   1. The information required in this report identified in paragraph ~~Subsection~~ 2 of this subsection must be ~~itemized~~ categorized by the number of full-time equivalent employees: 10 or fewer, 11-25, 26-50, and 51-100.

   2. The following information referred to below is to be reported for the groups specified in paragraph 1 of this ~~S~~subsection ~~1 of this section~~:

      a. The total number of groups~~.~~:

      b. The average group size~~.~~:

c. The number of lives covered in Colorado.;

d. The mean and median attachment points.; and

e. The source of prior coverage for the groups including:

(1) Employers previously self-insured with excess loss coverage.;

(2) Employers previously self-insured without excess loss coverage.;

(3) Employers previously not offering coverage.;

(4) Groups previously fully insured outside the ~~Colorado Health Benefit~~ Exchange.; and

(5) Groups previously fully insured inside the ~~Colorado Health Benefit~~ Exchange.

3. The smallest group size covered and ~~insurer~~ carrier's minimum group size requirements.

Section 8 Incorporat~~ed~~ion ~~Materials~~ by Reference

~~The MS-DRG is incorporated by reference, but this rule does not cover amendments to this law or model act that were promulgated later than the effective date of this rule. A copy of the MS-DRG codes may be examined at any state publications depository library. For additional information regarding how relevant portions of the these codes can be obtained or examined, contact the Director of Market Regulation, Colorado Division of Insurance, 1560 Broadway, Ste 850, Denver, CO 80202.~~

~~The Federal Register Vol. 77, No. 92 published by Centers for Medicare & Medicaid Services shall mean Federal Register Vol. 77, No. 92 as published on the effective date of this regulation and does not include later amendments to or editions of Federal Register Vol. 77, No. 92. A copy of the Federal Register Vol. 77, No. 92 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A Certified copy of the Federal Register Vol. 77, No. 92 may be requested from Center for Medicare & Medicaid Services, Baltimore Headquarters telephone number 877-267-2323. A charge for certification or copies may apply. A copy may also be obtained online at http://www.gpo.gov/fdsys/pkg/FR-2012-05-11/pdf/2012-9985.pdf.~~

FY 2014 Final Rule Tables, Table 5 published by the Centers for Medicare & Medicaid Services organization shall mean FY 2014 Final Rule Tables, Table 5 as published on the effective date of this regulation and does not include later amendments to or editions of FY 2014 Final Rule Tables, Table 5. A copy of FY 2014 Final Rule Tables, Table 5 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202, or by visiting the Centers for Medicare & Medicaid Services website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html. A certified copy of FY 2014 Final Rule Tables, Table 5 may be requested from the Colorado Division of Insurance for a fee.

Section 9 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This regulation shall become effective on ~~November~~ August 1~~5~~, 201~~35~~.

Section 12 History

New Regulation 4-2-31, Effective January 1, 2010.
Amended Regulation, Effective August 1, 2011.
Amended Regulation, Effective December 1, 2012.
Amended Regulation, Effective November 15, 2013.
Amended Regulation, Effective August 1, 2015.

Notice of Proposed Rulemaking

Tracking number

2015-00231

Department

700 - Department of Regulatory Agencies

Agency

723 - Public Utilities Commission

CCR number

4 CCR 723-6

Rule title

RULES REGULATING TRANSPORTATION BY MOTOR VEHICLE

Rulemaking Hearing

Date

06/01/2015

Time

09:00 AM

Location

Colorado Public Utilities Commission Hearing Room, 1560 Broadway, Suite 250, Denver, CO 80202

Subjects and issues involved

To describe the manner of regulation over Transportation Network Companies (TNCs) in Colorado; to preserve the health, safety, and welfare of Coloradans and visitors to our state who use TNC services.

Statutory authority

Sections 40-2-108, and 40-10.1.601 through 608, C.R.S. and Senate Bill 14-125

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COLORADO DEPARTMENT OF REGULATORY AGENCIES

Public Utilities Commission

4 *CODE OF COLORADO REGULATIONS* (CCR) 723-6

PART 6
RULES REGULATING TRANSPORTATION BY MOTOR VEHICLE

* * * * *

[indicates omission of unaffected rules]

GENERAL PROVISIONS

6000. Scope and Applicability.

All rules in this Part 6, the "6000" series, shall apply to all Commission proceedings and operations concerning regulated entities providing transportation by motor vehicle, unless a specific statute or rule provides otherwise. Rules 6000 – 6099 apply to all common carriers, contract carriers, limited regulation carriers, towing carriers, movers, UCR registrants, and drivers as defined herein. For hazardous materials carriers and nuclear materials carriers, only rule 6008 and the related definitions in rule 6001 shall apply. Rules 6700 – 6724 apply to all transportation network companies. Specific provisions regarding the applicability of this Part 6 can be found in rules 6100, 6200, 6250, 6300, 6400, 6500, ~~and~~ 6600, and 6700.

* * * * *

[indicates omission of unaffected rules]

[The following are proposed to entirely replace the current temporary Transportation Network Company Rules.]

6612. – 6699. [Reserved].

TRANSPORTATION NETWORK COMPANY RULES

6700. Applicability of Transportation Network Company Rules.

Rules 6700 through 6724 apply to all transportation network companies (TNCs) as defined by § 40-10.1-602(3), C.R.S. and to all Commission proceedings and operations concerning TNCs including applicants, TNC employees and TNC drivers.

6701. Definitions.

The following definitions apply throughout rules 6700 through 6724, except where a specific rule or statute provides otherwise.

(b) "Enforcement official" means:

(I) any person appointed or hired by the director, or the director's designee, to perform any function associated with the regulation of transportation network companies; or

(II) as defined by § 42-20-103(2), C.R.S.

(c) "Logged in" means that a driver's credentials have been accepted to connect to a transportation company digital network such that the driver is capable of being matched to a rider [OR a driver has gained access to a transportation company digital network]

(d) "Logged out" means that a driver is disconnected or not connected to a transportation company digital network.

(e) "Matched" means the point in time when a driver accepts a requested ride through a transportation network company's digital network.

(f) "Permit" means the permit required for the operation of a transportation network company pursuant to Part 6 of Article 10.1 of Title 40, C.R.S.

(g) "Person" means any individual, firm, partnership, corporation, company, association, joint stock association, or other legal entity and any person acting as or in the capacity of officer, director, manager, employee, member, partner, lessee, trustee, or receiver thereof, whether appointed by a court or otherwise.

(h) "Personal vehicle" means a vehicle that is used by a transportation network company driver in connection with providing services for a transportation network company that meets the vehicle criteria set forth in § 40-10.1-605(1)(h), C.R.S.

(i) "Prearranged ride" means a period of time that begins when a driver accepts a requested ride through a digital network, continues while the driver transports the rider in a personal vehicle, and ends when the rider departs from the personal vehicle.

(j) "Transportation network company" (TNC) means a corporation, partnership, sole proprietorship, or other entity, operating in Colorado, that uses a digital network to connect riders to drivers for the purpose of providing transportation. A transportation network company does not provide taxi service, transportation service arranged through a transportation broker, ridesharing arrangements, as defined in § 39-22-509 (1) (a) (II), C.R.S. or any transportation service over fixed routes at regular intervals. A transportation network company is not deemed to own, control, operate, or manage the personal vehicles used by transportation network company drivers. A transportation network company does not include a political subdivision or other entity exempted from federal income tax under § 115 of the federal "Internal Revenue Code of 1986", as amended.

(k) "Transportation network company driver" or "driver" means an individual who uses his or her personal vehicle to provide transportation network company services for riders matched to the driver through a transportation network company's digital network. A driver need not be an employee of a transportation network company.

(l) "Transportation network company rider" or "rider" means a passenger in a personal vehicle for whom a driver provides transportation network company services, including:

(I) an individual who uses a transportation network company's online application or digital network to connect with a driver to obtain services in the driver's vehicle for the individual and anyone in the individual's party; or

(II) anyone for whom another individual uses a transportation network company's online application or digital network to connect with a driver to obtain services in the driver's vehicle.

(III) “rider” includes service animals as defined in § 24-34-803, C.R.S., accompanying any passenger.

(m) “Transportation network company services" or "services" means the provision of transportation by a driver to a rider with whom the driver is matched through a transportation network company. The term does not include services provided either directly by or under contract with a political subdivision or other entity exempt from federal income tax under § 115 of the federal "Internal Revenue Code of 1986", as amended.

6702. Permit Requirements.

(a) No person shall operate or offer to operate as a TNC in Colorado without a valid permit issued by the Commission.

(b) To obtain a TNC permit, a person must:

(I) complete and submit an application on a Commission-prescribed form;

(II) pay the annual application fee; and

(III) cause to be filed with the Commission proof of financial responsibility that complies with the requirements found in these rules and § 40-10.1-604 C.R.S.

(c) No person shall file an application under a name or trade name that identifies a type of transportation service not authorized by the TNC statutes, §§ 40-10.1-601 to -608, C.R.S. (e.g., a TNC shall not have the word “taxi” in its name). Applications filed in violation of this rule, shall not be processed.

(d) A permit is valid for a period of one year from the later of the effective date or the date of issuance.

(e) A TNC thereafter shall annually reapply for a permit and pay the fee.

6703. Commission’s Records, Name Changes, Address Changes, and Address Additions.

(a) Any information provided by a TNC for the Commission’s files shall be relied on to be accurate until changed by the TNC.

(b) TNCs are required to notify the Commission in writing of any change of name, mailing address, physical address, or telephone number on file with the Commission within two days of making said change. The notification shall identify the person making the change and the affected permit. A notice of name change including trade name changes and trade name additions shall include supporting documentation from the Colorado Secretary of State.

(I) In the event of a name change or an address change, the TNC shall comply with all other applicable Commission rules, including but not limited to, rules regarding financial responsibility.

(II) No name change shall be effective until proper proof of financial responsibility in the TNC's new name has been filed with the Commission.

6704. Notice.

Any notice to a TNC sent to a physical, mailing, or email address of a TNC's designated agent on file with the Commission shall constitute prima facie evidence that the TNC received the notice.

6705. Designation of Agent.

(a) Each TNC shall file in writing with the Commission, and shall maintain on file, its designation of the name, mailing address, physical address, email address, and phone number of a person upon whom service may be made of any lawful notice, order, process, or demand. The named person is the designated agent. A TNC shall not designate as its agent the Colorado Secretary of State. The person designated, if a natural person, shall be at least 18 years of age. The addresses of the person designated shall be in the state of Colorado.

(b) TNCs shall notify the Commission of any changes in the designated agent's identity, name, mailing address, physical address, email address, or phone number by filing a new designation within two days following the effective date of such change.

(c) Service upon a designated agent, as on file with the Commission, shall be deemed to be service upon the TNC.

6706. Financial Responsibility.

(a) Every TNC shall obtain and keep in force at all times motor vehicle liability insurance coverage that conforms with the requirements of § 40-10.1-604(2), C.R.S. Every TNC shall cause to be filed a Commission-prescribed Form T: TNC Bodily Injury and Property Damage Liability Certificate of Insurance. The form shall be executed by a duly authorized agent of the insurer. The insurer must be authorized to do business in the state of Colorado.

(b) If a TNC chooses to maintain primary automobile insurance coverage on behalf of a driver or drivers that conforms with the requirements of § 40-10.1-604(3), C.R.S., it shall cause to be filed a Commission-prescribed Form P: TNC Primary Liability Certificate of Insurance. The form shall be executed by a duly authorized agent of the insurer. The insurer must be authorized to do business in the state of Colorado.

(c) For purposes of this rule, surplus line insurers authorized under article 5 of title 10, C.R.S., are within the meaning of an insurer authorized to do business in the state of Colorado.

(d) If a TNC chooses not to maintain primary automobile insurance on behalf of a driver or drivers, it shall file a certification that each driver who is authorized by a TNC to log in to the TNC's digital network is in compliance with the provisions of § 40-10.1-604(3), C.R.S.

(e) Administrative cancellation of certificates of insurance and/or surety bond.

(I) When a new certificate of insurance and/or surety bond is filed with the Commission, all certificates of insurance and/or surety bond for the same type and category of coverage with an older effective date shall be administratively cancelled upon the effective date of the new certificate of insurance and/or surety bond.

(II) When the Commission receives notice from a TNC to cancel its permit, all the certificates of insurance and/or surety bond for the TNC shall be administratively cancelled.

6707. Financial Responsibility - Revocation, Suspension, Alteration, or Amendment.

(a) Summary suspension and/or revocation for lack of financial responsibility of a TNC.

(I) Summary suspension.

(A) Whenever Commission records indicate that a TNC's, required insurance or surety coverage, is or will be canceled, and the Commission has no proof on file indicating replacement coverage, the Commission shall, pursuant to § 24-4-104(3) and (4), C.R.S., summarily suspend such permit.

(B) Failure on the part of an insurance company to respond to a Commission inquiry for verification of insurance coverage within 60 days shall be treated as a cancellation of insurance. The Commission will provide notice to a TNC that its insurance company has failed to respond to an inquiry for verification of insurance coverage at least 15 days prior to the expiration of the 60 day period.

(C) The summary suspension shall be effective on the date of coverage cancellation.

(II) The Commission will advise the TNC:

(A) that the Commission is in receipt of insurance or surety cancellation, and the effective date of such cancellation;

(B) that its permit is summarily suspended as of the coverage cancellation date;

(C) that it shall not conduct TNC services under its permit after the coverage cancellation date;

(D) that the Commission has initiated complaint proceedings to revoke its permit;

(E) that it may submit, at a hearing convened to determine whether its permit should be revoked, written data, views, and arguments showing why such permit should not be revoked; and

(F) the date, time, and place set for such hearing.

(III) Until proper proof of insurance or surety coverage, is filed with the Commission, a TNC receiving notice of summary suspension shall not conduct TNC services after the effective date of such summary suspension.

(IV) If the Commission receives proper proof of coverage prior to the hearing, the summary suspension and complaint will be dismissed without further order of the Commission. TNC services performed during lapses in coverage are subject to civil penalty assessments.

(V) If the Commission receives proper proof of coverage prior to revocation, the Commission will dismiss the summary suspension and complaint. TNC services performed during lapses in coverage are subject to civil penalty assessments.

(b) After a hearing upon at least ten days' notice to the TNC affected, and upon proof of violation, the Commission may issue an order to cease and desist, suspend, revoke, alter, or amend any permit for a violation of, or failure to comply with, any statute, order, or rule concerning a TNC.

6708. Driver Minimum Qualifications.

(a) A TNC shall not permit a person to act as a driver unless the person is at least 21 years of age; has a valid driver's license; is medically qualified to drive as required by rule 6713; is not disqualified to drive based on the results of the driving history research report required by rule 6711 or the criminal history record check required by rule 6712; and reads and speaks English sufficiently to read signs and communicate with passengers and enforcement officials.

(b) A TNC shall require a driver to maintain on their person or in their personal vehicle the following documents in physical or electronic form: a current medical certification card; valid driver's license; current vehicle inspection form; any waiver granted by the Commission; and proof of all required insurance, including TNC required insurance. These documents shall be immediately provided by the driver to an enforcement official upon request.

6709. Waivers or Variances.

A TNC that is granted a waiver or variance, or that engages a driver who has been granted a waiver or variance, shall maintain a copy of the waiver or variance during the term of the TNC's or the driver's service and for six months thereafter. This rule shall have no effect on the right and discretion of a TNC to decide not to contract with a driver applicant or to disconnect a driver from its TNC platform.

6710. Record Maintenance and Retention.

(a) A TNC or third party on behalf of a TNC may maintain records in electronic format, provided that copies can be reproduced in their original format and in paper copy.

(b) A TNC shall maintain the following data for each trip, as applicable, for a minimum of one year from the date of each such prearranged ride: the personal vehicle's license plate number; the identity of the driver; the identity of the matched individual using the TNC application to request a prearranged ride; the date and time of the rider's request for service; the originating address; the date and time of pickup; the destination address; and the date and time of drop-off.

(c) A TNC, or third party on behalf of a TNC, shall maintain the following records for each driver and the driver's personal vehicles.

(I) A driver's application submitted to the TNC which must, at a minimum, contain the following information: the applicant's name, address, date of birth, and driver license number; the date the application was submitted; and the applicant's signature attesting that all the information provided on the application is true and accurate. A driver's application must be maintained during the period of service and for six months thereafter.

(II) The disclosures provided to the driver within the driver's terms of service, including the driver's acknowledgement of said terms. The terms of service disclosures and acknowledgement shall be maintained during the period of service and for six months thereafter.

(III) The driving history research reports. The driving history research reports shall be maintained for a period of three years from the date the research was conducted.

(IV) The results of the criminal history record check. The results of the criminal history record check shall be maintained for a period of five years from the date the record check was conducted.

(V) The driver's state issued driver's license. The driver's license shall be maintained during the period of service and for six months thereafter.

(VI) The driver's current medical certificate. The driver's most current medical certificate shall be maintained for a period of three years from the date of certification.

(VII) If applicable, any current medical waiver or variances issued to the driver.

(VIII) Hours of service records required by rule 6722. Accurate and true hours of service records, including all supporting documentation verifying such time records, shall be maintained for the most recent six months during the term of service; and such records shall be maintained for six months after the term of service.

(IX) The initial and periodic vehicle inspections. Vehicle inspections shall be maintained for a period of fourteen months from the date of inspection.

(d) A TNC shall maintain the following data for each written report of conduct in violation of § 40-10.1-605(6) for a minimum of one year from the date the report is received by the TNC:

(I) the written report;

(II) actions taken to address the alleged violation; and

(III) documentation showing the TNC's monitoring of the driver's performance.

6711. Driving History Research Report.

(a) Before permitting an individual to act as a driver on its digital network, a TNC shall obtain and review a driving history research report for the individual. The driving history research report shall include at a minimum any moving violation in the United States for the three-year period preceding the individual's application. An individual with moving violations identified in § 40-10.1-605(4)(b)(I) and (II), C.R.S. shall not serve as a driver for the TNC.

(b) At least once every 12 months, a TNC shall obtain and review a driving history research report for each driver authorized to use the TNC's digital network. The driving history research report shall include at a minimum any moving violation in the United States for the preceding three-year period. An individual with moving violations identified in § 40-10.1-605(4)(b)(I) and (II), C.R.S. shall not continue to serve as a driver for the TNC.

6712. Criminal History Record Checks.

(a) Before permitting an individual to act as a driver on its digital network, a TNC shall obtain and review a criminal history record check for the individual that complies with § 40-10.1-605(3)(a). If a privately administered national criminal history record check is used, the criminal history record check must include a fingerprint investigation, and custody of the record check shall be direct from the entity administering the check to the TNC.

(b) At least once every five years, a TNC shall obtain and review a criminal history record check for each driver authorized to use the TNC's digital network.

(c) No TNC shall permit any individual convicted of or who pled guilty or nolo contendere to any of the offenses listed in § 40-10.1-605(3)(c), C.R.S. to log in to its digital network or serve as a driver for the TNC.

6713. Proof of Medical Fitness.

(a) No TNC shall permit any driver to log in to its digital network that is not medically examined and certified pursuant to 49 C.F.R. § 391.41, as revised on October 1, 2010.

(b) All medical examiners issuing driver medical certification cards must be qualified pursuant to 49 C.F.R. § 391.43, as revised on October 1, 2010.

6714. Vehicle Inspections.

A TNC shall conduct or have a vehicle inspector conduct an initial safety inspection of a prospective driver's vehicle before it is approved for use as a personal vehicle and shall have periodic inspections of personal vehicles conducted thereafter, at intervals of at least one inspection per year. A driver and TNC shall ensure that the initial and periodic inspections are completed on the form prescribed by the Commission. A vehicle shall be placed out-of-service if it failed to meet the vehicle inspection criteria identified in this rule. The TNC may reinstate the personal vehicle for service after the out-of-service condition is removed or resolved.

Initial inspections, periodic inspections, and inspections by an enforcement official shall include an inspection of the items set forth in § 40-10.1-605(1)(g)(I), C.R.S., based upon the following criteria.

(a) Foot brakes: each vehicle shall be equipped with brakes acting on all wheels and capable of operating as designed by the manufacturer; the brake lining/pad thickness on the steering axle shall not be less than 3/16 of an inch and shall not be less than 1/16 of an inch on the non-steering axle; the thickness of the drums or rotors shall not be less than the limits established by the brake drum or rotor manufacturer and no evidence of metal to metal contact or rusting on contact surfaces; and shall not have missing or broken calipers, pad retaining components, brake pad, shoes, or linings.

(b) Emergency brake: each vehicle shall be equipped with an emergency brake that will hold a parked vehicle in place as designed by the manufacturer.

(c) Steering mechanism: each vehicle shall not have steering wheel lash that exceeds four inches. Universal joints and ball and socket joints shall not be worn, faulty or repaired by welding and all components of the power steering system must be present with no parts missing and belts shall not be frayed, worn or slipping. Telescoping or tilt steering wheels shall lock in a fixed position.

(d) Windshield: shall be free of discoloration or intersecting cracks which interfere with the driver's field of view.

(e) Rear window and other glass: vehicle windows to the side and rear of the driver shall be fully operational if originally manufactured to be so and shall be free from intersecting cracks.

(f) Windshield wipers: vehicles shall be equipped with a wiping system and washer system that are in proper working condition and capable of being controlled by the driver from within the vehicle.

(g) Head lights: each vehicle must have head lights that do not have broken or missing lenses covers and that have both upper and lower beams; and are in proper working condition.

(h) Tail lights: each vehicle must have tail lights that do not have broken or missing lenses covers and are in proper working condition.

(i) Turn indicator lights: vehicle must have turn indicator lights that do not have broken or missing lenses covers and are in proper working condition. The vehicle must be equipped with a hazard warning signal operating unit that is in proper working condition.

(j) Stop lights (lamps): all vehicles must have stop lamps that do not have broken or missing lens covers and are in proper working condition.

(k) Front seat adjustment mechanism: the vehicle must be equipped with a front seat adjustment mechanism that is capable of locking in at least one fixed position.

(l) Doors: all vehicles must be equipped with a minimum of four doors; all doors must be in proper working condition and capable of opening, closing, locking, and unlocking as designed by the original manufacturer.

(m) Horn: all vehicles must be equipped with a horn and actuating element that shall give an adequate warning signal that is in proper working condition.

(n) Speedometer: all vehicles must be equipped with an operating speedometer that is paired with an OEM approved tire size.

(o) Bumpers: all vehicles must be equipped with both front and rear bumpers which are not loose or protruding so as to create a hazard.

(p) Mufflers and exhaust system: all vehicles must be equipped with a securely fastened and properly located muffler and exhaust system capable of expelling and directing harmful combustion fumes as designed by the original manufacturer. No part of the exhaust system shall leak or be repaired with wrap or patches.

(q) Tires and wheels: no tire shall have any tread or sidewall separation or has a cut to the extent that the ply or belt material is exposed; any tire on the front or rear wheels of a vehicle shall have a tread groove pattern depth of at least 4/32 of an inch when measured at any point on a major tread groove. The measurement shall not be made where the tie bars, humps or fillets are located; and vehicle wheels shall not have cracks or missing spokes, shall be securely attached to the vehicle and not have loose or missing lug nuts.

(r) Rear view mirrors: all vehicles must be equipped with rear view mirrors as designed by the original manufacturer.

(s) Safety belts: all vehicles must be designed by the original manufacturer to carry no more than eight passengers, be equipped with no more than eight safety belts as designed by the original manufacturer, and must be equipped with safety belts for both the driver and all riding passengers that are in proper working condition and capable of being operated at all times.

6715. Vehicle Inspectors.

(a) Individuals performing the initial vehicle inspection or a periodic inspection by or for a TNC shall be a certified mechanic or a person that is capable of performing an inspection by reason of experience, training, or both.

(b) TNCs must retain evidence of the individual's qualifications under this rule if the inspection was completed by an individual substituting training and experience for a certificate from a federal or state sponsored training program. TNCs must retain this evidence for the period during which that individual is performing vehicle inspections for the TNC and for one year thereafter.

(c) For purposes of this rule, a TNC's receipt of certification by a company authorized to do business in Colorado that inspections are performed only by persons capable of performing the 19-point inspection listed in rule 6714 by reason of experience, training, or both, satisfies the TNC's obligations in paragraphs (a) and (b) of this rule.

6716. Authority to Interview Personnel and Inspect Records and Personal Vehicles.

For purposes of investigating compliance with, or a violation of, these rules or applicable law, an enforcement official has the authority to interview persons, drivers and riders, to inspect records, and to inspect personal vehicles used in providing TNC services.

(a) Upon request of an enforcement official during normal business hours, a TNC shall provide to the enforcement official, any requested records relating to insurance under rule 6707, medical certification under rule 6713, hours of service under rule 6722, vehicle inspections under rules 6714, 6715, and 6717, and waivers or variances under rule 6709. A TNC shall also include in its driver policies a requirement that a TNC driver immediately provides all of these documents, except those under rule 6722, to an enforcement official upon request.

(b) Within 72 hours of notice by an enforcement official, a TNC shall provide to the enforcement official, electronic copies of the requested records that TNCs are required to be retained by these rules. Paper copies shall be provided if requested by an enforcement official.

(c) Upon reasonable notice and request by an enforcement official, and in addition to other inspection requirements, a driver shall make his/her personal vehicles used in providing TNC services available for inspection and the driver shall assist, if requested, in the inspection of such personal vehicle. If a driver refuses to make such personal vehicles available for inspection, upon notice to the TNC the TNC shall disconnect the driver from its TNC platform until the driver makes the vehicles available for inspection.

(d) Upon reasonable notice and request by an enforcement official, TNC personnel and drivers shall be available for interview during normal business hours.

(e) When a request under this rule implicates multiple response times the shortest time period shall apply.

6717. Inspection of Drivers and Vehicles.

A driver and the driver's vehicle are subject to inspection by and producing documentation to an enforcement officer if the driver is logged into a TNC's digital network or is at that time offering or providing service.

6718. Inspection Process.

(a) When a driver or vehicle is inspected by an enforcement official the enforcement official shall tender a copy of a Driver/Vehicle Compliance Report (DVCR) to the driver. The enforcement official will provide notice to the TNC that a driver and/or vehicle inspection was conducted and that violations were found, if any.

(b) The TNC shall be responsible to contact and obtain a copy of the DVCR from the driver.

(c) Within 15 days following the date of the inspection, the TNC shall:

(I) ensure all violations or defects noted thereon are corrected before any other TNC services are provided;

(II) complete the TNC official's signature, title, and date portions of the DVCR, certifying that all violations on the DVCR have been corrected;

(III) return the completed DVCR to the Commission in the manner stated on the DVCR; and

(IV) retain a copy of the DVCR in its records.

(d) A vehicle that would likely cause an accident or breakdown due to its mechanical condition as determined by an enforcement official shall be placed out-of-service. A TNC shall disconnect the driver of the vehicle from the TNC digital network upon notice from the enforcement official that the vehicle has been placed out-of-service.

(e) A driver who, by reason of the driver's lack of qualification under rule 6708, sickness or fatigue, violation of hours of service provisions under rule 6722, or being under the influence of drugs or alcohol, would likely cause an accident as determined by an enforcement official shall be placed out-of-service. A TNC shall disconnect the driver of the vehicle from the TNC digital network upon notice from the enforcement official that the driver has been placed out-of-service.

(f) Declaring a personal vehicle and/or a driver out-of-service on a DVCR and communicating that condition to the TNC shall constitute an out-of-service order.

(g) The TNC may reinstate the personal vehicle and/or the driver for service after the out of service condition is removed or resolved.

6719. Vehicle Markings.

A TNC shall require that a driver displays the TNC's vehicle marking in or on the personal vehicle while logged in to a TNC's digital network. The TNC shall file a description and location of vehicle markings that drivers are required to display. Vehicle marking shall be readily visible from 50 feet during the daytime.

6720. Annual Report of Drivers' Refusals to Transport and Driver Discipline.

(a) Prior to February 1 of each calendar year, each TNC shall report to the Commission the number of incidents in which a driver has reported to the TNC, pursuant to § 40-10.1-605(9), C.R.S., each refusal to transport a passenger after the driver and rider were matched, for the previous calendar year, based on one of the reasons listed in § 40-10.1-605(6)(a), C.R.S. Each report must include, but is not limited to the following information: the TNC's name; the TNC permit number; the period being reported; the identity of each involved driver; the date the trip was requested; the address from which the trip was requested; the destination to which the trip was intended; and the reason the trip was refused. The report shall contain a record of any discipline administered to the driver. The report also shall contain the signature, the printed name and title of the person completing the form; the signature, the printed name and title of an officer authorized to file the report; and an oath that the information is accurate.

(b) Prior to February 1 of each calendar year, each TNC shall report to the Commission a record of any discipline administered to a driver for a violation of statute or rules. Each report must include, but is not limited to the following information: the TNC's name; the TNC permit number; the period being reported; the identity of each involved driver, the violation, the discipline administered, including a notation whether the driver was subsequently monitored and involved in any other violations.

6721. Offering of TNC Service.

(a) No TNC, or any officer, agent, employee, or representative of said company, shall offer a TNC service in a name other than a name as it appears on the TNC's permit, including matching the characters, numbers and letters as used on the permit (e.g., A and B Transportation violates this rule when advertising as A & B Transportation). If a TNC operates under registered trade names, registered d/b/a designations, or registered trademarks, the TNC's permit shall also reflect that the TNC is using the registered trade names, registered d/b/a designations, or registered trademarks in providing TNC service.

(b) If a TNC operates under registered trade names, registered d/b/a designations, or registered trademarks, nothing in this paragraph shall be construed to require advertising under all names appearing on said TNC's permit.

6722. Hours of Service.

(a) No TNC shall require or permit any driver, nor shall any driver be logged in to a TNC's digital network for more than 12 consecutive hours.

(b) At the end of the 16 hour after logging in to the TNC's digital network, no TNC shall require or permit any driver to drive nor shall a driver drive for any TNC or motor carrier and shall be logged out of any TNC's digital network for eight consecutive hours. Drivers may be logged out of the TNC's digital network for any period of time during the 16-hour period, but the 16-hour period may restart only after eight consecutive hours logged out of the TNC's digital network.

(c) No TNC shall require or permit any driver, nor shall any driver be logged in to a TNC's digital network for a minimum period of eight consecutive hours after having been logged in to a TNC's digital network 80 hours in eight consecutive days. In no instance shall a driver's time logged in to a TNC's digital network exceed 80 hours in any rolling eight consecutive day period.

(d) A TNC that engages a driver shall maintain and retain true and accurate time records, including all supporting documents verifying such time records, for a period of six months showing:

(I) each time(s) the driver logs in to the TNC's digital network each day;

(II) each time(s) the driver logs out of the TNC's digital network each day; and

(III) the total number of hours the driver is logged in to the TNC's digital network each day.

6723. Prohibitions.

(a) No TNC shall permit any driver declared and ordered out-of-service to operate, nor shall any driver operate, any personal vehicle until the driver's out-of-service condition has been corrected.

(b) No TNC shall permit any driver to operate, nor shall any driver operate, any personal vehicle declared and ordered out-of-service until all repairs required by the out-of-service order have been satisfactorily completed.

(c) No TNC shall permit any driver to operate any personal vehicle when the driver's ability to operate the personal vehicle is impaired through illness, fatigue, or any other condition that would likely cause the unsafe operation of the personal vehicle. A TNC that is notified by an enforcement official or confirms on its own or through another means that a driver has violated this rule shall disconnect the driver from its digital network until the condition is no longer present.

(d) No TNC shall permit any driver to operate any personal vehicle if the driver is under the influence or uses any drug or substance that renders the driver incapable of safely operating a personal vehicle. This does not apply to possession or use of a substance administered by or under the instruction of a qualified medical professional, provided that the medical professional certifies the substance will not affect the safe operation of a personal vehicle. A TNC that is notified by an enforcement official or confirms on its own or through another means that a driver has violated this rule shall permanently disconnect the driver from its digital network.

(e) No TNC shall permit any driver to operate any personal vehicle if the driver has consumed alcohol within four hours of logging in to the TNC network or is under the influence of alcohol while logged in to the TNC network. A TNC that is notified by an enforcement official or confirms on its own or through another means that a driver has violated this rule shall permanently disconnect the driver from its digital network .

(f) No TNC shall permit any driver to engage in texting while operating a personal vehicle and the driver is logged in to the TNC network. A TNC that is notified by an enforcement official or confirms on its own or through another means that a driver has violated this rule shall disconnect the driver from its digital network for a minimum of 30 days.

(g) No TNC shall permit any driver to solicit or accept the on-demand summoning of a ride otherwise known as a "street hail." A TNC that is notified by an enforcement official or confirms on its own or through another means that a driver has violated this rule shall disconnect that driver from its digital network for a minimum of seven days.

(h) A TNC that is notified by an enforcement official or confirms on its own or through another means that that a driver failed to provide records to an enforcement official upon request in accordance with paragraph 6716(a) shall disconnect that driver from its digital network for a minimum of one day.

(i) A TNC that is notified by an enforcement official or confirms on its own or through another means that that a driver failed to display a vehicle marking in or on the personal vehicle while logged in to a TNC's digital network in accordance with the description on file with the Commission shall disconnect that driver from its digital network for a minimum of one day.

(j) No TNC shall make or cause to be made fraudulent or intentionally false statements or records to the Commission or Commission staff.

(k) No person shall falsify, destroy, mutilate, change, or cause falsification, destruction, mutilation, or change to any record, subject to inspection by the Commission.

(l) No TNC shall permit any driver to log in to its digital network before the vehicle that will be used as a personal vehicle is confirmed to have satisfied the requirements of rule 6714.

(m) A TNC shall not permit a driver to drive if:

(I) the TNC has not complied with rule 6711 or § 40-10.1-605(4)(a), C.R.S.;

(II) the driver has not complied with rule 6712 or § 40-10.1-605(3)(a), C.R.S.;

(III) the driver is not qualified to drive under rule 6708;

(IV) the driver's qualification status under rule 6708 has expired; or

(V) the driver has been placed out-of-service by an enforcement official pursuant to rule 6718.

6724. Violations, Civil Enforcement, and Enhancement of Civil Penalties.

Civil penalty assessments are in addition to any other penalties provided by law.

TNCs are subject to §§ 40-7-112, C.R.S. and 40-7-113 - 40-7-116, for violations of Part 6 of Title 40, C.R.S., or these rules, and may be assessed civil penalties for any such violation.

(a) $11,000 per violation.

(I) Failure to obtain and keep in force liability insurance that conforms with the requirements of §40-10.1-604.

(b) $10,000 per violation.

(I) Permitting a driver to operate a personal vehicle during the period the driver was placed out of service.

(II) Permitting the operation of a personal vehicle placed out of service before the required repairs are made but after the TNC has received notice of the defect.

(III) Violation of subparagraph 6723(m)(V).

(c) $2,500 per violation.

(I) Making, or causing to make, fraudulent or intentionally false statements or records and/or reproducing fraudulent records if such action misrepresents a fact that constitutes a violation other than a reporting or recordkeeping violation.

(II) Violation of rule 6708

(III) Violation of paragraph 6722(a),(b) or (c).

(IV) Violation of subparagraph 6723(m)(III) or (IV).

(d) $1,100 per violation.

(I) Violation of rule 6713.

(II) Violation of the periodic inspection requirements of rule 6714.

(III) Violation of rule 6702.

(IV) Violation of rule 6721.

(f) $500 per violation up to $10,000 (Record Keeping).

(I) Violation of rule 6710.

(II) Failure to return the completed DVCR as required by subparagraph 6718(a)(IV).

(III) Violation of paragraph 6722(d).

(g) $275 per violation.

(I) Violation of subparagraph 6723(m)(II).

(h) $250 per violation.

(I) Violation of subparagraph 6723(m)(I).

(II) Violation of any rule not specified above.

(i) Notwithstanding any provision in these rules to the contrary, the Commission may assess a civil penalty of two times the amount or three times the amount, as provided in § 40-7-113, C.R.S.

(I) The amounts in paragraphs (a) through (g) shall be two times the specified amount if:

(A) the person engaged in prior conduct which resulted in the issuance of a prior civil penalty assessment notice;

(B) the conduct is of the same or narrower character as the conduct that was cited in the prior civil penalty assessment notice;

(C) the conduct occurred within one year after the date of violation in the prior civil penalty assessment notice; and

(D) the conduct occurred after the person's receipt of the prior civil penalty assessment notice.

(II) The amounts in paragraphs (a) through (g) shall be three times the specified amount if:

(A) the person engaged in two or more instances of prior conduct which resulted in the issuance of two or more prior civil penalty assessment notices;

(B) the conduct is of the same or narrower character as the conduct that was cited in the prior civil penalty assessment notices;

(C) the conduct occurred within one year after the two most recent prior instances of conduct cited in the prior civil penalty assessment notices; and

(D) the conduct occurred after the person's receipt of two or more prior civil penalty assessment notices.

(j) The civil penalty assessment notice shall contain the maximum penalty amounts prescribed for the violation; the amount of the penalty surcharge pursuant to § 24-34-108(2); and a separate provision for a reduced penalty of 50 percent of the maximum penalty amount if paid within ten days after the civil penalty assessment notice is tendered.

6725. – 6799. [Reserved].

Decision No. C15-0407

BEFORE THE PUBLIC UTILITIES COMMISSION OF THE STATE OF COLORADO

PROCEEDING NO. 15R-0250TR

IN THE MATTER OF THE PROPOSED RULES REGULATING TRANSPORTATION NETWORK COMPANIES, 4 CODE OF COLORADO REGULATIONS 723-6.

NOTICE OF PROPOSED RULEMAKING

Mailed Date: April 30, 2015
Adopted Date: April 16, 2015

I. BY THE COMMISSION

A. Statement

1. The Colorado Public Utilities Commission (Commission) issues this Notice of Proposed Rulemaking regarding proposed Rules Regulating Transportation by Motor Vehicle, 4 *Code of Colorado Regulations* (CCR) 723-6. The proposed rules generally describe the manner of regulation over Transportation Network Companies (TNCs) in the State of Colorado. More specifically, the purpose of Rules 6701-6724 is to preserve the health, safety, and welfare of Coloradans and visitors to our state who use TNC services.

2. For the reasons set forth in this Decision, we have the authority to adopt these rules under § 40-2-108, and 40-10.1.601 through 608, C.R.S.

3. The proposed rules are available as Attachment A through the Commission's E-Filings system in this proceeding (15R-0250TR) at:

https://www.dora.state.co.us/pls/efi/EFI.Show_Docket?p_session_id=&p_docket_id=15R-0250TR

B. Background

4. On June 5, 2014, Senate Bill 14-125 became effective, authorizing TNCs to operate in Colorado. *See* §§ 40-10.1-601 to 608, C.R.S. (TNC Statute)[1] A TNC "uses a digital network to connect riders to drivers for the purpose of providing transportation." § 40-10.1-602(3).

5. On July 8, 2014, we issued a Decision adopting temporary rules implementing Senate Bill 14-125.[2] *See* Rules 6700-6703 of the Rules Regulating Transportation by Motor Vehicle, 4 *Colorado Code of Regulations (CCR)* 723-6. These temporary rules were in effect through February 3, 2015. *See* § 40-2-108(2), C.R.S.

6. On October 17, 2014, we opened a miscellaneous proceeding to allow interested participants to provide information to the Commission and to suggest permanent rules before the Commission issues a Notice of Proposed Rulemaking.[3] The TNCs operating in Colorado have experience operating in many parts of the nation and the world, and input received from industry members in this miscellaneous proceeding promoted the efficient use of the Commission's and participants' resources. We also referred the matter to an Administrative Law Judge (ALJ) and set a hearing date.

7. Interested participants, including TNCs, taxicab companies, and Staff of the Commission, filed proposed rule language and comments on proposed language into that proceeding. After holding a hearing, the ALJ issued Recommended Decision, R15-0223,

[1] Senate Bill 14-125 also amended §§ 40-1-102, C.R.S., 40-7-112, C.R.S., 40-10.1-101, C.R.S., 40-10.1-103, C.R.S., and 40-10.1-117, C.R.S.

[2] Decision No. C14-0773 in Proceeding No. 14R-0737TR.

[3] Decision C14-1246 in Proceeding No. 14M-1014TR.

which suggested rule language, posed questions to be answered in a future rule-making proceeding, and closed the proceeding.[4]

8. Because permanent rules would not be effective before the temporary rules expired, on January 29, 2015, the Commission issued new temporary rules to continue needed protections for the public health, safety and welfare.[5] The new temporary rules, rules 6700-6703, 4 CCR 723-6, became effective on February 4, 2015 and will remain in effect through September 2, 2015, or until permanent rules take effect.

C. Findings and Conclusions

9. The TNC statute requires TNCs to obtain a permit from the Commission before operating in Colorado. § 40-10.1-606(1). "The Commission shall determine the form and manner of application for a Transportation Network Company permit." § 40-10.1-606(3). The TNC Statute also contains important public safety provisions. For example, § 40-10.1-605(1)(d)(IV) requires TNCs to confirm that their drivers are medically fit to drive, pursuant to Commission rules. The TNC Statute limits the number of consecutive hours a driver may offer or provide services to 12; however, it does not address the length of time after a 12-hour consecutive driving period that a driver is not permitted to resume the offering or provisioning of TNC services. § 40-10.1-605(1)(e). The TNC Statute requires TNCs to conduct safety inspections on a vehicle before use for TNC services; but, it does not prescribe the standards applicable to these inspections. § 40-10.1-605(1)(g)(I). The TNC statute also imposes certain insurance and financial responsibility requirements upon TNC operations. § 40-10.1-604(2), (4).

[4] Decision No. R15-0223 in Proceeding No. 14M-1014TR, issued March 10, 2015.
[5] Decision No. C15-0106 in Proceeding No. 15R-0062TR.

10. These matters and others require our continuing attention to protect public safety. We therefore issue this Notice of Proposed Rulemaking to address the public safety, health, and welfare of Coloradoans and visitors to our state who use TNC services.

11. The ALJ's suggested rules are the foundation for the proposed rules, but we propose certain changes, which include the following:

a) Rule 6702(e) requires each TNC to annually reapply for a permit and pay the fee;

b) Rule 6708(a) requires driver to be able to read and speak English sufficiently to communicate with passengers and enforcement officials;

c) Rule 6708(b) clarifies that drivers must carry proof of TNC insurance;

d) Rule 6712 requires that all criminal history record checks must be fingerprint-based, whether conducted pursuant to procedures set forth in Section 40-10.1-110 as supplemented by Commission rules or conducted through a privately administered national criminal history record check;

e) Rule 6719 requires TNCs to ensure that a driver displays vehicle markings while logged in to the digital network;

f) Rule 6720(b) requires TNCs to report annually to the Commission a record of discipline administered to drivers for violation of statutes or rules;

g) Rules 6722(a)-(c) establish hours of service requirements and applies what is known as the "80 in 8" rule for common carriers, which sets the maximum number of hours a driver may be logged into the TNC's digital network at 80 in an 8-day period;[6]

[6] The Commission is addressing the interpretation of the so called "80 in 8 rule," rule 6103(c), 4 CCR 723-6, in Proceeding No. 15D-0060CP. The outcome of that proceeding will necessarily affect any TNC rule addressing driver fatigue.

h) Rules 6723(c)-(g) require that a TNC prohibit specified conduct by drivers, such as driving while intoxicated or texting while driving, the TNC is subject to civil penalties if it fails to prevent such behavior or take required actions against it;

i) Rules 6723(c)-(i) require a TNC to disconnect a driver from the digital network if an enforcement official notifies the TNC that a driver has violated certain safety rules;

j) Rules 6723(d) and (e) require a TNC to permanently disconnect a driver from the digital network if a driver violates a rule prohibiting driving under the influence of drugs or alcohol;

k) Rule 6723(f) requires a TNC to disconnect a driver from the digital network for 30 days if a logged in driver is texting while operating a personal vehicle; and

l) Rule 6724 modifies the civil penalty amounts for some violations making TNC penalties consistent with common carrier penalties for similar violations.

12. The Commission invites interested participants to comment and submit information on the attached proposed rules. We also invite comment on the following questions:

a) Does the TNC Statute impose obligations upon drivers, or only TNCs? If the statute imposes obligations on drivers, what enforcement mechanisms may the Commission impose upon drivers? Is a TNC subject to a civil penalty for driver violations of the TNC Statute or Commission rules?

b) Should these rules specify the location and size of the required exterior markings that identify a vehicle used to provide TNC services? Should these rules require that these exterior markings remain in place even though the driver is not logged into the digital network and not providing TNC services?

c) Should TNC drivers be prohibited from stationing their personal vehicles at or near a recognized taxicab stand, a designated passenger pickup point at an airport, a hotel, or a motel without first being matched with a rider through a digital network?

d) What is the correct length of time that a TNC must retain a driver's application after that person is no longer providing services for that TNC? Should the length of time correspond to statutes of limitation for any applicable civil or criminal complaints?

e) Should the Commission require additional vehicle components or equipment be inspected for safety, in addition to the 19 items required to be inspected under § 40-10.1-605(g)(I)? What forms of experience and training qualify a person as capable of performing a vehicle inspection? Do the inspection standards in the proposed rules adequately promote safety?

f) The fiscal note for Senate Bill 14-125 assumed that 50% of personal vehicles would be inspected by enforcement staff each year. What processes should the Commission implement to meet this expectation?

g) What constitutes reasonable notice and request by an enforcement official to inspect a personal vehicle and interview TNC personnel and drivers? Should a TNC driver and the driver's vehicle be subject to inspection by an enforcement officer only when the driver is logged into a TNC's digital network, or should enforcement officials be able to investigate a vehicle that operates as a TNC vehicle, even when the driver is logged off? Should a driver be able to avoid a vehicle inspection by logging off?

13. Interested parties may file written comment, including data, views, or arguments, no later than **May 15, 2015.** We also request commenters to include proposed or alternate rule language, as necessary, with their comments. The Commission prefers and encourages interested

persons to submit comments through its Electronic Filing System in this proceeding (15R-0250TR). The Commission will consider all submissions, whether oral or written.

14. We refer this proceeding to an ALJ to hold a public hearing on **June 1, 2015**. Interested persons may provide oral comments at the public hearing unless the ALJ deems oral presentations unnecessary. The ALJ shall provide the record in this proceeding to the Commission for the Commission to issue an initial Commission Decision under § 40-6-109(6), C.R.S.

15. Under § 24-4-103(3)(a.5), C.R.S., the Commission is notifying the members of the General Assembly of the issuance of these proposed rules, because they contain increases in fees or fines. The Commission will place a copy of the notice to the General Assembly into the record of this proceeding.

II. ORDER

A. The Commission Orders That:

1. This Notice of Proposed Rulemaking shall be filed with the Colorado Secretary of State for publication in the May 10, 2015 edition of *The Colorado Register*.

2. A Hearing on the proposed rules and related matters shall be held before an Administrative Law Judge (ALJ) as follows:

DATE: June 1, 2015

TIME: 9:00 a.m.

PLACE: Commission Hearing Room
Suite 250
1560 Broadway
Denver, Colorado

3. The ALJ may set additional hearings, if necessary.

4. Interested persons may file written comments on or before May 15, 2015. The Commission prefers and encourages interested persons to submit comments through its Electronic Filing System at https://www.dora.state.co.us/pls/efi/EFI.homepage in this proceeding (15R-0250TR). Interested persons may present comments orally at the hearing, unless the ALJ deems oral comments unnecessary.

5. This Decision is effective upon its Mailed Date.

B. ADOPTED IN COMMISSIONERS' WEEKLY MEETING April 16, 2015.

(S E A L)

THE PUBLIC UTILITIES COMMISSION OF THE STATE OF COLORADO

JOSHUA B. EPEL

PAMELA J. PATTON

GLENN A. VAAD

Commissioners

ATTEST: A TRUE COPY

Doug Dean,
Director

Notice of Proposed Rulemaking

Tracking number

2015-00226

Department

1000 - Department of Public Health and Environment

Agency

1007 - Hazardous Materials and Waste Management Division

CCR number

6 CCR 1007-1 Part 04

Rule title

RADIATION CONTROL - STANDARDS FOR PROTECTION AGAINST RADIATION

Rulemaking Hearing

Date

06/17/2015

Time

10:00 AM

Location

Sabin-Cleere Conference Room, Colorado Department of Public Health and Environment, Bldg. A, 4300 Cherry Creek Drive, South, Denver, CO. 80246

Subjects and issues involved

To consider the promulgation of amendments to 6 CCR 1007-1, Colorado Rules and Regulations Pertaining to Radiation Control, Part 4, Standards for Protection Against Radiation.

Statutory authority

Section 25-1.5-101(1)(k), 25-1.5(1)(l), 25-11-103, 25-11-104, and 25-1-108 C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

To: Members of the State Board of Health

From: James Jarvis, Health Physicist, Hazardous Materials and Waste Management Division

Through: Gary Baughman, Division Director GB

Date: March 30, 2015

Subject: **Request for Rulemaking Hearing**
Proposed amendments to 6 CCR 1007-1, Part 4, Standards for Radiation, with a request for the rulemaking hearing to occur in June of 2015

The Division is proposing minor amendments to regulatory part 4, titled *Standards for Protection Against Radiation*.

The regulatory part is being amended to remove information that is no longer valid, to correct typographical errors, to add language specific to the handling and recordkeeping for decay-in-storage consistent with other regulatory parts, and to reformat a table containing a typographic spelling error.

The specific proposed Part 4 changes include:
(1) Removing an invalid web address (also known as a Uniform Resource Locator or "URL") due to revisions to the Departments website in 2014. The web address references Tables 4B1, 4B2, and 4B3;
(2) Inserting Tables 4B1, 4B2, 4B3 into the body of the rule without change. These tables have been maintained separate from the rule (due to their complex formatting) but were linked via website address/URL to the rule. The URLs are no longer valid;
(3) Replacing and reformatting Table 4C in its entirety to correct a spelling error (with no other changes to table values proposed);
(4) Adding language pertaining to requirements and recordkeeping for short-lived radioactive materials held for decay-in-storage consistent with Part 7 rule language; and
(5) Correction of typographical errors.

Approximately 500 stakeholders were notified of the proposed rule amendment and were provided the opportunity to comment. Due to the minor nature of the rule changes, no stakeholder meetings were scheduled. The stakeholder comment period remains open through April 8. To date, the Division received no written comments from stakeholders.

Further details are listed in a Statement of Basis and Purpose and Specific Statutory Authority for the proposed rule, which, along with a Regulatory Analysis and supporting information, is available at: http://www.colorado.gov/pacific/cdphe/radregs

At the April 15, 2015 request for rulemaking, the Radiation Program requests that the Board of Health set a rulemaking hearing for June of 2015.

cc: Deborah Nelson, Administrator, State Board of Health

DRAFT

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1007-1, Radiation Control, Part 4, Standards for Protection Against Radiation

Basis and Purpose.

The Colorado Radiation Control Act, Title 25, Article 11, Colorado Revised Statutes (the Act), requires the State Board of Health to formulate, adopt and promulgate rules and regulations pertaining to radiation control.

Section 25-11-103 of the Act requires the Colorado Department of Public Health and Environment (Department) to develop and conduct programs for evaluation and control of hazards associated with the use of sources of ionizing radiation. Under this authority the Department requires registration of sources of ionizing radiation such as radiation machines and licenses governing the use of radioactive materials.

Section 25-11-104 of the Act requires Colorado's radiation regulations to be consistent with the Suggested State Regulations for Control of Radiation (SSRCR) of the Conference of Radiation Control Program Directors, Inc., except when the Board of Health concludes, on the basis of detailed findings, that a substantial deviation from the SSRCR is warranted. The Department's regulations, where applicable, must also be compatible with the regulations adopted by the U.S. Nuclear Regulatory Commission (NRC) in order to maintain status as an Agreement State. The Act establishes the SSRCR as the model for Colorado to use in adopting NRC regulatory provisions. In some instances, maintaining consistency with the SSRCR may not be possible due to the model regulation being out of date with NRC changes, where no model regulation exists, or where there are specific programmatic needs that differ greatly from the SSRCR. Colorado's Part 4 - is based upon SSRCR Part "D" (2003).

The Department is proposing minor changes to Part 4 to correct minor errors and due to internal and programmatic needs. The proposed rule changes are not specifically driven by NRC compatibility or requirements. Maintaining proper tables of limits is however a matter of compatibility, and thus the correction of table link errors will help to maintain compatibility.

Note that editorial comments, notes, and information shown in the right side margin of the draft proposed rule changes are for information only to aid the reader, and are not considered part of the regulation. These will be removed from the final regulation prior to submission to the Colorado Secretary of State's office for publishing in the Colorado register.

Specific Statutory Authority.
These rules are promulgated pursuant to the following statutory provisions: 25-1.5-101(1)(k), 25-1.5(1)(l), 25-11-103, 25-11-104, and 25-1-108, C.R.S.

SUPPLEMENTAL QUESTIONS

Is this rulemaking due to a change in state statute?

_____ Yes, the bill number is _____; rules are ___ authorized ___ required.
___X__ No

Is this rulemaking due to a federal statutory or regulatory change?

_____ Yes
__X__ No

Does this rule incorporate materials by reference?

__X__ Yes**
_____ No

****The rule in its entirety does incorporate materials by reference. The proposed rule changes which are excerpts of the complete rule do not contain materials by reference.**

Does this rule create or modify fines or fees?

_____ Yes
__X__ No

DRAFT

REGULATORY ANALYSIS

for Amendments to

6 CCR 1007-1, Radiation Control, Part 4, Standards for Protection Against Radiation

1. **A description of the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.**

   The proposed rule change is expected to have little to no impact on licensees and there is no cost associated with the rule amendment. The proposed changes are primarily corrections and/or editorial in nature without substantive changes. One added provision pertaining to decay in storage is consistent with language contained in another part (Part 7) of the current rules. The Part 7 rule applies only to medical use licensees, adding this language to Part 4 will apply equivalent requirements to all other licensees thereby eliminating the need to have the requirements in individual license condition.

   There are no specific classes of persons that are expected to benefit from the proposed rule.

   Registrants or users of radiation producing (x-ray) machines are <u>not</u> impacted by the proposed rule changes. This rule change applies only to specific radioactive materials licensees and typically only those licensees using unsealed radioactive materials.

2. **To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.**

   Due to the minor nature of the proposed changes, there are no expected quantitative or qualitative impacts of the proposed rule.

3. **The probable costs to the agency and to any other agency for the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.**

   There are no anticipated costs to the Department as a result of the proposed rule change. The majority of changes are administrative in nature.

   A minor cost savings may be realized due to the added provision pertaining to decay in storage in the proposed rule. The additional language pertaining to decay in storage is expected to benefit the Department by eliminating the need to have special provisions or language pertaining to this topic in the licenses. With the language added to the rule, language specific to decay in storage will be consistent for all types of licensees and not limited to medical licensees.

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

There are no anticipated costs as a result of the proposed rule. The benefits of amending the rule will be to correct invalid website links in the rule and to correct other typographical type errors. The addition of the decay-in-storage provision will eliminate the need to add this language to licensees by deferring to regulation.

Inaction on the proposed rule will retain website links which are no longer appropriate or valid and will not correct the typographical errors in the rule. This may result in confusion on the part of the regulated community due to the unavailability of tables of limits that licensees are required to adhere to.

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

The Radiation Program believes there are no less costly or less intrusive methods for implementing these minor changes. The changes are necessary to correct functional and typographical errors in the rule which will benefit both the regulated community and the regulatory program responsible for enforcing the rule. The added provision is expected to ensure licensees have clear and concise requirements in regulation.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

There are no alternative rules or rulemaking considered.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

Both the short-term and long-term consequences of failing to implement the proposed regulatory changes would result in the rule continuing to have or contain invalid information and typographical errors. Failing to implement the proposed change pertaining to waste disposal would also result in the program continuing to add requirements to license condition rather than deferring to rule, which in the long term is likely to be less efficient.

DRAFT

STAKEHOLDER COMMENTS
for Amendments to
6 CCR 1007-1, Radiation Control, Part 4, Standards for Protection Against Radiation

The following individuals and/or entities were included in the development of these proposed rules: All radioactive materials licensees with valid email addresses, and other interested stakeholders.

On March 9-11, 2015, specific radioactive materials licensees and other entities were notified of the opportunity to comment on the proposed draft rule. The entities notified represented:
- All ~300+ radioactive materials licensees;
- Approximately 190 "other stakeholders" representing individuals who have specifically signed up to receive notification of proposed radiation regulation changes and who represent a wide variety of interests, most of whom would not be impacted by the proposed rule changes. These stakeholder entities include: x-ray registrants, radioactive materials licensees; private citizens; private companies; professional organizations; and special interest groups.

This rulemaking does not include a local government mandate. The burden of regulatory conformity to this rule applies to the regulated entities (licensees) only. EO5 does not apply.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

To date, no stakeholders have provided written comments opposing or supporting the rule, nor have changes to the rule been suggested.

No specific policy issues have been identified with development of the proposed rule changes. The minor rule changes address programmatic needs and typographical error corrections to ensure that both the regulated community and program staff have true and correct information in the rule.

Please identify health equity and environmental justice (HEEJ) impacts. Does this proposal impact Coloradoans equally or equitably? Does this proposal provide an opportunity to advance HEEJ? Are there other factors that influenced these rules?

The Department has proposed minor, mostly editorial rule changes that treat entities that possess and use radioactive materials equitably. The proposed changes are neutral with respect to HEEJ.

DRAFT 1 03/30/15

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Hazardous Materials and Waste Management Division

RADIATION CONTROL - STANDARDS FOR PROTECTION AGAINST RADIATION

6 CCR 1007-1 Part 04

Adopted by the Board of Health June 17, 2015

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

PART 4: STANDARDS FOR PROTECTION AGAINST RADIATION

STANDARDS FOR PROTECTION AGAINST RADIATION

[* * * = Indicates omission of unaffected rule sections]

*** * ***

Comment [JJ1]: The draft date is for information only and is not part of the final rule or rule language.

Comment [JJ2]:
EDITORIAL NOTE 1: ALL COMMENTS (SUCH AS THIS ONE) SHOWN IN THE RIGHT SIDE MARGIN OF THIS DOCUMENT ARE FOR INFORMATION PURPOSES ONLY TO PROVIDE ADDITIONAL INFORMATION AND TO AID THE READER IN UNDERSTANDING THE PROPOSED RULE DURING THE DRAFT REVIEW PROCESS. SINCE THIS IS A NEW RULE, MOST COMMENTS REFLECT CROSS-REFERENCE INFORMATION TO THE SUGGESTED STATE REGULATION AND NRC REGULATION.

THESE COMMENTS ARE **NOT** PART OF THE RULE AND ALL COMMENTS WILL BE DELETED PRIOR TO FINAL SUBMISSION.

EDITORIAL NOTE 2: THE ENTIRE RULE IS NOT PROVIDED/PRESENTED AS THE PROPOSED CHANGES IMPACT ONLY A LIMITED NUMBER OF SECTIONS. UNAFFECTED SECTIONS ARE OMITTED FROM THE DRAFT.

Comment [JJ3]: This reflects the date of anticipated approval by the Colorado Board of Health. The effective date is approximately 60 days beyond this date, pending additional review and approvals.

This date is subject to change as determined by the Board of Health. Changes to this date will be properly reflected in the rule, as applicable.

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Comment [JJ4]: The language in brackets and subsequent "***" marks are not part of the final rule and will be deleted prior to final submission.

WASTE DISPOSAL

4.33 General Requirements.

4.33.1 A licensee or registrant shall dispose of licensed or registered material only:

4.33.1.1 By transfer to an authorized recipient as provided in 4.38 or in Parts 3, 14, or 18 of these regulations, or to the U.S. Department of Energy; or

4.33.1.2 By decay in storage **in accordance with the following**~~:; or~~

(1) A licensee may hold radioactive material with a physical half-life of less than or equal to 120 days for decay-in-storage before disposal without regard for its radioactivity if the licensee:

(a) Monitors radioactive material at the container surface before disposal and determines that its radioactivity cannot be distinguished from the background radiation level with a radiation detection survey instrument set on its most sensitive scale and with no interposed shielding; and

(b) Removes or obliterates all radiation labels, except for material that will be handled as biomedical waste after release;

or

4.33.1.3 By release in effluents within the limits in 4.14; or

4.33.1.4 As authorized pursuant to 4.34, 4.35, 4.36, 4.37 or 4.39.2

4.33.2 A person shall be specifically licensed or registered to receive waste containing licensed or registered material from other persons for:

4.33.2.1 Treatment prior to disposal; or

4.33.2.2 Treatment or disposal by incineration; or

4.33.2.3 Decay in storage; or

4.33.2.4 Disposal at a land disposal facility pursuant to Part 14 of these regulations or as authorized under Parts 3 or 18 of these regulations; or

4.33.2.5 Storage until transferred to a storage or disposal facility authorized to receive the waste.

* * *

4.48 Records of Waste Disposal.

Comment [JJ5]:
For consistency, the added language puts forth equivalent requirements (for all licensees) that are identical to the requirements contained in Part 7, Section 7.29 (which is only applicable to medical/healing arts licensees).

The proposed change is not required by NRC regulation but is necessary to address a programmatic need to ensure consistency between medical and non-medical licensees with respect to decay in storage.

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4.48.1 Each licensee or registrant shall maintain records of the disposal of licensed or registered materials made pursuant to 4.34, 4.35, 4.36, 4.37, Part 14 of these regulations, and disposal by burial in soil, including burials authorized before December 30, 1985.

4.48.2 The licensee or registrant shall retain the records required by 4.48.1 in accordance with 3.15.4 until the Department terminates each pertinent license or registration requiring the record.

4.48.3 For radioactive material disposed in accordance with 4.33.1.2, the licensee shall retain a record of each decay in storage disposal for 3 years. The record must include the date of the disposal, the survey instrument used, the background radiation level, the radiation level measured at the surface of each waste container, and the name of the individual who performed the survey.

* * *

Comment [JJ6]:
For consistency, the added language puts forth equivalent requirements (for all licensees) that are identical to the requirements contained in Part 7, Section 7.29 (which is only applicable to medical/healing arts licensees).

The proposed change is not required by NRC regulation but is necessary to address a programmatic need to ensure consistency between medical and non-medical licensees with respect to decay in storage disposal records.

4.61 Radiological Criteria For License Termination.

4.61.1 The criteria in this section apply to the decommissioning of facilities licensed under Parts 3, 5, 7, 14, 16, and 19 of these regulations. For low-level waste disposal facilities licensed under Part 14, the criteria apply only to the ancillary surface facilities that support radioactive waste disposal activities.

4.61.1.1 The criteria in this section do not apply to uranium and thorium recovery facilities already subject to Appendix ~~18~~A of Part 18; uranium solution extraction facilities; sites which have been decommissioned and the license terminated prior to July 1, 1999; or sites which submitted a decommissioning plan prior to July 1, 2000 and received Department approval of that decommissioning plan prior to July 1, 2001.

Comment [JJ7]:
This corrects a typographical cross-reference error. Currently, Appendix A of Part 18 is titled Appendix A, and not Appendix "18A".

* * *

PART 4, APPENDIX 4B: ANNUAL LIMITS ON INTAKE (ALI) AND DERIVED AIR CONCENTRATIONS (DAC) OF RADIONUCLIDES FOR OCCUPATIONAL EXPOSURE; EFFLUENT CONCENTRATIONS; CONCENTRATIONS FOR RELEASE TO SANITARY SEWERAGE

~~**ANNUAL LIMITS ON INTAKE (ALI) AND DERIVED AIR CONCENTRATIONS (DAC) OF RADIONUCLIDES FOR OCCUPATIONAL EXPOSURE; EFFLUENT CONCENTRATIONS; CONCENTRATIONS FOR RELEASE TO SANITARY SEWERAGE**~~

Comment [JJ8]: A redundant (duplicative) section title is removed.

Introduction

For each radionuclide, Table 4B1 indicates the chemical form which is to be used for selecting the appropriate ALI or DAC value. The ALIs and DACs for inhalation are given for an aerosol with an activity median aerodynamic diameter (AMAD) of 1 μm, micron, and for three classes (D, W, Y) of radioactive material, which refer to their retention (approximately days, weeks or years) in the pulmonary region of the lung. This classification applies to a range of clearance half times for D if less than 10 days, for W from 10 to 100 days, and for Y greater than 100 days. Table 4B2 provides concentration limits for airborne and liquid effluents released to the general environment. Table 4B3 provides concentration limits for discharges to sanitary sewerage.

Note:

The values in Table 4B1, Table 4B2, and Table 4B3 are presented in the computer "E" notation. In this notation a value of 6E-02 represents a value of 6×10^{-2} or 0.06, 6E+2 represents 6×10^{2} or 600, and 6E+0 represents 6×10^{0} or 6.

Table 4B1 "Occupational Values"

Note that the columns in Table 4B1 of this appendix captioned "Oral Ingestion ALI," "Inhalation ALI," and "DAC," are applicable to occupational exposure to radioactive material.

The ALIs in this appendix are the annual intakes of given radionuclide by "reference man" which would result in either (1) a committed effective dose equivalent of 0.05 Sv (5 rem), stochastic ALI, or (2) a committed dose equivalent of 0.5 Sv (50 rem) to an organ or tissue, non-stochastic ALI. The stochastic ALIs were derived to result in a risk, due to irradiation of organs and tissues, comparable to the risk associated with deep dose equivalent to the whole body of 0.05 Sv (5 rem). The derivation includes multiplying the committed dose equivalent to an organ or tissue by a weighting factor, w_T. This weighting factor is the proportion of the risk of stochastic effects resulting from irradiation of the organ or tissue, T, to the total risk of stochastic effects when the whole body is irradiated uniformly. The values of w_T are listed under the definition of weighting factor in 4.3. The non-stochastic ALIs were derived to avoid non-stochastic effects, such as prompt damage to tissue or reduction in organ function.

A value of $w_T = 0.06$ is applicable to each of the five organs or tissues in the "remainder" category receiving the highest dose equivalents, and the dose equivalents of all other remaining tissues may be disregarded. The following portions of the GI tract — stomach, small intestine, upper large intestine, and lower large intestine — are to be treated as four separate organs.

Note that the dose equivalents for an extremity, skin and lens of the eye are not considered in computing the committed effective dose equivalent, but are subject to limits that must be met separately.

When an ALI is defined by the stochastic dose limit, this value alone is given. When an ALI is determined by the non-stochastic dose limit to an organ, the organ or tissue to which the limit applies is shown, and the ALI for the stochastic limit is shown in parentheses. Abbreviated organ or tissue designations are used:

LLI wall = lower large intestine wall;

St. wall = stomach wall;

Blad wall = bladder wall; and

Bone surf = bone surface.

The use of the ALIs listed first, the more limiting of the stochastic and non-stochastic ALIs, will ensure that non-stochastic effects are avoided and that the risk of stochastic effects is limited to an acceptably low value. If, in a particular situation involving a radionuclide for which the non-stochastic ALI is limiting, use of that non-stochastic ALI is considered unduly conservative, the licensee may use the stochastic ALI to determine the committed effective dose equivalent. However, the licensee shall also ensure that the 0.5 Sv (50 rem) dose equivalent limit for any organ or tissue is not exceeded by the sum of the external deep dose equivalent plus the internal committed dose equivalent to that organ, not the effective dose. For the case where there is no external dose contribution, this would be demonstrated if the sum of the fractions of the nonstochastic ALIs (ALI_{ns}) that contribute to the committed dose equivalent to t he organ receiving the highest dose does not exceed unity, that is, $\sum$ (intake (in μCi) of each radionuclide/ALI_{ns}) ≤ 1.0. If there is an external deep dose equivalent contribution of H_d, then this sum must be less than 1 - (H_d/50), instead of ≤ 1.0.

Note that the dose equivalents for an extremity, skin, and lens of the eye are not considered in computing the committed effective dose equivalent, but are subject to limits that must be met separately.

The derived air concentration (DAC) values are derived limits intended to control chronic occupational exposures. The relationship between the DAC and the ALI is given by:

DAC = ALI (in μCi)/(2000 hours per working year x 60 minutes/hour x 2 x 10^4 ml per minute) = (ALI/2.4 x 10^9) μCi/ml, where 2 x 10^4 ml is the volume of air breathed per minute at work by reference man under working conditions of light work.

The DAC values relate to one of two modes of exposure: either external submersion or the internal committed dose equivalents resulting from inhalation of radioactive materials. DACs based upon submersion are for immersion in a semi-infinite cloud of uniform concentration and apply to each radionuclide separately.

The ALI and DAC values include contributions to exposure by the single radionuclide named and any in-growth of decay product radionuclides produced in the body by decay of the parent. However, intakes that include both the parent and decay product radionuclides should be treated by the general method appropriate for mixtures.

The values of ALI and DAC do not apply directly when the individual both ingests and inhales a radionuclide, when the individual is exposed to a mixture of radionuclides by either inhalation or ingestion or both, or when the individual is exposed to both internal and external irradiation. See 4.7. When an individual is exposed to radioactive materials which fall under several of the translocation classifications of the same radionuclide, such as, Class D, Class W, or Class Y, the exposure may be evaluated as if it were a mixture of different radionuclides.

It should be noted that the classification of a compound as Class D, W, or Y is based on the chemical form of the compound and does not take into account the radiological half-life of different radionuclides. For this reason, values are given for Class D, W, and Y compounds, even for very short-lived radionuclides.

Table 4B2 “Effluent Concentrations”

The columns in Table 4B2 of this appendix captioned “Effluents,” “Air” and “Water” are applicable to the assessment and control of dose to the public, particularly in the implementation of the provisions of 4.15.

The concentration values given in Columns 1 and 2 of Table 4B2 are equivalent to the radionuclide concentrations which, if inhaled or ingested continuously over the course of a year, would produce a total effective dose equivalent of 0.5 mSv (0.05 rem).

Consideration of non-stochastic limits has not been included in deriving the air and water effluent concentration limits because non-stochastic effects are presumed not to occur at or below the dose levels established for individual members of the public. For radionuclides, where the non-stochastic limit was governing in deriving the occupational DAC, the stochastic ALI was used in deriving the corresponding airborne effluent limit in Table 4B2. For this reason, the DAC and airborne effluent limits are not always proportional as they were in Appendix A of Part D of the Eighth Edition of Volume I of the Suggested State Regulations for Control of Radiation, April 2004.

The air concentration values listed in Table 4B2, Column 1, were derived by one of two methods. For those radionuclides for which the stochastic limit is governing, the occupational stochastic inhalation ALI was divided by 2.4 x 10^9, relating the inhalation ALI to the DAC, as explained above, and then divided by a factor of 300. The factor of 300 includes the following components: a factor of 50 to relate the 0.05 Sv (5 rem) annual occupational dose limit to the 0.1 rem limit for members of the public, a factor of 3 to adjust for the difference in exposure time and the inhalation rate for a worker and that for members of the public; and a factor of 2 to adjust the occupational values, derived for adults, so that they are applicable to other age groups.

For those radionuclides for which submersion, that is external dose, is limiting, the occupational DAC in Table 4B1, Column 3 was divided by 219. The factor of 219 is composed of a factor of 50, as described above, and a factor of 4.38 relating occupational exposure for 2,000 hours per year to full-time exposure (8,760 hours per year). Note that an additional factor of 2 for age considerations is not warranted in the submersion case.

The water concentrations were derived by taking the most restrictive occupational stochastic oral ingestion ALI and dividing by 7.3 x 10^7. The factor of 7.3 x 10^7 (ml) includes the following components: the factors of 50 and 2 described above and a factor of 7.3 x 10^5 (ml) which is the annual water intake of reference man.

Note 2 of this appendix provides groupings of radionuclides which are applicable to unknown mixtures of radionuclides. These groupings, including occupational inhalation ALIs and DACs, air and water effluent concentrations and releases to sewer, require demonstrating that the most limiting radionuclides in successive classes are absent. The limit for the unknown mixture is defined when the presence of one of the listed radionuclides cannot be definitely excluded as being present either from knowledge of the radionuclide composition of the source or from actual measurements.

Table 4B3 "Releases to Sewerage"

The monthly average concentrations for release to sanitary sewerage are applicable to the provisions in 4.35. The concentration values were derived by taking the most restrictive occupational stochastic oral ingestion ALI and dividing by 7.3 x 10^6 (ml). The factor of 7.3 x 10^6 (ml) is composed of a factor of 7.3 x 10^5 (ml), the annual water intake by reference man, and a factor of 10, such that the concentrations, if the sewage released by the licensee were the only source of water ingested by a reference man during a year, would result in a committed effective dose equivalent off 0.5 rem.

Table 4B1, Table 4B2, and Table 4B3 ~~are found at~~

~~http://www.colorado.gov/cs/Satellite/CDPHE-Main/CBON/1251607674329~~

Comment [JJ9]: The reference to this URL link is no longer valid due to 2014 changes to the CDPHE website and the link is therefore removed from the rule.

Tables 4B1, 4B2, and 4B3 will be inserted directly into the rule in the final published version. (Due to complex formatting of these tables, versions in WORD format will be two separate files).

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
89	Actinium-224	D, all compounds except those given for W and Y	2E+3 LLI wall (2E+3)	3E+1 Bone surf (4E+1)	1E-8 -	- 5E-11	- 3E-5	- 3E-4
		W, halides and nitrates	-	5E+1	2E-8	7E-11	-	-
		Y, oxides and hydroxides	-	5E+1	2E-8	6E-11	-	-
89	Actinium-225	D, see ^{224}Ac	5E+1 LLI wall (5E+1)	3E-1 Bone surf (5E-1)	1E-10 -	- 7E-13	- 7E-7	- 7E-6
		W, see ^{224}Ac	-	6E-1	3E-10	9E-13	-	-
		Y, see ^{224}Ac	-	6E-1	3E-10	9E-13	-	-
89	Actinium-226	D, see ^{224}Ac	1E+2 LLI wall (1E+2)	3E+0 Bone surf (4E+0)	1E-9 -	- 5E-12	- 2E-6	- 2E-5
		W, see ^{224}Ac	-	5E+0	2E-9	7E-12	-	-
		Y, see ^{224}Ac	-	5E+0	2E-9	6E-12	-	-
89	Actinium-227	D, see ^{224}Ac	2E-1 Bone surf (4E-1)	4E-4 Bone surf (8E-4)	2E-13 -	- 1E-15	- 5E-9	- 5E-8
		W, see ^{224}Ac	-	2E-3 Bone surf (3E-3)	7E-13 -	- 4E-15	- -	- -
		Y, see ^{224}Ac	-	4E-3	2E-12	6E-15	-	-
89	Actinium-228	D, see ^{224}Ac	2E+3 -	9E+0 Bone surf (2E+1)	4E-9 -	- 2E-11	3E-5 -	3E-4 -
		W, see ^{224}Ac	-	4E+1 Bone surf (6E+1)	2E-8 -	- 8E-11	- -	- -
		Y, see ^{224}Ac	-	4E+1	2E-8	6E-11	-	-
13	Aluminum-26	D, all compounds except those given for W	4E+2	6E+1	3E-8	9E-11	6E-6	6E-5
		W, oxides, hydroxides, carbides, halides, and nitrates	-	9E+1	4E-8	1E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (µCi)	ALI (µCi)	DAC (µCi/ml)	Air (µCi/ml)	Water (µCi/ml)	Monthly Average Concentration (µCi/ml)
95	Americium-237[2]	W, all compounds	8E+4	3E+5	1E-4	4E-7	1E-3	1E-2
95	Americium-238[2]	W, all compounds	4E+4	3E+3	1E-6	-	5E-4	5E-3
			-	Bone surf (6E+3)	-	9E-9	-	-
95	Americium-239	W, all compounds	5E+3	1E+4	5E-6	2E-8	7E-5	7E-4
95	Americium-240	W, all compounds	2E+3	3E+3	1E-6	4E-9	3E-5	3E-4
95	Americium-241	W, all compounds	8E-1	6E-3	3E-12	-	-	-
			Bone surf (1E+0)	Bone surf (1E-2)	-	2E-14	2E-8	2E-7
95	Americium-242	W, all compounds	4E+3	8E+1	4E-8	-	5E-5	5E-4
			-	Bone surf (9E+1)	-	1E-10	-	-
95	Americium-242m	W, all compounds	8E-1	6E-3	3E-12	-	-	-
			Bone surf (1E+0)	Bone surf (1E-2)	-	2E-14	2E-8	2E-7
95	Americium-243	W, all compounds	8E-1	6E-3	3E-12	-	-	-
			Bone surf (1E+0)	Bone surf (1E-2)	-	2E-14	2E-8	2E-7
95	Americium-244	W, all compounds	3E+3	2E+2	8E-8	-	4E-5	4E-4
			-	Bone surf (3E+2)	-	4E-10	-	-
95	Americium-244m[2]	W, all compounds	6E+4	4E+3	2E-6	-	-	-
			St wall (8E+4)	Bone surf (7E+3)	-	1E-8	1E-3	1E-2
95	Americium-245	W, all compounds	3E+4	8E+4	3E-5	1E-7	4E-4	4E-3
95	Americium-246[2]	W, all compounds	3E+4	1E+5	4E-5	1E-7	4E-4	4E-3
95	Americium-246m[2]	W, all compounds	5E+4	2E+5	8E-5	3E-7	-	-
			St wall (6E+4)	-	-	-	8E-4	8E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
51	Antimony-115[2]	D, all compounds except those given for W	8E+4	2E+5	1E-4	3E-7	1E-3	1E-2
		W, oxides, hydroxides, halides, sulfides, sulfates, and nitrates	-	3E+5	1E-4	4E-7	-	-
51	Antimony-116[2]	D, see ^{115}Sb	7E+4 St wall (9E+4)	3E+5	1E-4	4E-7	-	-
		W, see ^{115}Sb	-	3E+5	1E-4	5E-7	1E-3 -	1E-2 -
51	Antimony-116m[2]	D, see ^{115}Sb	2E+4	7E+4	3E-5	1E-7	3E-4	3E-3
		W, see ^{115}Sb	-	1E+5	6E-5	2E-7	-	-
51	Antimony-117	D, see ^{115}Sb	7E+4	2E+5	9E-5	3E-7	9E-4	9E-3
		W, see ^{115}Sb	-	3E+5	1E-4	4E-7	-	-
51	Antimony-118m	D, see ^{115}Sb	6E+3	2E+4	8E-6	3E-8	7E-5	7E-4
		W, see ^{115}Sb	5E+3	2E+4	9E-6	3E-8	-	-
51	Antimony-119	D, see ^{115}Sb	2E+4	5E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{115}Sb	2E+4	3E+4	1E-5	4E-8	-	-
51	Antimony-120 (5.76 d)	D, see ^{115}Sb	1E+3	2E+3	9E-7	3E-9	1E-5	1E-4
		W, see ^{115}Sb	9E+2	1E+3	5E-7	2E-9	-	-
51	Antimony-120[2] (16 min)	D, see ^{115}Sb	1E+5 St wall (2E+5)	4E+5	2E-4	6E-7	-	-
		W, see ^{115}Sb	-	5E+5	2E-4	7E-7	2E-3 -	2E-2 -
51	Antimony-122	D, see ^{115}Sb	8E+2 LLI wall (8E+2)	2E+3	1E-6	3E-9	-	-
		W, see ^{115}Sb	7E+2	1E+3	4E-7	2E-9	1E-5 -	1E-4 -
51	Antimony-124	D, see ^{115}Sb	6E+2	9E+2	4E-7	1E-9	7E-6	7E-5
		W, see ^{115}Sb	5E+2	2E+2	1E-7	3E-10	-	-
51	Antimony-124m[2]	D, see ^{115}Sb	3E+5	8E+5	4E-4	1E-6	3E-3	3E-2
		W, see ^{115}Sb	2E+5	6E+5	2E-4	8E-7	-	-
51	Antimony-125	D, see ^{115}Sb	2E+3	2E+3	1E-6	3E-9	3E-5	3E-4
		W, see ^{115}Sb	-	5E+2	2E-7	7E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (µCi)	ALI (µCi)	DAC (µCi/ml)	Air (µCi/ml)	Water (µCi/ml)	Monthly Average Concentration (µCi/ml)
51	Antimony-126	D, see ^{115}Sb	6E+2	1E+3	5E-7	2E-9	7E-6	7E-5
		W, see ^{115}Sb	5E+2	5E+2	2E-7	7E-10	-	-
51	Antimony-126m[2]	D, see ^{115}Sb	5E+4 St wall (7E+4)	2E+5	8E-5	3E-7	-	-
		W, see ^{115}Sb	-	2E+5	8E-5	3E-7	9E-4 -	9E-3 -
51	Antimony-127	D, see ^{115}Sb	8E+2 LLI wall (8E+2)	2E+3	9E-7	3E-9	-	-
		W, see ^{115}Sb	7E+2	9E+2	4E-7	1E-9	1E-5 -	1E-4 -
51	Antimony-128 (9.01 h)	D, see ^{115}Sb	1E+3	4E+3	2E-6	6E-9	2E-5	2E-4
		W, see ^{115}Sb	-	3E+3	1E-6	5E-9	-	-
51	Antimony-128[2] (10.4 min)	D, see ^{115}Sb	8E+4 St wall (1E+5)	4E+5	2E-4	5E-7	-	-
		W, see ^{115}Sb	-	4E+5	2E-4	6E-7	1E-3 -	1E-2 -
51	Antimony-129	D, see ^{115}Sb	3E+3	9E+3	4E-6	1E-8	4E-5	4E-4
		W, see ^{115}Sb	-	9E+3	4E-6	1E-8	-	-
51	Antimony-130[2]	D, see ^{115}Sb	2E+4	6E+4	3E-5	9E-8	3E-4	3E-3
		W, see ^{115}Sb	-	8E+4	3E-5	1E-7	-	-
51	Antimony-131[2]	D, see ^{115}Sb	1E+4 Thyroid (2E+4)	2E+4 Thyroid (4E+4)	1E-5	-	-	-
		W, see ^{115}Sb	-	2E+4 Thyroid (4E+4)	- 1E-5 -	6E-8 6E-8	2E-4 - -	2E-3 - -
18	Argon-37	Submersion[1]	-	-	1E+0	6E-3	-	-
18	Argon-39	Submersion[1]	-	-	2E-4	8E-7	-	-
18	Argon-41	Submersion[1]	-	-	3E-6	1E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
33	Arsenic-69[2]	W, all compounds	3E+4	1E+5	5E-5	2E-7	-	-
			St wall (4E+4)	-	-	-	6E-4	6E-3
33	Arsenic-70[2]	W, all compounds	1E+4	5E+4	2E-5	7E-8	2E-4	2E-3
33	Arsenic-71	W, all compounds	4E+3	5E+3	2E-6	6E-9	5E-5	5E-4
33	Arsenic-72	W, all compounds	9E+2	1E+3	6E-7	2E-9	1E-5	1E-4
33	Arsenic-73	W, all compounds	8E+3	2E+3	7E-7	2E-9	1E-4	1E-3
33	Arsenic-74	W, all compounds	1E+3	8E+2	3E-7	1E-9	2E-5	2E-4
33	Arsenic-76	W, all compounds	1E+3	1E+3	6E-7	2E-9	1E-5	1E-4
33	Arsenic-77	W, all compounds	4E+3	5E+3	2E-6	7E-9	-	-
			LLI wall (5E+3)	-	-	-	6E-5	6E-4
33	Arsenic-78[2]	W, all compounds	8E+3	2E+4	9E-6	3E-8	1E-4	1E-3
85	Astatine-207[2]	D, halides	6E+3	3E+3	1E-6	4E-9	8E-5	8E-4
		W	-	2E+3	9E-7	3E-9	-	-
85	Astatine-211	D, halides	1E+2	8E+1	3E-8	1E-10	2E-6	2E-5
		W	-	5E+1	2E-8	8E-11	-	-
56	Barium-126[2]	D, all compounds	6E+3	2E+4	6E-6	2E-8	8E-5	8E-4
56	Barium-128	D, all compounds	5E+2	2E+3	7E-7	2E-9	7E-6	7E-5
56	Barium-131	D, all compounds	3E+3	8E+3	3E-6	1E-8	4E-5	4E-4
56	Barium-131m[2]	D, all compounds	4E+5	1E+6	6E-4	2E-6	-	-
			St wall (5E+5)	-	-	-	7E-3	7E-2
56	Barium-133	D, all compounds	2E+3	7E+2	3E-7	9E-10	2E-5	2E-4
56	Barium-133m	D, all compounds	2E+3	9E+3	4E-6	1E-8	-	-
			LLI wall (3E+3)	-	-	-	4E-5	4E-4
56	Barium-135m	D, all compounds	3E+3	1E+4	5E-6	2E-8	4E-5	4E-4
56	Barium-139[2]	D, all compounds	1E+4	3E+4	1E-5	4E-8	2E-4	2E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (μCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (μCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (μCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (μCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (μCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (μCi/ml)
56	Barium-140	D, all compounds	5E+2	1E+3	6E-7	2E-9	-	-
			LLI wall (6E+2)	-	-	-	8E-6	8E-5
56	Barium-141[2]	D, all compounds	2E+4	7E+4	3E-5	1E-7	3E-4	3E-3
56	Barium-142[2]	D, all compounds	5E+4	1E+5	6E-5	2E-7	7E-4	7E-3
97	Berkelium-245	W, all compounds	2E+3	1E+3	5E-7	2E-9	3E-5	3E-4
97	Berkelium-246	W, all compounds	3E+3	3E+3	1E-6	4E-9	4E-5	4E-4
97	Berkelium-247	W, all compounds	5E-1	4E-3	2E-12	-	-	-
			Bone surf (1E+0)	Bone surf (9E-3)	-	1E-14	2E-8	2E-7
97	Berkelium-249	W, all compounds	2E+2	2E+0	7E-10	-	-	-
			Bone surf (5E+2)	Bone surf (4E+0)	-	5E-12	6E-6	6E-5
97	Berkelium-250	W, all compounds	9E+3	3E+2	1E-7	-	1E-4	1E-3
			-	Bone surf (7E+2)	-	1E-9	-	-
4	Beryllium-10	W, see ^{7}Be	1E+3	2E+2	6E-8	2E-10	-	-
			LLI wall (1E+3)	-	-	-	2E-5	2E-4
		Y, see ^{7}Be	-	1E+1	6E-9	2E-11	-	-
4	Beryllium-7	W, all compounds except those given for Y	4E+4	2E+4	9E-6	3E-8	6E-4	6E-3
		Y, oxides, halides, and nitrates	-	2E+4	8E-6	3E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
83	Bismuth-200[2]	D, nitrates	3E+4	8E+4	4E-5	1E-7	4E-4	4E-3
		W, all other compounds	-	1E+5	4E-5	1E-7	-	-
83	Bismuth-201[2]	D, see ^{200}Bi	1E+4	3E+4	1E-5	4E-8	2E-4	2E-3
		W, see ^{200}Bi	-	4E+4	2E-5	5E-8	-	-
83	Bismuth-202[2]	D, see ^{200}Bi	1E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{200}Bi	-	8E+4	3E-5	1E-7	-	-
83	Bismuth-203	D, see ^{200}Bi	2E+3	7E+3	3E-6	9E-9	3E-5	3E-4
		W, see ^{200}Bi	-	6E+3	3E-6	9E-9	-	-
83	Bismuth-205	D, see ^{200}Bi	1E+3	3E+3	1E-6	3E-9	2E-5	2E-4
		W, see ^{200}Bi	-	1E+3	5E-7	2E-9	-	-
83	Bismuth-206	D, see ^{200}Bi	6E+2	1E+3	6E-7	2E-9	9E-6	9E-5
		W, see ^{200}Bi	-	9E+2	4E-7	1E-9	-	-
83	Bismuth-207	D, see ^{200}Bi	1E+3	2E+3	7E-7	2E-9	1E-5	1E-4
		W, see ^{200}Bi	-	4E+2	1E-7	5E-10	-	-
83	Bismuth-210	D, see ^{200}Bi	8E+2	2E+2	1E-7	-	1E-5	1E-4
			-	Kidneys				
			-	(4E+2)	-	5E-10	-	-
		W, see ^{200}Bi	-	3E+1	1E-8	4E-11	-	-
83	Bismuth-210m	D, see ^{200}Bi	4E+1	5E+0	2E-9	-	-	-
			Kidneys	Kidneys				
			(6E+1)	(6E+0)	-	9E-12	8E-7	8E-6
		W, see ^{200}Bi	-	7E-1	3E-10	9E-13	-	-
83	Bismuth-212[2]	D, see ^{200}Bi	5E+3	2E+2	1E-7	3E-10	7E-5	7E-4
		W, see ^{200}Bi	-	3E+2	1E-7	4E-10	-	-
83	Bismuth-213[2]	D, see ^{200}Bi	7E+3	3E+2	1E-7	4E-10	1E-4	1E-3
		W, see ^{200}Bi	-	4E+2	1E-7	5E-10	-	-
83	Bismuth-214[2]	D, see ^{200}Bi	2E+4	8E+2	3E-7	1E-9	-	-
			St wall					
			(2E+4)	-	-	-	3E-4	3E-3
		W, see ^{200}Bi	-	9E-2	4E-7	1E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Col. 2 Inhalation ALI (µCi)	Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
35	Bromine-74[2]	D, see ^{74m}Br	2E+4	7E+4	3E-5	1E-7	-	-
			St wall (4E+4)	-	-	-	5E-4	5E-3
		W, see ^{74m}Br	-	8E+4	4E-5	1E-7	-	-
35	Bromine-74m[2]	D, bromides of H, Li, Na, K, Rb, Cs, and Fr	1E+4	4E+4	2E-5	5E-8	-	-
			St wall (2E+4)	-	-	-	3E-4	3E-3
		W, bromides of lantha-nides, Be, Mg, Ca, Sr, Ba, Ra, Al, Ga, In, Tl, Ge, Sn, Pb, As, Sb, Bi, Fe, Ru, Os, Co, Rh, Ir, Ni, Pd, Pt, Cu, Ag, Au, Zn, Cd, Hg, Sc, Y, Ti, Zr, Hf, V, Nb, Ta, Mn, Tc, and Re	-	4E+4	2E-5	6E-8	-	-
35	Bromine-75[2]	D, see ^{74m}Br	3E+4	5E+4	2E-5	7E-8	-	-
			St wall (4E+4)	-	-	-	5E-4	5E-3
		W, see ^{74m}Br	-	5E+4	2E-5	7E-8	-	-
35	Bromine-76	D, see ^{74m}Br	4E+3	5E+3	2E-6	7E-9	5E-5	5E-4
		W, see ^{74m}Br	-	4E+3	2E-6	6E-9	-	-
35	Bromine-77	D, see ^{74m}Br	2E+4	2E+4	1E-5	3E-8	2E-4	2E-3
		W, see ^{74m}Br	-	2E+4	8E-6	3E-8	-	-
35	Bromine-80[2]	D, see ^{74m}Br	5E+4	2E+5	8E-5	3E-7	-	-
			St wall (9E+4)	-	-	-	1E-3	1E-2
		W, see ^{74m}Br	-	2E+5	9E-5	3E-7	-	-
35	Bromine-80m	D, see ^{74m}Br	2E+4	2E+4	7E-6	2E-8	3E-4	3E-3
		W, see ^{74m}Br	-	1E+4	6E-6	2E-8	-	-
35	Bromine-82	D, see ^{74m}Br	3E+3	4E+3	2E-6	6E-9	4E-5	4E-4
		W, see ^{74m}Br	-	4E+3	2E-6	5E-9	-	-
35	Bromine-83	D, see ^{74m}Br	5E+4	6E+4	3E-5	9E-8	-	-
			St wall (7E+4)	-	-	-	9E-4	9E-3
		W, see ^{74m}Br	-	6E+4	3E-5	9E-8	-	-
35	Bromine-84[2]	D, see ^{74m}Br	2E+4	6E+4	2E-5	8E-8	-	-
			St wall (3E+4)	-	-	-	4E-4	4E-3
		W, see ^{74m}Br	-	6E+4	3E-5	9E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
48	Cadmium-104[2]	D, all compounds except those given for W and Y	2E+4	7E+4	3E-5	9E-8	3E-4	3E-3
		W, sulfides, halides, and nitrates	-	1E+5	5E-5	2E-7	-	-
		Y, oxides and hydroxides	-	1E+5	5E-5	2E-7	-	-
48	Cadmium-107	D, see ^{104}Cd	2E+4	5E+4	2E-5	8E-8	3E-4	3E-3
		W, see ^{104}Cd	-	6E+4	2E-5	8E-8	-	-
		Y, see ^{104}Cd	-	5E+4	2E-5	7E-8	-	-
48	Cadmium-109	D, see ^{104}Cd	3E+2 Kidneys (4E+2)	4E+1 Kidneys (5E+1)	1E-8	-	-	-
		W, see ^{104}Cd	-	1E+2 Kidneys (1E+2)	5E-8	7E-11	6E-6	6E-5
		Y, see ^{104}Cd	-	1E+2	5E-8	2E-10	-	-
48	Cadmium-113	D, see ^{104}Cd	2E+1 Kidneys (3E+1)	2E+0 Kidneys (3E+0)	9E-10	-	-	-
		W, see ^{104}Cd	-	8E+0 Kidneys (1E+1)	3E-9	5E-12	4E-7	4E-6
		Y, see ^{104}Cd	-	1E+1	6E-9	2E-11	-	-
48	Cadmium-113m	D, see ^{104}Cd	2E+1 Kidneys (4E+1)	2E+0 Kidneys (4E+0)	1E-9	-	-	-
		W, see ^{104}Cd	-	8E+0 Kidneys (1E+1)	4E-9	5E-12	5E-7	5E-6
		Y, see ^{104}Cd	-	1E+1	5E-9	2E-11	-	-
48	Cadmium-115	D, see ^{104}Cd	9E+2 LLI wall (1E+3)	1E+3	6E-7	2E-9	-	-
		W, see ^{104}Cd	-	1E+3	5E-7	2E-9	1E-5	1E-4
		Y, see ^{104}Cd	-	1E+3	6E-7	2E-9	-	-
48	Cadmium-115m	D, see ^{104}Cd	3E+2	5E+1 Kidneys (8E+1)	2E-8	-	4E-6	4E-5
		W, see ^{104}Cd	-	1E+2	5E-8	1E-10	-	-
		Y, see ^{104}Cd	-	1E+2	6E-8	2E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
48	Cadmium-117	D, see ^{104}Cd	5E+3	1E+4	5E-6	2E-8	6E-5	6E-4
		W, see ^{104}Cd	-	2E+4	7E-6	2E-8	-	-
		Y, see ^{104}Cd	-	1E+4	6E-6	2E-8	-	-
48	Cadmium-117m	D, see ^{104}Cd	5E+3	1E+4	5E-6	2E-8	6E-5	6E-4
		W, see ^{104}Cd	-	2E+4	7E-6	2E-8	-	-
		Y, see ^{104}Cd	-	1E+4	6E-6	2E-8	-	-
20	Calcium-41	W, all compounds	3E+3 Bone surf	4E+3 Bone surf	2E-6	-	-	-
			(4E+3)	(4E+3)	-	5E-9	6E-5	6E-4
20	Calcium-45	W, all compounds	2E+3	8E+2	4E-7	1E-9	2E-5	2E-4
20	Calcium-47	W, all compounds	8E+2	9E+2	4E-7	1E-9	1E-5	1E-4
98	Californium-244[2]	W, all compounds except those given for Y	3E+4 St wall	6E+2	2E-7	8E-10	-	-
			(3E+4)	-	-	-	4E-4	4E-3
		Y, oxides and hydroxides	-	6E+2	2E-7	8E-10	-	-
98	Californium-246	W, see ^{244}Cf	4E+2	9E+0	4E-9	1E-11	5E-6	5E-5
		Y, see ^{244}Cf	-	9E+0	4E-9	1E-11	-	-
98	Californium-248	W, see ^{244}Cf	8E+0 Bone surf	6E-2 Bone surf	3E-11	-	-	-
			(2E+1)	(1E-1)	-	2E-13	2E-7	2E-6
		Y, see ^{244}Cf	-	1E-1	4E-11	1E-13	-	-
98	Californium-249	W, see ^{244}Cf	5E-1 Bone surf	4E-3 Bone surf	2E-12	-	-	-
			(1E+0)	(9E-3)	-	1E-14	2E-8	2E-7
		Y, see ^{244}Cf	-	1E-2 Bone surf	4E-12	-	-	-
			-	(1E-2)	-	2E-14	-	-
98	Californium-250	W, see ^{244}Cf	1E+0 Bone surf	9E-3 Bone surf	4E-12	-	-	-
			(2E+0)	(2E-2)	-	3E-14	3E-8	3E-7
		Y, see ^{244}Cf	-	3E-2	1E-11	4E-14	-	-
98	Californium-251	W, see ^{244}Cf	5E-1 Bone surf	4E-3 Bone surf	2E-12	-	-	-
			(1E+0)	(9E-3)	-	1E-14	2E-8	2E-7
		Y, see ^{244}Cf	-	1E-2 Bone surf	4E-12	-	-	-
			-	(1E-2)	-	2E-14	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
98	Californium-252	W, see ^{244}Cf	2E+0	2E-2	8E-12	-	-	-
			Bone surf (5E+0)	Bone surf (4E-2)	-	5E-14	7E-8	7E-7
		Y, see ^{244}Cf	-	3E-2	1E-11	5E-14	-	-
98	Californium-253	W, see ^{244}Cf	2E+2	2E+0	8E-10	3E-12	-	-
			Bone surf (4E+2)	-	-	-	5E-6	5E-5
		Y, see ^{244}Cf	-	2E+0	7E-10	2E-12	-	-
98	Californium-254	W, see ^{244}Cf	2E+0	2E-2	9E-12	3E-14	3E-8	3E-7
		Y, see ^{244}Cf	-	2E-2	7E-12	2E-14	-	-
6	Carbon-11[2]	Monoxide	-	1E+6	5E-4	2E-6	-	-
		Dioxide	-	6E+5	3E-4	9E-7	-	-
		Compounds	4E+5	4E+5	2E-4	6E-7	6E-3	6E-2
6	Carbon-14	Monoxide	-	2E+6	7E-4	2E-6	-	-
		Dioxide	-	2E+5	9E-5	3E-7	-	-
		Compounds	2E+3	2E+3	1E-6	3E-9	3E-5	3E-4
58	Cerium-134	W, all compounds except those given for Y	5E+2	7E+2	3E-7	1E-9	-	-
			LLI wall (6E+2)	-	-	-	8E-6	8E-5
		Y, oxides, hydroxides, and fluorides	-	7E+2	3E-7	9E-10	-	-
58	Cerium-135	W, see ^{134}Ce	2E+3	4E+3	2E-6	5E-9	2E-5	2E-4
		Y, see ^{134}Ce	-	4E+3	1E-6	5E-9	-	-
58	Cerium-137	W, see ^{134}Ce	5E+4	1E+5	6E-5	2E-7	7E-4	7E-3
		Y, see ^{134}Ce	-	1E+5	5E-5	2E-7	-	-
58	Cerium-137m	W, see ^{134}Ce	2E+3	4E+3	2E-6	6E-9	-	-
			LLI wall (2E+3)	-	-	-	3E-5	3E-4
		Y, see ^{134}Ce	-	4E+3	2E-6	5E-9	-	-
58	Cerium-139	W, see ^{134}Ce	5E+3	8E+2	3E-7	1E-9	7E-5	7E-4
		Y, see ^{134}Ce	-	7E+2	3E-7	9E-10	-	-
58	Cerium-141	W, see ^{134}Ce	2E+3	7E+2	3E-7	1E-9	-	-
			LLI wall (2E+3)	-	-	-	3E-5	3E-4
		Y, see ^{134}Ce	-	6E+2	2E-7	8E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
58	Cerium-143	W, see ^{134}Ce	1E+3	2E+3	8E-7	3E-9	-	-
	LLI wall		(1E+3)	-	-	-	2E-5	2E-4
		Y, see ^{134}Ce	-	2E+3	7E-7	2E-9	-	-
58	Cerium-144	W, see ^{134}Ce	2E+2	3E+1	1E-8	4E-11	-	-
			LLI wall (3E+2)	-	-	-	3E-6	3E-5
		Y, see ^{134}Ce	-	1E+1	6E-9	2E-11	-	-
55	Cesium-125[2]	D, all compounds	5E+4	1E+5	6E-5	2E-7	-	-
			St wall (9E+4)	-	-	-	1E-3	1E-2
55	Cesium-127	D, all compounds	6E+4	9E+4	4E-5	1E-7	9E-4	9E-3
55	Cesium-129	D, all compounds	2E+4	3E+4	1E-5	5E-8	3E-4	3E-3
55	Cesium-130[2]	D, all compounds	6E+4	2E+5	8E-5	3E-7	-	-
			St wall (1E+5)	-	-	-	1E-3	1E-2
55	Cesium-131	D, all compounds	2E+4	3E+4	1E-5	4E-8	3E-4	3E-3
55	Cesium-132	D, all compounds	3E+3	4E+3	2E-6	6E-9	4E-5	4E-4
55	Cesium-134	D, all compounds	7E+1	1E+2	4E-8	2E-10	9E-7	9E-6
55	Cesium-134m	D, all compounds	1E+5	1E+5	6E-5	2E-7	-	-
			St wall (1E+5)	-	-	-	2E-3	2E-2
55	Cesium-135	D, all compounds	7E+2	1E+3	5E-7	2E-9	1E-5	1E-4
55	Cesium-135m[2]	D, all compounds	1E+5	2E+5	8E-5	3E-7	1E-3	1E-2
55	Cesium-136	D, all compounds	4E+2	7E+2	3E-7	9E-10	6E-6	6E-5
55	Cesium-137	D, all compounds	1E+2	2E+2	6E-8	2E-10	1E-6	1E-5
55	Cesium-138[2]	D, all compounds	2E+4	6E+4	2E-5	8E-8	-	-
			St wall (3E+4)	-	-	-	4E-4	4E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (μCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (μCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (μCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (μCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (μCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (μCi/ml)
17	Chlorine-36	D, chlorides of H, Li, Na, K, Rb, Cs, and Fr	2E+3	2E+3	1E-6	3E-9	2E-5	2E-4
		W, chlorides of lantha-nides, Be, Mg, Ca, Sr, Ba, Ra, Al, Ga, In, Tl, Ge, Sn, Pb, As, Sb, Bi, Fe, Ru, Os, Co, Rh, Ir, Ni, Pd, Pt, Cu, Ag, Au, Zn, Cd, Hg, Sc, Y, Ti, Zr, Hf, V, Nb, Ta, Cr, Mo, W, Mn, Tc, and Re	-	2E+2	1E-7	3E-10	-	-
17	Chlorine-38[2]	D, see ^{36}Cl	2E+4 St wall (3E+4)	4E+4 -	2E-5 -	6E-8 -	- 3E-4	- 3E-3
		W, see ^{36}Cl	-	5E+4	2E-5	6E-8	-	-
17	Chlorine-39[2]	D, see ^{36}Cl	2E+4 St wall (4E+4)	5E+4 -	2E-5 -	7E-8 -	- 5E-4	- 5E-3
		W, see ^{36}Cl	-	6E+4	2E-5	8E-8	-	-
24	Chromium-48	D, all compounds except those given for W and Y	6E+3	1E+4	5E-6	2E-8	8E-5	8E-4
		W, halides and nitrates	-	7E+3	3E-6	1E-8	-	-
		Y, oxides and hydroxides	-	7E+3	3E-6	1E-8	-	-
24	Chromium-49[2]	D, see ^{48}Cr	3E+4	8E+4	4E-5	1E-7	4E-4	4E-3
		W, see ^{48}Cr	-	1E+5	4E-5	1E-7	-	-
		Y, see ^{48}Cr	-	9E+4	4E-5	1E-7	-	-
24	Chromium-51	D, see ^{48}Cr	4E+4	5E+4	2E-5	6E-8	5E-4	5E-3
		W, see ^{48}Cr	-	2E+4	1E-5	3E-8	-	-
		Y, see ^{48}Cr	-	2E+4	8E-6	3E-8	-	-
27	Cobalt-55	W, all compounds except those given for Y	1E+3	3E+3	1E-6	4E-9	2E-5	2E-4
		Y, oxides, hydroxides, halides, and nitrates	-	3E+3	1E-6	4E-9	-	-
27	Cobalt-56	W, see ^{55}Co	5E+2	3E+2	1E-7	4E-10	6E-6	6E-5
		Y, see ^{55}Co	4E+2	2E+2	8E-8	3E-10	-	-
27	Cobalt-57	W, see ^{55}Co	8E+3	3E+3	1E-6	4E-9	6E-5	6E-4
		Y, see ^{55}Co	4E+3	7E+2	3E-7	9E-10	-	-
27	Cobalt-58	W, see ^{55}Co	2E+3	1E+3	5E-7	2E-9	2E-5	2E-4
		Y, see ^{55}Co	1E+3	7E+2	3E-7	1E-9	-	-
27	Cobalt-58m	W, see ^{55}Co	6E+4	9E+4	4E-5	1E-7	8E-4	8E-3
		Y, see ^{55}Co	-	6E+4	3E-5	9E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
27	Cobalt-60	W, see ^{55}Co	5E+2	2E+2	7E-8	2E-10	3E-6	3E-5
		Y, see ^{55}Co	2E+2	3E+1	1E-8	5E-11	-	-
27	Cobalt-60m[2]	W, see ^{55}Co	1E+6 St wall (1E+6)	4E+6 -	2E-3 -	6E-6 -	- 2E-2	- 2E-1
		Y, see ^{55}Co	-	3E+6	1E-3	4E-6	-	-
27	Cobalt-61[2]	W, see ^{55}Co	2E+4	6E+4	3E-5	9E-8	3E-4	3E-3
		Y, see ^{55}Co	2E+4	6E+4	2E-5	8E-8	-	-
27	Cobalt-62m[2]	W, see ^{55}Co	4E+4 St wall (5E+4)	2E+5 -	7E-5 -	2E-7 -	- 7E-4	- 7E-3
		Y, see ^{55}Co	-	2E+5	6E-5	2E-7	-	-
29	Copper-60[2]	D, all compounds except those given for W and Y	3E+4 St wall (3E+4)	9E+4 -	4E-5 -	1E-7 -	- 4E-4	- 4E-3
		W, sulfides, halides, and nitrates	-	1E+5	5E-5	2E-7	-	-
		Y, oxides and hydroxides	-	1E+5	4E-5	1E-7	-	-
29	Copper-61	D, see ^{60}Cu	1E+4	3E+4	1E-5	4E-8	2E-4	2E-3
		W, see ^{60}Cu	-	4E+4	2E-5	6E-8	-	-
		Y, see ^{60}Cu	-	4E+4	1E-5	5E-8	-	-
29	Copper-64	D, see ^{60}Cu	1E+4	3E+4	1E-5	4E-8	2E-4	2E-3
		W, see ^{60}Cu	-	2E+4	1E-5	3E-8	-	-
		Y, see ^{60}Cu	-	2E+4	9E-6	3E-8	-	-
29	Copper-67	D, see ^{60}Cu	5E+3	8E+3	3E-6	1E-8	6E-5	6E-4
		W, see ^{60}Cu	-	5E+3	2E-6	7E-9	-	-
		Y, see ^{60}Cu	-	5E+3	2E-6	6E-9	-	-
96	Curium-238	W, all compounds	2E+4	1E+3	5E-7	2E-9	2E-4	2E-3
96	Curium-240	W, all compounds	6E+1 Bone surf (8E+1)	6E-1 Bone surf (6E-1)	2E-10 -	- 9E-13	- 1E-6	- 1E-5
96	Curium-241	W, all compounds	1E+3 -	3E+1 Bone surf (4E+1)	1E-8 -	- 5E-11	2E-5 -	2E-4 -
96	Curium-242	W, all compounds	3E+1 Bone surf (5E+1)	3E-1 Bone surf (3E-1)	1E-10 -	- 4E-13	- 7E-7	- 7E-6
96	Curium-243	W, all compounds	1E+0 Bone surf (2E+0)	9E-3 Bone surf (2E-2)	4E-12 -	- 2E-14	- 3E-8	- 3E-7

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (µCi)	ALI (µCi)	DAC (µCi/ml)	Air (µCi/ml)	Water (µCi/ml)	Monthly Average Concentration (µCi/ml)
96	Curium-244	W, all compounds	1E+0	1E-2	5E-12	-	-	-
			Bone surf	Bone surf				
			(3E+0)	(2E-2)	-	3E-14	3E-8	3E-7
96	Curium-245	W, all compounds	7E-1	6E-3	3E-12	-	-	-
			Bone surf	Bone surf				
			(1E+0)	(1E-2)	-	2E-14	2E-8	2E-7
96	Curium-246	W, all compounds	7E-1	6E-3	3E-12	-	-	-
			Bone surf	Bone surf				
			(1E+0)	(1E-2)	-	2E-14	2E-8	2E-7
96	Curium-247	W, all compounds	8E-1	6E-3	3E-12	-	-	-
			Bone surf	Bone surf				
			(1E+0)	(1E-2)	-	2E-14	2E-8	2E-7
96	Curium-248	W, all compounds	2E-1	2E-3	7E-13	-	-	-
			Bone surf	Bone surf				
			(4E-1)	(3E-3)	-	4E-15	5E-9	5E-8
96	Curium-249[2]	W, all compounds	5E+4	2E+4	7E-6	-	7E-4	7E-3
				Bone surf				
			-	(3E+4)	-	4E-8	-	-
96	Curium-250	W, all compounds	4E-2	3E-4	1E-13	-	-	-
			Bone surf	Bone surf				
			(6E-2)	(5E-4)	-	8E-16	9E-10	9E-9
66	Dysprosium-155	W, all compounds	9E+3	3E+4	1E-5	4E-8	1E-4	1E-3
66	Dysprosium-157	W, all compounds	2E+4	6E+4	3E-5	9E-8	3E-4	3E-3
66	Dysprosium-159	W, all compounds	1E+4	2E+3	1E-6	3E-9	2E-4	2E-3
66	Dysprosium-165	W, all compounds	1E+4	5E+4	2E-5	6E-8	2E-4	2E-3
66	Dysprosium-166	W, all compounds	6E+2	7E+2	3E-7	1E-9	-	-
			LLI wall					
			(8E+2)	-	-	-	1E-5	1E-4
99	Einsteinium-250	W, all compounds	4E+4	5E+2	2E-7	-	6E-4	6E-3
				Bone surf				
			-	(1E+3)	-	2E-9	-	-
99	Einsteinium-251	W, all compounds	7E+3	9E+2	4E-7	-	1E-4	1E-3
				Bone surf				
			-	(1E+3)	-	2E-9	-	-
99	Einsteinium-253	W, all compounds	2E+2	1E+0	6E-10	2E-12	2E-6	2E-5

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
99	Einsteinium-254	W, all compounds	8E+0	7E-2	3E-11	-	-	-
			Bone surf (2E+1)	Bone surf (1E-1)	-	2E-13	2E-7	2E-6
99	Einsteinium-254m	W, all compounds	3E+2	1E+1	4E-9	1E-11	-	-
			LLI wall (3E+2)	-	-	-	4E-6	4E-5
68	Erbium-161	W, all compounds	2E+4	6E+4	3E-5	9E-8	2E-4	2E-3
68	Erbium-165	W, all compounds	6E+4	2E+5	8E-5	3E-7	9E-4	9E-3
68	Erbium-169	W, all compounds	3E+3	3E+3	1E-6	4E-9	-	-
			LLI wall (4E+3)	-	-	-	5E-5	5E-4
68	Erbium-171	W, all compounds	4E+3	1E+4	4E-6	1E-8	5E-5	5E-4
68	Erbium-172	W, all compounds	1E+3	1E+3	6E-7	2E-9	-	-
			LLI wall (E+3)	-	-	-	2E-5	2E-4
63	Europium-145	W, all compounds	2E+3	2E+3	8E-7	3E-9	2E-5	2E-4
63	Europium-146	W, all compounds	1E+3	1E+3	5E-7	2E-9	1E-5	1E-4
63	Europium-147	W, all compounds	3E+3	2E+3	7E-7	2E-9	4E-5	4E-4
63	Europium-148	W, all compounds	1E+3	4E+2	1E-7	5E-10	1E-5	1E-4
63	Europium-149	W, all compounds	1E+4	3E+3	1E-6	4E-9	2E-4	2E-3
63	Europium-150 (12.62 h)	W, all compounds	3E+3	8E+3	4E-6	1E-8	4E-5	4E-4
63	Europium-150 (34.2 y)	W, all compounds	8E+2	2E+1	8E-9	3E-11	1E-5	1E-4
63	Europium-152	W, all compounds	8E+2	2E+1	1E-8	3E-11	1E-5	1E-4
63	Europium-152m	W, all compounds	3E+3	6E+3	3E-6	9E-9	4E-5	4E-4
63	Europium-154	W, all compounds	5E+2	2E+1	8E-9	3E-11	7E-6	7E-5
63	Europium-155	W, all compounds	4E+3	9E+1	4E-8	-	5E-5	5E-4
			-	Bone surf (1E+2)	-	2E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
63	Europium-156	W, all compounds	6E+2	5E+2	2E-7	6E-10	8E-6	8E-5
63	Europium-157	W, all compounds	2E+3	5E+3	2E-6	7E-9	3E-5	3E-4
63	Europium-158[2]	W, all compounds	2E+4	6E+4	2E-5	8E-8	3E-4	3E-3
100	Fermium-252	W, all compounds	5E+2	1E+1	5E-9	2E-11	6E-6	6E-5
100	Fermium-253	W, all compounds	1E+3	1E+1	4E-9	1E-11	1E-5	1E-4
100	Fermium-254	W, all compounds	3E+3	9E+1	4E-8	1E-10	4E-5	4E-4
100	Fermium-255	W, all compounds	5E+2	2E+1	9E-9	3E-11	7E-6	7E-5
100	Fermium-257	W, all compounds	2E+1 Bone surf (4E+1)	2E-1 Bone surf (2E-1)	7E-11 -	- 3E-13	- 5E-7	- 5E-6
9	Fluorine-18[2]	D, fluorides of H, Li, Na, K, Rb, Cs, and Fr	5E+4 St wall (5E+4)	7E+4 -	3E-5 -	1E-7 -	- 7E-4	- 7E-3
		W, fluorides of Be, Mg, Ca, Sr, Ba, Ra, Al, Ga, In, Tl, As, Sb, Bi, Fe, Ru, Os, Co, Ni, Pd, Pt, Cu, Ag, Au, Zn, Cd, Hg, Sc, Y, Ti, Zr, V, Nb, Ta, Mn, Tc, and Re	-	9E+4	4E-5	1E-7	-	-
		Y, lanthanum fluoride	-	8E+4	3E-5	1E-7	-	-
87	Francium-222[2]	D, all compounds	2E+3	5E+2	2E-7	6E-10	3E-5	3E-4
87	Francium-223[2]	D, all compounds	6E+2	8E+2	3E-7	1E-9	8E-6	8E-5
64	Gadolinium-145[2]	D, all compounds except those given for W	5E+4 St wall (5E+4)	2E+5 -	6E-5 -	2E-7 -	- 6E-4	- 6E-3
		W, oxides, hydroxides, and fluorides	-	2E+5	7E-5	2E-7	-	-
64	Gadolinium-146	D, see ^{145}Gd	1E+3	1E+2	5E-8	2E-10	2E-5	2E-4
		W, see ^{145}Gd	-	3E+2	1E-7	4E-10	-	-
64	Gadolinium-147	D, see ^{145}Gd	2E+3	4E+3	2E-6	6E-9	3E-5	3E-4
		W, see ^{145}Gd	-	4E+3	1E-6	5E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
64	Gadolinium-148	D, see ^{145}Gd	1E+1	8E+3	3E-12	-	-	-
			Bone surf (2E+1)	Bone surf (2E+2)	-	2E-14	3E-7	3E-6
		W, see ^{145}Gd	-	3E-2	1E-11	-	-	-
			-	Bone surf (6E-2)	-	8E-14	-	-
64	Gadolinium-149	D, see ^{145}Gd	3E+3	2E+3	9E-7	3E-9	4E-5	4E-4
		W, see ^{145}Gd	-	2E+3	1E-6	3E-9	-	-
64	Gadolinium-151	D, see ^{145}Gd	6E+3	4E+2	2E-7	-	9E-5	9E-4
			-	Bone surf (6E+2)	-	9E-10	-	-
		W, see ^{145}Gd	-	1E+3	5E-7	2E-9	-	-
64	Gadolinium-152	D, see ^{145}Gd	2E+1	1E-2	4E-12	-	-	-
			Bone surf (3E+1)	Bone surf (2E-2)	-	3E-14	4E-7	4E-6
		W, see ^{145}Gd	-	4E-2	2E-11	-	-	-
			-	Bone surf (8E-2)	-	1E-13	-	-
64	Gadolinium-153	D, see ^{145}Gd	5E+3	1E+2	6E-8	-	6E-5	6E-4
			-	Bone surf (2E+2)	-	3E-10	-	-
		W, see ^{145}Gd	-	6E+2	2E-7	8E-10	-	-
64	Gadolinium-159	D, see ^{145}Gd	3E+3	8E+3	3E-6	1E-8	4E-5	4E-4
		W, see ^{145}Gd	-	6E+3	2E-6	8E-9	-	-
31	Gallium-65[2]	D, all compounds except those given for W	5E+4	2E+5	7E-5	2E-7	-	-
			St wall (6E+4)	-	-	-	9E-4	9E-3
		W, oxides, hydroxides, carbides, halides, and nitrates	-	2E+5	8E-5	3E-7	-	-
31	Gallium-66	D, see ^{65}Ga	1E+3	4E+3	1E-6	5E-9	1E-5	1E-4
		W, see ^{65}Ga	-	3E+3	1E-6	4E-9	-	-
31	Gallium-67	D, see ^{65}Ga	7E+3	1E+4	6E-6	2E-8	1E-4	1E-3
		W, see ^{65}Ga	-	1E+4	4E-6	1E-8	-	-
31	Gallium-68[2]	D, see ^{65}Ga	2E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{65}Ga	-	5E+4	2E-5	7E-8	-	-
31	Gallium-70[2]	D, see ^{65}Ga	5E+4	2E+5	7E-5	2E-7	-	-
			St wall (7E+4)	-	-	-	1E-3	1E-2
		W, see ^{65}Ga	-	2E+5	8E-5	3E-7	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
31	Gallium-72	D, see ^{65}Ga	1E+3	4E+3	1E-6	5E-9	2E-5	2E-4
		W, see ^{65}Ga	-	3E+3	1E-6	4E-9	-	-
31	Gallium-73	D, see ^{65}Ga	5E+3	2E+4	6E-6	2E-8	7E-5	7E-4
		W, see ^{65}Ga	-	2E+4	6E-6	2E-8	-	-
32	Germanium-66	D, all compounds except those given for W	2E+4	3E+4	1E-5	4E-8	3E-4	3E-3
		W, oxides, sulfides, and halides	-	2E+4	8E-6	3E-8	-	-
32	Germanium-67[2]	D, see ^{66}Ge	3E+4 St wall (4E+4)	9E+4	4E-5	1E-7	-	-
				-	-	-	6E-4	6E-3
		W, see ^{66}Ge	-	1E+5	4E-5	1E-7	-	-
32	Germanium-68	D, see ^{66}Ge	5E+3	4E+3	2E-6	5E-9	6E-5	6E-4
		W, see ^{66}Ge	-	1E+2	4E-8	1E-10	-	-
32	Germanium-69	D, see ^{66}Ge	1E+4	2E+4	6E-6	2E-8	2E-4	2E-3
		W, see ^{66}Ge	-	8E+3	3E-6	1E-8	-	-
32	Germanium-71	D, see ^{66}Ge	5E+5	4E+5	2E-4	6E-7	7E-3	7E-2
		W, see ^{66}Ge	-	4E+4	2E-5	6E-8	-	-
32	Germanium-75[2]	D, see ^{66}Ge	4E+4 St wall (7E+4)	8E+4	3E-5	1E-7	-	-
				-	-	-	9E-4	9E-3
		W, see ^{66}Ge	-	8E+4	4E-5	1E-7	-	-
32	Germanium-77	D, see ^{66}Ge	9E+3	1E+4	4E-6	1E-8	1E-4	1E-3
		W, see ^{66}Ge	-	6E+3	2E-6	8E-9	-	-
32	Germanium-78[2]	D, see ^{66}Ge	2E+4 St wall (2E+4)	2E+4	9E-6	3E-8	-	-
				-	-	-	3E-4	3E-3
		W, see ^{66}Ge	-	2E+4	9E-6	3E-8	-	-
79	Gold-193	D, all compounds except those given for W and Y	9E+3	3E+4	1E-5	4E-8	1E-4	1E-3
		W, halides and nitrates	-	2E+4	9E-6	3E-8	-	-
		Y, oxides and hydroxides	-	2E+4	8E-6	3E-8	-	-
79	Gold-194	D, see ^{193}Au	3E+3	8E+3	3E-6	1E-8	4E-5	4E-4
		W, see ^{193}Au	-	5E+3	2E-6	8E-9	-	-
		Y, see ^{193}Au	-	5E+3	2E-6	7E-9	-	-
79	Gold-195	D, see ^{193}Au	5E+3	1E+4	5E-6	2E-8	7E-5	7E-4
		W, see ^{193}Au	-	1E+3	6E-7	2E-9	-	-
		Y, see ^{193}Au	-	4E+2	2E-7	6E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
79	Gold-198	D, see ^{193}Au	1E+3	4E+3	2E-6	5E-9	2E-5	2E-4
		W, see ^{193}Au	-	2E+3	8E-7	3E-9	-	-
		Y, see ^{193}Au	-	2E+3	7E-7	2E-9	-	-
79	Gold-198m	D, see ^{193}Au	1E+3	3E+3	1E-6	4E-9	1E-5	1E-4
		W, see ^{193}Au	-	1E+3	5E-7	2E-9	-	-
		Y, see ^{193}Au	-	1E+3	5E-7	2E-9	-	-
79	Gold-199	D, see ^{193}Au	3E+3 LLI wall (3E+3)	9E+3	4E-6	1E-8	-	-
				-	-	-	4E-5	4E-4
		W, see ^{193}Au	-	4E+3	2E-6	6E-9	-	-
		Y, see ^{193}Au	-	4E+3	2E-6	5E-9	-	-
79	Gold-200[2]	D, see ^{193}Au	3E+4	6E+4	3E-5	9E-8	4E-4	4E-3
		W, see ^{193}Au	-	8E+4	3E-5	1E-7	-	-
		Y, see ^{193}Au	-	7E+4	3E-5	1E-7	-	-
79	Gold-200m	D, see ^{193}Au	1E+3	4E+3	1E-6	5E-9	2E-5	2E-4
		W, see ^{193}Au	-	3E+3	1E-6	4E-9	-	-
		Y, see ^{193}Au	-	2E+4	1E-6	3E-9	-	-
79	Gold-201[2]	D, see ^{193}Au	7E+4 St wall (9E+4)	2E+5	9E-5	3E-7	-	-
				-	-	-	1E-3	1E-2
		W, see ^{193}Au	-	2E+5	1E-4	3E-7	-	-
		Y, see ^{193}Au	-	2E+5	9E-5	3E-7	-	-
72	Hafnium-170	D, all compounds except those given for W	3E+3	6E+3	2E-6	8E-9	4E-5	4E-4
		W, oxides, hydroxides, carbides, and nitrates	-	5E+3	2E-6	6E-9	-	-
72	Hafnium-172	D, see ^{170}Hf	1E+3	9E+0 Bone surf (2E+1)	4E-9	-	2E-5	2E-4
			-	-	-	3E-11	-	-
		W, see ^{170}Hf	-	4E+1 Bone surf (6E+1)	2E-8	-	-	-
			-	-	-	8E-11	-	-
72	Hafnium-173	D, see ^{170}Hf	5E+3	1E+4	5E-6	2E-8	7E-5	7E-4
		W, see ^{170}Hf	-	1E+4	5E-6	2E-8	-	-
72	Hafnium-175	D, see ^{170}Hf	3E+3	9E+2 Bone surf (1E+3)	4E-7	-	4E-5	4E-4
			-	-	-	1E-9	-	-
		W, see ^{170}Hf	-	1E+3	5E-7	2E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
72	Hafnium-177m[2]	D, see ^{170}Hf	2E+4	6E+4	2E-5	8E-8	3E-4	3E-3
		W, see ^{170}Hf	-	9E+4	4E-5	1E-7	-	-
72	Hafnium-178m	D, see ^{170}Hf	3E+2	1E+0 Bone surf	5E-10	-	3E-6	3E-5
			-	(2E+0)	-	3E-12	-	-
		W, see ^{170}Hf	-	5E+0	2E-9	-	-	-
			-	Bone surf (9E+0)	-	1E-11	-	-
72	Hafnium-179m	D, see ^{170}Hf	1E+3	3E+2	1E-7	-	1E-5	1E-4
			-	Bone surf (6E+2)	-	8E-10	-	-
		W, see ^{170}Hf	-	6E+2	3E-7	8E-10	-	-
72	Hafnium-180m	D, see ^{170}Hf	7E+3	2E+4	9E-6	3E-8	1E-4	1E-3
		W, see ^{170}Hf	-	3E+4	1E-5	4E-8	-	-
72	Hafnium-181	D, see ^{170}Hf	1E+3	2E+2	7E-8	-	2E-5	2E-4
			-	Bone surf (4E+2)	-	6E-10	-	-
		W, see ^{170}Hf	-	4E+2	2E-7	6E-10	-	-
72	Hafnium-182	D, see ^{170}Hf	2E+2 Bone surf (4E+2)	8E-1 Bone surf (2E+0)	3E-10	-	-	-
					-	2E-12	5E-6	5E-5
		W, see ^{170}Hf	-	3E+0	1E-9	-	-	-
			-	Bone surf (7E+0)	-	1E-11	-	-
72	Hafnium-182m[2]	D, see ^{170}Hf	4E+4	9E+4	4E-5	1E-7	5E-4	5E-3
		W, see ^{170}Hf	-	1E+5	6E-5	2E-7	-	-
72	Hafnium-183[2]	D, see ^{170}Hf	2E+4	5E+4	2E-5	6E-8	3E-4	3E-3
		W, see ^{170}Hf	-	6E+4	2E-5	8E-8	-	-
72	Hafnium-184	D, see ^{170}Hf	2E+3	8E+3	3E-6	1E-8	3E-5	3E-4
		W, see ^{170}Hf	-	6E+3	3E-6	9E-9	-	-
67	Holmium-155[2]	W, all compounds	4E+4	2E+5	6E-5	2E-7	6E-4	6E-3
67	Holmium-157[2]	W, all compounds	3E+5	1E+6	6E-4	2E-6	4E-3	4E-2
67	Holmium-159[2]	W, all compounds	2E+5	1E+6	4E-4	1E-6	3E-3	3E-2
67	Holmium-161	W, all compounds	1E+5	4E+5	2E-4	6E-7	1E-3	1E-2

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
67	Holmium-162[2]	W, all compounds	5E+5	2E+6	1E-3	3E-6	-	-
			St wall (8E+5)	-	-	-	1E-2	1E-1
67	Holmium-162m[2]	W, all compounds	5E+4	3E+5	1E-4	4E-7	7E-4	7E-3
67	Holmium-164[2]	W, all compounds	2E+5	6E+5	3E-4	9E-7	-	-
			St wall (2E+5)	-	-	-	3E-3	3E-2
67	Holmium-164m[2]	W, all compounds	1E+5	3E+5	1E-4	4E-7	1E-3	1E-2
67	Holmium-166	W, all compounds	9E+2	2E+3	7E-7	2E-9	-	-
			LLI wall (9E+2)	-	-	-	1E-5	1E-4
67	Holmium-167	W, all compounds	2E+4	6E+4	2E-5	8E-8	2E-4	2E-3
67	Holmium-166m	W, all compounds	6E+2	7E+0	3E-9	9E-12	9E-6	9E-5
1	Hydrogen-3	Water, DAC includes skin absorption	8E+4	8E+4	2E-5	1E-7	1E-3	1E-2
		Gas (HT or T_2) Submersion[1]: Use above values as HT and T_2 oxidize in air and in the body to HTO.						
49	Indium-109	D, all compounds except those given for W	2E+4	4E+4	2E-5	6E-8	3E-4	3E-3
		W, oxides, hydroxides, halides, and nitrates	-	6E+4	3E-5	9E-8	-	-
49	Indium-110 (4.9 h)	D, see ^{109}In	5E+3	2E+4	7E-6	2E-8	7E-5	7E-4
		W, see ^{109}In	-	2E+4	8E-6	3E-8	-	-
49	Indium-110[2] (69.1 min)	D, see ^{109}In	2E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{109}In	-	6E+4	2E-5	8E-8	-	-
49	Indium-111	D, see ^{109}In	4E+3	6E+3	3E-6	9E-9	6E-5	6E-4
		W, see ^{109}In	-	6E+3	3E-6	9E-9	-	-
49	Indium-112[2]	D, see ^{109}In	2E+5	6E+5	3E-4	9E-7	2E-3	2E-2
		W, see ^{109}In	-	7E+5	3E-4	1E-6	-	-
49	Indium-113m[2]	D, see ^{109}In	5E+4	1E+5	6E-5	2E-7	7E-4	7E-3
		W, see ^{109}In	-	2E+5	8E-5	3E-7	-	-
49	Indium-114m	D, see ^{109}In	3E+2	6E+1	3E-8	9E-11	-	-
			LLI wall (4E+2)	-	-	-	5E-6	5E-5
		W, see ^{109}In	-	1E+2	4E-8	1E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (µCi)	ALI (µCi)	DAC (µCi/ml)	Air (µCi/ml)	Water (µCi/ml)	Monthly Average Concentration (µCi/ml)
49	Indium-115	D, see ^{109}In	4E+1	1E+0	6E-10	2E-12	5E-7	5E-6
		W, see ^{109}In	-	5E+0	2E-9	8E-12	-	-
49	Indium-115m	D, see ^{109}In	1E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{109}In	-	5E+4	2E-5	7E-8	-	-
49	Indium-116m[2]	D, see ^{109}In	2E+4	8E+4	3E-5	1E-7	3E-4	3E-3
		W, see ^{109}In	-	1E+5	5E-5	2E-7	-	-
49	Indium-117[2]	D, see ^{109}In	6E+4	2E+5	7E-5	2E-7	8E-4	8E-3
		W, see ^{109}In	-	2E+5	9E-5	3E-7	-	-
49	Indium-117m[2]	D, see ^{109}In	1E+4	3E+4	1E-5	5E-8	2E-4	2E-3
		W, see ^{109}In	-	4E+4	2E-5	6E-8	-	-
49	Indium-119m[2]	D, see ^{109}In	4E+4 St wall (5E+4)	1E+5	5E-5	2E-7	-	-
				-	-	-	7E-4	7E-3
		W, see ^{109}In	-	1E+5	6E-5	2E-7	-	-
53	Iodine-120[2]	D, all compounds	4E+3 Thyroid (8E+3)	9E+3 Thyroid (1E+4)	4E-6	-	-	-
					-	2E-8	1E-4	1E-3
53	Iodine-120m[2]	D, all compounds	1E+4 Thyroid (1E+4)	2E+4	9E-6	3E-8	-	-
				-	-	-	2E-4	2E-3
53	Iodine-121	D, all compounds	1E+4 Thyroid (3E+4)	2E+4 Thyroid (5E+4)	8E-6	-	-	-
					-	7E-8	4E-4	4E-3
53	Iodine-123	D, all compounds	3E+3 Thyroid (1E+4)	6E+3 Thyroid (2E+4)	3E-6	-	-	-
					-	2E-8	1E-4	1E-3
53	Iodine-124	D, all compounds	5E+1 Thyroid (2E+2)	8E+1 Thyroid (3E+2)	3E-8	-	-	-
					-	4E-10	2E-6	2E-5
53	Iodine-125	D, all compounds	4E+1 Thyroid (1E+2)	6E+1 Thyroid (2E+2)	3E-8	-	-	-
					-	3E-10	2E-6	2E-5
53	Iodine-126	D, all compounds	2E+1 Thyroid (7E+1)	4E+1 Thyroid (1E+2)	1E-8	-	-	-
					-	2E-10	1E-6	1E-5
53	Iodine-128[2]	D, all compounds	4E+4 St wall (6E+4)	1E+5	5E-5	2E-7	-	-
				-	-	-	8E-4	8E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
53	Iodine-129	D, all compounds	5E+0 Thyroid (2E+1)	9E+0 Thyroid (3E+1)	4E-9 -	- 4E-11	- 2E-7	- 2E-6
53	Iodine-130	D, all compounds	4E+2 Thyroid (1E+3)	7E+2 Thyroid (2E+3)	3E-7 -	- 3E-9	- 2E-5	- 2E-4
53	Iodine-131	D, all compounds	3E+1 Thyroid (9E+1)	5E+1 Thyroid (2E+2)	2E-8 -	- 2E-10	- 1E-6	- 1E-5
53	Iodine-132	D, all compounds	4E+3 Thyroid (9E+3)	8E+3 Thyroid (1E+4)	3E-6 -	- 2E-8	- 1E-4	- 1E-3
53	Iodine-132m[2]	D, all compounds	4E+3 Thyroid (1E+4)	8E+3 Thyroid (2E+4)	4E-6 -	- 3E-8	- 1E-4	- 1E-3
53	Iodine-133	D, all compounds	1E+2 Thyroid (5E+2)	3E+2 Thyroid (9E+2)	1E-7 -	- 1E-9	- 7E-6	- 7E-5
53	Iodine-134[2]	D, all compounds	2E+4 Thyroid (3E+4)	5E+4 -	2E-5 -	6E-8 -	- 4E-4	- 4E-3
53	Iodine-135	D, all compounds	8E+2 Thyroid (3E+3)	2E+3 Thyroid (4E+3)	7E-7 -	- 6E-9	- 3E-5	- 3E-4
77	Iridium-182[2]	D, all compounds except those given for W and Y	4E+4 St wall (4E+4)	1E+5 -	6E-5 -	2E-7 -	- 6E-4	- 6E-3
		W, halides, nitrates, and metallic iridium	-	2E+5	6E-5	2E-7	-	-
		Y, oxides and hydroxides	-	1E+5	5E-5	2E-7	-	-
77	Iridium-184	D, see ^{182}Ir	8E+3	2E+4	1E-5	3E-8	1E-4	1E-3
		W, see ^{184}Ir	-	3E+4	1E-5	5E-8	-	-
		Y, see ^{182}Ir	-	3E+4	1E-5	4E-8	-	-
77	Iridium-185	D, see ^{182}Ir	5E+3	1E+4	5E-6	2E-8	7E-5	7E-4
		W, see ^{184}Ir	-	1E+4	5E-6	2E-8	-	-
		Y, see ^{184}Ir	-	1E+4	4E-6	1E-8	-	-
77	Iridium-186	D, see ^{182}Ir	2E+3	8E+3	3E-6	1E-8	3E-5	3E-4
		W, see ^{184}Ir	-	6E+3	3E-6	9E-9	-	-
		Y, see ^{182}Ir	-	6E+3	2E-6	8E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
77	Iridium-187	D, see ^{182}Ir	1E+4	3E+4	1E-5	5E-8	1E-4	1E-3
		W, see ^{182}Ir	-	3E+4	1E-5	4E-8	-	-
		Y, see ^{182}Ir	-	3E+4	1E-5	4E-8	-	-
77	Iridium-188	D, see ^{182}Ir	2E+3	5E+3	2E-6	6E-9	3E-5	3E-4
		W, see ^{182}Ir	-	4E+3	1E-6	5E-9	-	-
		Y, see ^{182}Ir	-	3E+3	1E-6	5E-9	-	-
77	Iridium-189	D, see ^{182}Ir	5E+3	5E+3	2E-6	7E-9	-	-
			LLI wall (5E+3)	-	-	-	7E-5	7E-4
		W, see ^{182}Ir	-	4E+3	2E-6	5E-9	-	-
		Y, see ^{182}Ir	-	4E+3	1E-6	5E-9	-	-
77	Iridium-190	D, see ^{182}Ir	1E+3	9E+2	4E-7	1E-9	1E-5	1E-4
		W, see ^{182}Ir	-	1E+3	4E-7	1E-9	-	-
		Y, see ^{182}Ir	-	9E+2	4E-7	1E-9	-	-
77	Iridium-190m^{2}	D, see ^{182}Ir	2E+5	2E+5	8E-5	3E-7	2E-3	2E-2
		W, see ^{182}Ir	-	2E+5	9E-5	3E-7	-	-
		Y, see ^{182}Ir	-	2E+5	8E-5	3E-7	-	-
77	Iridium-192	D, see ^{182}Ir	9E+2	3E+2	1E-7	4E-10	1E-5	1E-4
		W, see ^{182}Ir	-	4E+2	2E-7	6E-10	-	-
		Y, see ^{182}Ir	-	2E+2	9E-8	3E-10	-	-
77	Iridium-192m	D, see ^{182}Ir	3E+3	9E+1	4E-8	1E-10	4E-5	4E-4
		W, see ^{182}Ir	-	2E+2	9E-8	3E-10	-	-
		Y, see ^{182}Ir	-	2E+1	6E-9	2E-11	-	-
77	Iridium-194	D, see ^{182}Ir	1E+3	3E+3	1E-6	4E-9	1E-5	1E-4
		W, see ^{182}Ir	-	2E+3	9E-7	3E-9	-	-
		Y, see ^{182}Ir	-	2E+3	8E-7	3E-9	-	-
77	Iridium-194m	D, see ^{182}Ir	6E+2	9E+1	4E-8	1E-10	9E-6	9E-5
		W, see ^{182}Ir	-	2E+2	7E-8	2E-10	-	-
		Y, see ^{182}Ir	-	1E+2	4E-8	1E-10	-	-
77	Iridium-195	D, see ^{182}Ir	1E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{182}Ir	-	5E+4	2E-5	7E-8	-	-
		Y, see ^{182}Ir	-	4E+4	2E-5	6E-8	-	-
77	Iridium-195m	D, see ^{182}Ir	8E+3	2E+4	1E-5	3E-8	1E-4	1E-3
		W, see ^{182}Ir	-	3E+4	1E-5	4E-8	-	-
		Y, see ^{182}Ir	-	2E+4	9E-6	3E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
26	Iron-52	D, all compounds except those given for W	9E+2	3E+3	1E-6	4E-9	1E-5	1E-4
		W, oxides, hydroxides, and halides	-	2E+3	1E-6	3E-9	-	-
26	Iron-55	D, see ^{52}Fe	9E+3	2E+3	8E-7	3E-9	1E-4	1E-3
		W, see ^{52}Fe	-	4E+3	2E-6	6E-9	-	-
26	Iron-59	D, see ^{52}Fe	8E+2	3E+2	1E-7	5E-10	1E-5	1E-4
		W, see ^{52}Fe	-	5E+2	2E-7	7E-10	-	-
26	Iron-60	D, see ^{52}Fe	3E+1	6E+0	3E-9	9E-12	4E-7	4E-6
		W, see ^{52}Fe	-	2E+1	8E-9	3E-11	-	-
36	Krypton-74[2]	Submersion[1]	-	-	3E-6	1E-8	-	-
36	Krypton-76	Submersion[1]	-	-	9E-6	4E-8	-	-
36	Krypton-77[2]	Submersion[1]	-	-	4E-6	2E-8	-	-
36	Krypton-79	Submersion[1]	-	-	2E-5	7E-8	-	-
36	Krypton-81	Submersion[1]	-	-	7E-4	3E-6	-	-
36	Krypton-83m[2]	Submersion[1]	-	-	1E-2	5E-5	-	-
36	Krypton-85	Submersion[1]	-	-	1E-4	7E-7	-	-
36	Krypton-85m	Submersion[1]	-	-	2E-5	1E-7	-	-
36	Krypton-87[2]	Submersion[1]	-	-	5E-6	2E-8	-	-
36	Krypton-88	Submersion[1]	-	-	2E-6	9E-9	-	-
57	Lanthanum-131[2]	D, all compounds except those given for W	5E+4	1E+5	5E-5	2E-7	6E-4	6E-3
		W, oxides and hydroxides	-	2E+5	7E-5	2E-7	-	-
57	Lanthanum-132	D, see ^{131}La	3E+3	1E+4	4E-6	1E-8	4E-5	4E-4
		W, see ^{131}La	-	1E+4	5E-6	2E-8	-	-
57	Lanthanum-135	D, see ^{131}La	4E+4	1E+5	4E-5	1E-7	5E-4	5E-3
		W, see ^{131}La	-	9E+4	4E-5	1E-7	-	-
57	Lanthanum-137	D, see ^{131}La	1E+4	6E+1 Liver	3E-8	-	2E-4	2E-3
			-	(7E+1)	-	1E-10	-	-
		W, see ^{131}La	-	3E+2 Liver	1E-7	-	-	-
			-	(3E+2)	-	4E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (µCi)	ALI (µCi)	DAC (µCi/ml)	Air (µCi/ml)	Water (µCi/ml)	Monthly Average Concentration (µCi/ml)
57	Lanthanum-138	D, see ^{131}La	9E+2	4E+0	1E-9	5E-12	1E-5	1E-4
		W, see ^{131}La	-	1E+1	6E-9	2E-11	-	-
57	Lanthanum-140	D, see ^{131}La	6E+2	1E+3	6E-7	2E-9	9E-6	9E-5
		W, see ^{131}La	-	1E+3	5E-7	2E-9	-	-
57	Lanthanum-141	D, see ^{131}La	4E+3	9E+3	4E-6	1E-8	5E-5	5E-4
		W, see ^{131}La	-	1E+4	5E-6	2E-8	-	-
57	Lanthanum-142[2]	D, see ^{131}La	8E+3	2E+4	9E-6	3E-8	1E-4	1E-3
		W, see ^{131}La	-	3E+4	1E-5	5E-8	-	-
57	Lanthanum-143[2]	D, see ^{131}La	4E+4 St wall (4E+4)	1E+5	4E-5	1E-7	-	-
				-	-	-	5E-4	5E-3
		W, see ^{131}La	-	9E+4	4E-5	1E-7	-	-
82	Lead-195m[2]	D, all compounds	6E+4	2E+5	8E-5	3E-7	8E-4	8E-3
82	Lead-198	D, all compounds	3E+4	6E+4	3E-5	9E-8	4E-4	4E-3
82	Lead-199[2]	D, all compounds	2E+4	7E+4	3E-5	1E-7	3E-4	3E-3
82	Lead-200	D, all compounds	3E+3	6E+3	3E-6	9E-9	4E-5	4E-4
82	Lead-201	D, all compounds	7E+3	2E+4	8E-6	3E-8	1E-4	1E-3
82	Lead-202	D, all compounds	1E+2	5E+1	2E-8	7E-11	2E-6	2E-5
82	Lead-202m	D, all compounds	9E+3	3E+4	1E-5	4E-8	1E-4	1E-3
82	Lead-203	D, all compounds	5E+3	9E+3	4E-6	1E-8	7E-5	7E-4
82	Lead-205	D, all compounds	4E+3	1E+3	6E-7	2E-9	5E-5	5E-4
82	Lead-209	D, all compounds	2E+4	6E+4	2E-5	8E-8	3E-4	3E-3
82	Lead-210	D, all compounds	6E1 Bone surf (1E+0)	2E1 Bone surf (4E-1)	1E-10	-	-	-
				-	-	6E-13	1E-8	1E-7
82	Lead-211[2]	D, all compounds	1E+4	6E+2	3E-7	9E-10	2E-4	2E-3
82	Lead-212	D, all compounds	8E+1 Bone surf (1E+2)	3E+1	1E-8	5E-11	-	-
				-	-	-	2E-6	2E-5
82	Lead-214[2]	D, all compounds	9E+3	8E+2	3E-7	1E-9	1E-4	1E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
71	Lutetium-169	W, all compounds except those given for Y	3E+3	4E+3	2E-6	6E-9	3E-5	3E-4
		Y, oxides, hydroxides, and fluorides	-	4E+3	2E-6	6E-9	-	-
71	Lutetium-170	W, see ^{169}Lu	1E+3	2E+3	9E-7	3E-9	2E-5	2E-4
		Y, see ^{169}Lu	-	2E+3	8E-7	3E-9	-	-
71	Lutetium-171	W, see ^{169}Lu	2E+3	2E+3	8E-7	3E-9	3E-5	3E-4
		Y, see ^{169}Lu	-	2E+3	8E-7	3E-9	-	-
71	Lutetium-172	W, see ^{169}Lu	1E+3	1E+3	5E-7	2E-9	1E-5	1E-4
		Y, see ^{169}Lu	-	1E+3	5E-7	2E-9	-	-
71	Lutetium-173	W, see ^{169}Lu	5E+3	3E+2	1E-7	-	7E-5	7E-4
			-	Bone surf (5E+2)	-	6E-10	-	-
		Y, see ^{169}Lu	-	3E+2	1E-7	4E-10	-	-
71	Lutetium-174	W, see ^{169}Lu	5E+3	1E+2	5E-8	-	7E-5	7E-4
			-	Bone surf (2E+2)	-	3E-10	-	-
		Y, see ^{169}Lu	-	2E+2	6E-8	2E-10	-	-
71	Lutetium-174m	W, see ^{169}Lu	2E+3	2E+2	1E-7	-	-	-
			LLI wall (3E+3)	Bone surf (3E+2)	-	5E-10	4E-5	4E-4
		Y, see ^{169}Lu	-	2E+2	9E-8	3E-10	-	-
71	Lutetium-176	W, see ^{169}Lu	7E+2	5E+0	2E-9	-	1E-5	1E-4
			-	Bone surf (1E+1)	-	2E-11	-	-
		Y, see ^{169}Lu	-	8E+0	3E-9	1E-11	-	-
71	Lutetium-176m	W, see ^{169}Lu	8E+3	3E+4	1E-5	3E-8	1E-4	1E-3
		Y, see ^{169}Lu	-	2E+4	9E-6	3E-8	-	-
71	Lutetium-177	W, see ^{169}Lu	2E+3	2E+3	9E-7	3E-9	-	-
			LLI wall (3E+3)	-	-	-	4E-5	4E-4
		Y, see ^{169}Lu	-	2E+3	9E-7	3E-9	-	-
71	Lutetium-177m	W, see ^{169}Lu	7E+2	1E+2	5E-8	-	1E-5	1E-4
			-	Bone surf (1E+2)	-	2E-10	-	-
		Y, see ^{169}Lu	-	8E+1	3E-8	1E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
71	Lutetium-178[2]	W, see ^{169}Lu	4E+4 St wall (4E+4)	1E+5 -	5E-5 -	2E-7 -	- 6E-4	- 6E-3
		Y, see ^{169}Lu	-	1E+5	5E-5	2E-7	-	-
71	Lutetium-178m[2]	W, see ^{169}Lu	5E+4 St. wall (6E+4)	2E+5 -	8E-5 -	3E-7 -	- 8E-4	- 8E-3
		Y, see ^{169}Lu	-	2E+5	7E-5	2E-7	-	-
71	Lutetium-179	W, see ^{169}Lu	6E+3	2E+4	8E-6	3E-8	9E-5	9E-4
		Y, see ^{169}Lu	-	2E+4	6E-6	3E-8	-	-
12	Magnesium-28	D, all compounds except those given for W	7E+2	2E+3	7E-7	2E-9	9E-6	9E-5
		W, oxides, hydroxides, carbides, halides, and nitrates	-	1E+3	5E-7	2E-9	-	-
25	Manganese-51[2]	D, all compounds except those given for W	2E+4	5E+4	2E-5	7E-8	3E-4	3E-3
		W, oxides, hydroxides, halides, and nitrates	-	6E+4	3E-5	8E-8	-	-
25	Manganese-52	D, see ^{51}Mn	7E+2	1E+3	5E-7	2E-9	1E-5	1E-4
		W, see ^{51}Mn	-	9E+2	4E-7	1E-9	-	-
25	Manganese-52m[2]	D, see ^{51}Mn	3E+4 St wall (4E+4)	9E+4 -	4E-5 -	1E-7 -	- 5E-4	- 5E-3
		W, see ^{51}Mn	-	1E+5	4E-5	1E-7	-	-
25	Manganese-53	D, see ^{51}Mn	5E+4	1E+4 Bone surf (2E+4)	5E-6 -	- 3E-8	7E-4 -	7E-3 -
		W, see ^{51}Mn	-	1E+4	5E-6	2E-8	-	-
25	Manganese-54	D, see ^{51}Mn	2E+3	9E+2	4E-7	1E-9	3E-5	3E-4
		W, see ^{51}Mn	-	8E+2	3E-7	1E-9	-	-
25	Manganese-56	D, see ^{51}Mn	5E+3	2E+4	6E-6	2E-8	7E-5	7E-4
		W, see ^{51}Mn	-	2E+4	9E-6	3E-8	-	-
101	Mendelevium-257	W, all compounds	7E+3 -	8E+1 Bone surf (9E+1)	4E-8 -	- 1E-10	1E-4 -	1E-3 -
101	Mendelevium-258	W, all compounds	3E+1 Bone surf (5E+1)	2E-1 Bone surf (3E-1)	1E-10 -	- 5E-13	- 6E-7	- 6E-6

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
80	Mercury-193	Vapor	-	3E+4	1E-5	4E-8	-	-
		Organic D	2E+4	6E+4	3E-5	9E-8	3E-4	3E-3
		D, see ^{193m}Hg	2E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{193m}Hg	-	4E+4	2E-5	6E-8	-	-
80	Mercury-193m	Vapor	-	8E+3	4E-6	1E-8	-	-
		Organic D	4E+3	1E+4	5E-6	2E-8	6E-5	6E-4
		D, sulfates	3E+3	9E+3	4E-6	1E-8	4E-5	4E-4
		W, oxides, hydroxides, halides, nitrates, and sulfides	-	8E+3	3E-6	1E-8	-	-
80	Mercury-194	Vapor	-	3E+1	1E-8	4E-11	-	-
		Organic D	2E+1	3E+1	1E-8	4E-11	2E-7	2E-6
		D, see ^{193m}Hg	8E+2	4E+1	2E-8	6E-11	1E-5	1E-4
		W, see ^{193m}Hg	-	1E+2	5E-8	2E-10	-	-
80	Mercury-195	Vapor	-	3E+4	1E-5	4E-8	-	-
		Organic D	2E+4	5E+4	2E-5	6E-8	2E-4	2E-3
		D, see ^{193m}Hg	1E+4	4E+4	1E-5	5E-8	2E-4	2E-3
		W, see ^{193m}Hg	-	3E+4	1E-5	5E-8	-	-
80	Mercury-195m	Vapor	-	4E+3	2E-6	6E-9	-	-
		Organic D	3E+3	6E+3	3E-6	8E-9	4E-5	4E-4
		D, see ^{193m}Hg	2E+3	5E+3	2E-6	7E-9	3E-5	3E-4
		W, see ^{193m}Hg	-	4E+3	2E-6	5E-9	-	-
80	Mercury-197	Vapor	-	8E+3	4E-6	1E-8	-	-
		Organic D	7E+3	1E+4	6E-6	2E-8	9E-5	9E-4
		D, see ^{193m}Hg	6E+3	1E+4	5E-6	2E-8	8E-5	8E-4
		W, see ^{193m}Hg	-	9E+3	4E-6	1E-8	-	-
80	Mercury-197m	Vapor	-	5E+3	2E-6	7E-9	-	-
		Organic D	4E+3	9E+3	4E-6	1E-8	5E-5	5E-4
		D, see ^{193m}Hg	3E+3	7E+3	3E-6	1E-8	4E-5	4E-4
		W, see ^{193m}Hg	-	5E+3	2E-6	7E-9	-	-
80	Mercury-199m[2]	Vapor	-	8E+4	3E-5	1E-7	-	-
		Organic D	6E+4	2E+5	7E-5	2E-7	-	-
			St wall (1E+5)	-	-	-	1E-3	1E-2
		D, see ^{193m}Hg	6E+4	1E+5	6E-5	2E-7	8E-4	8E-3
		W, see ^{193m}Hg	-	2E+5	7E-5	2E-7	-	-
80	Mercury-203	Vapor	-	8E+2	4E-7	1E-9	-	-
		Organic D	5E+2	8E+2	3E-7	1E-9	7E-6	7E-5
		D, see ^{193m}Hg	2E+3	1E+3	5E-7	2E-9	3E-5	3E-4
		W, see ^{193m}Hg	-	1E+3	5E-7	2E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
42	Molybdenum-101[2]	D, see ^{90}Mo	4E+4	1E+5	6E-5	2E-7	-	-
			St wall (5E+4)	-	-	-	7E-4	7E-3
		Y, see ^{90}Mo	-	1E+5	6E-5	2E-7	-	-
42	Molybdenum-90	D, all compounds except those given for Y	4E+3	7E+3	3E-6	1E-8	3E-5	3E-4
		Y, oxides, hydroxides, and MoS	2E+3	5E+3	2E-6	6E-9	-	-
42	Molybdenum-93	D, see ^{90}Mo	4E+3	5E+3	2E-6	8E-9	5E-5	5E-4
		Y, see ^{90}Mo	2E+4	2E+2	8E-8	2E-10	-	-
42	Molybdenum-93m	D, see ^{90}Mo	9E+3	2E+4	7E-6	2E-8	6E-5	6E-4
		Y, see ^{90}Mo	4E+3	1E+4	6E-6	2E-8	-	-
42	Molybdenum-99	D, see ^{90}Mo	2E+3	3E+3	1E-6	4E-9	-	-
			LLI wall (1E+3)	-	-	-	2E-5	2E-4
		Y, see ^{90}Mo	1E+3	1E+3	6E-7	2E-9	-	-
60	Neodymium-136[2]	W, all compounds except those given for Y	1E+4	6E+4	2E-5	8E-8	2E-4	2E-3
		Y, oxides, hydroxides, carbides, and fluorides	-	5E+4	2E-5	8E-8	-	-
60	Neodymium-138	W, see ^{136}Nd	2E+3	6E+3	3E-6	9E-9	3E-5	3E-4
		Y, see ^{136}Nd	-	5E+3	2E-6	7E-9	-	-
60	Neodymium-139[2]	W, see ^{136}Nd	9E+4	3E+5	1E-4	5E-7	1E-3	1E-2
		Y, see ^{136}Nd	-	3E+5	1E-4	4E-7	-	-
60	Neodymium-139m	W, see ^{136}Nd	5E+3	2E+4	7E-6	2E-8	7E-5	7E-4
		Y, see ^{136}Nd	-	1E+4	6E-6	2E-8	-	-
60	Neodymium-141	W, see ^{136}Nd	2E+5	7E+5	3E-4	1E-6	2E-3	2E-2
		Y, see ^{136}Nd	-	6E+5	3E-4	9E-7	-	-
60	Neodymium-147	W, see ^{136}Nd	1E+3	9E+2	4E-7	1E-9	-	-
			LLI wall (1E+3)	-	-	-	2E-5	2E-4
		Y, see ^{136}Nd	-	8E+2	4E-7	1E-9	-	-
60	Neodymium-149[2]	W, see ^{136}Nd	1E+4	3E+4	1E-5	4E-8	1E-4	1E-3
		Y, see ^{136}Nd	-	2E+4	1E-5	3E-8	-	-
60	Neodymium-151[2]	W, see ^{136}Nd	7E+4	2E+5	8E-5	3E-7	9E-4	9E-3
		Y, see ^{136}Nd	-	2E+5	8E-5	3E-7	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
93	Neptunium-232[2]	W, all compounds	1E+5	2E+3	7E-7	-	2E-3	2E-2
			-	Bone surf (5E+2)	-	6E-9	-	-
93	Neptunium-233[2]	W, all compounds	8E+5	3E+6	1E-3	4E-6	1E-2	1E-1
93	Neptunium-234	W, all compounds	2E+3	3E+3	1E-6	4E-9	3E-5	3E-4
93	Neptunium-235	W, all compounds	2E+4	8E+2	3E-7	-	-	-
			LLI wall (2E+4)	Bone surf (1E+3)	-	2E-9	3E-4	3E-3
93	Neptunium-236 (1.15E+5 y)	W, all compounds	3E+0	2E-2	9E-12	-	-	-
			Bone surf (6E+0)	Bone surf (5E-2)	-	8E-14	9E-8	9E-7
93	Neptunium-236 (22.5 h)	W, all compounds	3E+3	3E+1	1E-8	-	-	-
			Bone surf (4E+3)	Bone surf (7E+1)	-	1E-10	5E-5	5E-4
93	Neptunium-237	W, all compounds	5E-1	4E-3	2E-12	-	-	-
			Bone surf (1E+0)	Bone surf (1E-2)	-	1E-14	2E-8	2E-7
93	Neptunium-238	W, all compounds	1E+3	6E+1	3E-8	-	2E-5	2E-4
			-	Bone surf (2E+2)	-	2E-10	-	-
93	Neptunium-239	W, all compounds	2E+3	2E+3	9E-7	3E-9	-	-
			LLI wall (2E+3)	-	-	-	2E-5	2E-4
93	Neptunium-240[2]	W, all compounds	2E+4	8E+4	3E-5	1E-7	3E-4	3E-3
28	Nickel-56	D, all compounds except those given for W	1E+3	2E+3	8E-7	3E-9	2E-5	2E-4
		W, oxides, hydroxides, and carbides	-	1E+3	5E-7	2E-9	-	-
		Vapor	-	1E+3	5E-7	2E-9	-	-
28	Nickel-57	D, see ^{56}Ni	2E+3	5E+3	2E-6	7E-9	2E-5	2E-4
		W, see ^{56}Ni	-	3E+3	1E-6	4E-9	-	-
		Vapor	-	6E+3	3E-6	9E-9	-	-
28	Nickel-59	D, see ^{56}Ni	2E+4	4E+3	2E-6	5E-9	3E-4	3E-3
		W, see ^{56}Ni	-	7E+3	3E-6	1E-8	-	-
		Vapor	-	2E+3	8E-7	3E-9	-	-
28	Nickel-63	D, see ^{56}Ni	9E+3	2E+3	7E-7	2E-9	1E-4	1E-3
		W, see ^{56}Ni	-	3E+3	1E-6	4E-9	-	-
		Vapor	-	8E+2	3E-7	1E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
28	Nickel-65	D, see ^{56}Ni	8E+3	2E+4	1E-5	3E-8	1E-4	1E-3
		W, see ^{56}Ni	-	3E+4	1E-5	4E-8	-	-
		Vapor	-	2E+4	7E-6	2E-8	-	-
28	Nickel-66	D, see ^{56}Ni	4E+2 LLI wall (5E+2)	2E+3	7E-7	2E-9	-	-
				-	-	-	6E-6	6E-5
		W, see ^{56}Ni	-	6E+2	3E-7	9E-10	-	-
		Vapor	-	3E+3	1E-6	4E-9	-	-
41	Niobium-88[2]	W, all compounds except those given for Y	5E+4 St wall (7E+4)	2E+5	9E-5	3E-7	-	-
				-	-	-	1E-3	1E-2
		Y, oxides and hydroxides	-	2E+5	9E-5	3E-7	-	-
41	Niobium-89 (122 min)	W, see ^{88}Nb	5E+3	2E+4	8E-6	3E-8	7E-5	7E-4
		Y, see ^{88}Nb	-	2E+4	6E-6	2E-8	-	-
41	Niobium-89[2] (66 min)	W, see ^{88}Nb	1E+4	4E+4	2E-5	6E-8	1E-4	1E-3
		Y, see ^{88}Nb	-	4E+4	2E-5	5E-8	-	-
41	Niobium-90	W, see ^{88}Nb	1E+3	3E+3	1E-6	4E-9	1E-5	1E-4
		Y, see ^{88}Nb	-	2E+3	1E-6	3E-9	-	-
41	Niobium-93m	W, see ^{88}Nb	9E+3 LLI wall (1E+4)	2E+3	8E-7	3E-9	-	-
				-	-	-	2E-4	2E-3
		Y, see ^{88}Nb	-	2E+2	7E-8	2E-10	-	-
41	Niobium-94	W, see ^{88}Nb	9E+2	2E+2	8E-8	3E-10	1E-5	1E-4
		Y, see ^{88}Nb	-	2E+1	6E-9	2E-11	-	-
41	Niobium-95	W, see ^{88}Nb	2E+3	1E+3	5E-7	2E-9	3E-5	3E-4
		Y, see ^{88}Nb	-	1E+3	5E-7	2E-9	-	-
41	Niobium-95m	W, see ^{88}Nb	2E+3 LLI wall (2E+3)	3E+3	1E-6	4E-9	-	-
				-	-	-	3E-5	3E-4
		Y, see ^{88}Nb	-	2E+3	9E-7	3E-9	-	-
41	Niobium-96	W, see ^{88}Nb	1E+3	3E+3	1E-6	4E-9	2E-5	2E-4
		Y, see ^{88}Nb	-	2E+3	1E-6	3E-9	-	-
41	Niobium-97[2]	W, see ^{88}Nb	2E+4	8E+4	3E-5	1E-7	3E-4	3E-3
		Y, see ^{88}Nb	-	7E+4	3E-5	1E-7	-	-
41	Niobium-98[2]	W, see ^{88}Nb	1E+4	5E+4	2E-5	8E-8	2E-4	2E-3
		Y, see ^{88}Nb	-	5E+4	2E-5	7E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
7	Nitrogen-13[2]	Submersion[1]	-	-	4E-6	2E-8	-	-
76	Osmium-180[2]	D, all compounds except those given for W and Y	1E+5	4E+5	2E-4	5E-7	1E-3	1E-2
		W, halides and nitrates	-	5E+5	2E-4	7E-7	-	-
		Y, oxides and hydroxides	-	5E+5	2E-4	6E-7	-	-
76	Osmium-181[2]	D, see ^{180}Os	1E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, see ^{180}Os	-	5E+4	2E-5	6E-8	-	-
		Y, see ^{180}Os	-	4E+4	2E-5	6E-8	-	-
76	Osmium-182	D, see ^{180}Os	2E+3	6E+3	2E-6	8E-9	3E-5	3E-4
		W, see ^{180}Os	-	4E+3	2E-6	6E-9	-	-
		Y, see ^{180}Os	-	4E+3	2E-6	6E-9	-	-
76	Osmium-185	D, see ^{180}Os	2E+3	5E+2	2E-7	7E-10	3E-5	3E-4
		W, see ^{180}Os	-	8E+2	3E-7	1E-9	-	-
		Y, see ^{180}Os	-	8E+2	3E-7	1E-9	-	-
76	Osmium-189m	D, see ^{180}Os	8E+4	2E+5	1E-4	3E-7	1E-3	1E-2
		W, see ^{180}Os	-	2E+5	9E-5	3E-7	-	-
		Y, see ^{180}Os	-	2E+5	7E-5	2E-7	-	-
76	Osmium-191	D, see ^{180}Os	2E+3	2E+3	9E-7	3E-9	-	-
			LLI wall (3E+3)	-	-	-	3E-5	3E-4
		W, see ^{180}Os	-	2E+3	7E-7	2E-9	-	-
		Y, see ^{180}Os	-	1E+3	6E-7	2E-9	-	-
76	Osmium-191m	D, see ^{180}Os	1E+4	3E+4	1E-5	4E-8	2E-4	2E-3
		W, see ^{180}Os	-	2E+4	8E-6	3E-8	-	-
		Y, see ^{180}Os	-	2E+4	7E-6	2E-8	-	-
76	Osmium-193	D, see ^{180}Os	2E+3	5E+3	2E-6	6E-9	-	-
			LLI wall (2E+3)	-	-	-	2E-5	2E-4
		W, see ^{180}Os	-	3E+3	1E-6	4E-9	-	-
		Y, see ^{180}Os	-	3E+3	1E-6	4E-9	-	-
76	Osmium-194	D, see ^{180}Os	4E+2	4E+1	2E-8	6E-11	-	-
			LLI wall (6E+2)	-	-	-	8E-6	8E-5
		W, see ^{180}Os	-	6E+1	2E-8	8E-11	-	-
		Y, see ^{180}Os	-	8E+0	3E-9	1E-11	-	-
8	Oxygen-15[2]	Submersion[1]	-	-	4E-6	2E-8	-	-
46	Palladium-100	D, all compounds except those given for W and Y	1E+3	1E+3	6E-7	2E-9	2E-5	2E-4
		W, nitrates	-	1E+3	5E-7	2E-9	-	-
		Y, oxides and hydroxides	-	1E+3	6E-7	2E-9	-	-
46	Palladium-101	D, see ^{100}Pd	1E+4	3E+4	1E-5	5E-8	2E-4	2E-3
		W, see ^{100}Pd	-	3E+4	1E-5	5E-8	-	-
		Y, see ^{100}Pd	-	3E+4	1E-5	4E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
46	Palladium-103	D, see ^{100}Pd	6E+3	6E+3	3E-6	9E-9	-	-
			LLI wall (7E+3)	-	-	-	1E-4	1E-3
		W, see ^{100}Pd	-	4E+3	2E-6	6E-9	-	-
		Y, see ^{100}Pd	-	4E+3	1E-6	5E-9	-	-
46	Palladium-107	D, see ^{100}Pd	3E+4	2E+4	9E-6	-	-	-
			LLI wall (4E+4)	Kidneys (2E+4)	-	3E-8	5E-4	5E-3
		W, see ^{100}Pd	-	7E+3	3E-6	1E-8	-	-
		Y, see ^{100}Pd	-	4E+2	2E-7	6E-10	-	-
46	Palladium-109	D, see ^{100}Pd	2E+3	6E+3	3E-6	9E-9	3E-5	3E-4
		W, see ^{100}Pd	-	5E+3	2E-6	8E-9	-	-
		Y, see ^{100}Pd	-	5E+3	2E-6	6E-9	-	-
15	Phosphorus-32	D, all compounds except phosphates given for W	6E+2	9E+2	4E-7	1E-9	9E-6	9E-5
		W, phosphates of Zn^{2+}, S^{3+}, Mg^{2+}, Fe^{3+}, Bi^{3+}, and lanthanides	-	4E+2	2E-7	5E-10	-	-
15	Phosphorus-33	D, see ^{32}P	6E+3	8E+3	4E-6	1E-8	8E-5	8E-4
		W, see ^{32}P	-	3E+3	1E-6	4E-9	-	-
78	Platinum-186	D, all compounds	1E+4	4E+4	2E-5	5E-8	2E-4	2E-3
78	Platinum-188	D, all compounds	2E+3	2E+3	7E-7	2E-9	2E-5	2E-4
78	Platinum-189	D, all compounds	1E+4	3E+4	1E-5	4E-8	1E-4	1E-3
78	Platinum-191	D, all compounds	4E+3	8E+3	4E-6	1E-8	5E-5	5E-4
78	Platinum-193	D, all compounds	4E+4	2E+4	1E-5	3E-8	-	-
			LLI wall (5E+4)	-	-	-	6E-4	6E-3
78	Platinum-193m	D, all compounds	3E+3	6E+3	3E-6	8E-9	-	-
			LLI wall (3E+4)	-	-	-	4E-5	4E-4
78	Platinum-195m	D, all compounds	2E+3	4E+3	2E-6	6E-9	-	-
			LLI wall (2E+3)	-	-	-	3E-5	3E-4
78	Platinum-197	D, all compounds	3E+3	1E+4	4E-6	1E-8	4E-5	4E-4
78	Platinum-197m[2]	D, all compounds	2E+4	4E+4	2E-5	6E-8	2E-4	2E-3
78	Platinum-199[2]	D, all compounds	5E+4	1E+5	6E-5	2E-7	7E-4	7E-3
78	Platinum-200	D, all compounds	1E+3	3E+3	1E-6	5E-9	2E-5	2E-4

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
94	Plutonium-234	W, all compounds except PuO	8E+3	2E+2	9E-8	3E-10	1E-4	1E-3
		Y, PuO	-	2E+2	8E-8	3E-10	-	-
94	Plutonium-235[2]	W, see ^{234}Pu	9E+5	3E+6	1E-3	4E-6	1E-2	1E-1
		Y, see ^{234}Pu	-	3E+6	1E-3	3E-6	-	-
94	Plutonium-236	W, see ^{234}Pu	2E+0 Bone surf (4E+0)	2E-2 Bone surf (4E-2)	8E-12 -	- 5E-14	- 6E-8	- 6E-7
		Y, see ^{234}Pu	-	4E-2	2E-11	6E-14	-	-
94	Plutonium-237	W, see ^{234}Pu	1E+4	3E+3	1E-6	5E-9	2E-4	2E-3
		Y, see ^{234}Pu	-	3E+3	1E-6	4E-9	-	-
94	Plutonium-238	W, see ^{234}Pu	9E-1 Bone surf (2E+0)	7E-3 Bone surf (1E-2)	3E-12 -	- 2E-14	- 2E-8	- 2E-7
		Y, see ^{234}Pu	-	2E-2	8E-12	2E-14	-	-
94	Plutonium-239	W, see ^{234}Pu	8E-1 Bone surf (1E+0)	6E-3 Bone surf (1E-2)	3E-12 -	- 2E-14	- 2E-8	- 2E-7
		Y, see ^{234}Pu	- -	2E-2 Bone surf (2E-2)	7E-12 -	- 2E-14	- -	- -
94	Plutonium-240	W, see ^{234}Pu	8E-1 Bone surf (1E+0)	6E-3 Bone surf (1E-2)	3E-12 -	- 2E-14	- 2E-8	- 2E-7
		Y, see ^{234}Pu	- -	2E-2 Bone surf (2E-2)	7E-12 -	- 2E-14	- -	- -
94	Plutonium-241	W, see ^{234}Pu	4E+1 Bone surf (7E+1)	3E-1 Bone surf (6E-1)	1E-10 -	- 8E-13	- 1E-6	- 1E-5
		Y, see ^{234}Pu	- -	8E-1 Bone surf (1E+0)	3E-10 -	- 1E-12	- -	- -
94	Plutonium-242	W, see ^{234}Pu	8E-1 Bone surf (1E+0)	7E-3 Bone surf (1E-2)	3E-12 -	- 2E-14	- 2E-8	- 2E-7
		Y, see ^{234}Pu	- -	2E-2 Bone surf (2E-2)	7E-12 -	- 2E-14	- -	- -
94	Plutonium-243	W, see ^{234}Pu	2E+4	4E+4	2E-5	5E-8	2E-4	2E-3
		Y, see ^{234}Pu	-	4E+4	2E-5	5E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
94	Plutonium-244	W, see ^{234}Pu	8E-1	7E-3	3E-12	-	-	-
			Bone surf (2E+0)	Bone surf (1E-2)	-	2E-14	2E-8	2E-7
		Y, see ^{234}Pu	-	2E-2	7E-12	-	-	-
			-	Bone surf (2E-2)	-	2E-14	-	-
94	Plutonium-245	W, see ^{234}Pu	2E+3	5E+3	2E-6	6E-9	3E-5	3E-4
		Y, see ^{234}Pu	-	4E+3	2E-6	6E-9	-	-
94	Plutonium-246	W, see ^{234}Pu	4E+2	3E+2	1E-7	4E-10	-	-
			LLI wall (4E+2)	-	-	-	6E-6	6E-5
		Y, see ^{234}Pu	-	3E+2	1E-7	4E-10	-	-
84	Polonium-203[2]	D, all compounds except those given for W	3E+4	6E+4	3E-5	9E-8	3E-4	3E-3
		W, oxides, hydroxides, and nitrates	-	9E+4	4E-5	1E-7	-	-
84	Polonium-205[2]	D, see ^{203}Po	2E+4	4E+4	2E-5	5E-8	3E-4	3E-3
		W, see ^{203}Po	-	7E+4	3E-5	1E-7	-	-
84	Polonium-207	D, see ^{203}Po	8E+3	3E+4	1E-5	3E-8	1E-4	1E-3
		W, see ^{203}Po	-	3E+4	1E-5	4E-8	-	-
84	Polonium-210	D, see ^{203}Po	3E+0	6E-1	3E-10	9E-13	4E-8	4E-7
		W, see ^{203}Po	-	6E-1	3E-10	9E-13	-	-
19	Potassium-40	D, all compounds	3E+2	4E+2	2E-7	6E-10	4E-6	4E-5
19	Potassium-42	D, all compounds	5E+3	5E+3	2E-6	7E-9	6E-5	6E-4
19	Potassium-43	D, all compounds	6E+3	9E+3	4E-6	1E-8	9E-5	9E-4
19	Potassium-44[2]	D, all compounds	2E+4	7E+4	3E-5	9E-8	-	-
			St wall (4E+4)	-	-	-	5E-4	5E-3
19	Potassium-45[2]	D, all compounds	3E+4	1E+5	5E-5	2E-7	-	-
			St wall (5E+4)	-	-	-	7E-4	7E-3
59	Praseodymium-136[2]	W, all compounds except those given for Y	5E+4	2E+5	1E-4	3E-7	-	-
			St wall (7E+4)	-	-	-	1E-3	1E-2
		Y, oxides, hydroxides, carbides, and fluorides	-	2E+5	9E-5	3E-7	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
59	Praseodymium-137[2]	W, see ^{136}Pr	4E+4	2E+5	6E-5	2E-7	5E-4	5E-3
		Y, see ^{136}Pr	-	1E+5	6E-5	2E-7	-	-
59	Praseodymium-138m	W, see ^{136}Pr	1E+4	5E+4	2E-5	8E-8	1E-4	1E-3
		Y, see ^{136}Pr	-	4E+4	2E-5	6E-8	-	-
59	Praseodymium-139	W, see ^{136}Pr	4E+4	1E+5	5E-5	2E-7	6E-4	6E-3
		Y, see ^{136}Pr	-	1E+5	5E-5	2E-7	-	-
59	Praseodymium-142	W, see ^{136}Pr	1E+3	2E+3	9E-7	3E-9	1E-5	1E-4
		Y, see ^{136}Pr	-	2E+3	8E-7	3E-9	-	-
59	Praseodymium-142m[2]	W, see ^{136}Pr	8E+4	2E+5	7E-5	2E-7	1E-3	1E-2
		Y, see ^{136}Pr	-	1E+5	6E-5	2E-7	-	-
59	Praseodymium-143	W, see ^{136}Pr	9E+2	8E+2	3E-7	1E-9	-	-
			LLI wall (1E+3)	-	-	-	2E-5	2E-4
		Y, see ^{136}Pr	-	7E+2	3E-7	9E-10	-	-
59	Praseodymium-144[2]	W, see ^{136}Pr	3E+4	1E+5	5E-5	2E-7	-	-
			St wall (4E+4)	-	-	-	6E-4	6E-3
		Y, see ^{136}Pr	-	1E+5	5E-5	2E-7	-	-
59	Praseodymium-145	W, see ^{136}Pr	3E+3	9E+3	4E-6	1E-8	4E-5	4E-4
		Y, see ^{136}Pr	-	8E+3	3E-6	1E-8	-	-
59	Praseodymium-147[2]	W, see ^{136}Pr	5E+4	2E+5	8E-5	3E-7	-	-
			St wall (8E+4)	-	-	-	1E-3	1E-2
		Y, see ^{136}Pr	-	2E+5	8E-5	3E-7	-	-
61	Promethium-141[2]	W, all compounds except those given for Y	5E+4	2E+5	8E-5	3E-7	-	-
			St wall (6E+4)	-	-	-	8E-4	8E-3
		Y, oxides, hydroxides, carbides, and fluorides	-	2E+5	7E-5	2E-7	-	-
61	Promethium-143	W, see ^{141}Pm	5E+3	6E+2	2E-7	8E-10	7E-5	7E-4
		Y, see ^{141}Pm	-	7E+2	3E-7	1E-9	-	-
61	Promethium-144	W, see ^{141}Pm	1E+3	1E+2	5E-8	2E-10	2E-5	2E-4
		Y, see ^{141}Pm	-	1E+2	5E-8	2E-10	-	-
61	Promethium-145	W, see ^{141}Pm	1E+4	2E+2	7E-8	-	1E-4	1E-3
			-	Bone surf (2E+2)	-	3E-10	-	-
		Y, see ^{141}Pm	-	2E+2	8E-8	3E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
61	Promethium-146	W, see ^{141}Pm	2E+3	5E+1	2E-8	7E-11	2E-5	2E-4
		Y, see ^{141}Pm	-	4E+1	2E-8	6E-11	-	-
61	Promethium-147	W, see ^{141}Pm	4E+3 LLI wall (5E+3)	1E+2 Bone surf (2E+2)	5E-8 -	- 3E-10	- 7E-5	- 7E-4
		Y, see ^{141}Pm	-	1E+2	6E-8	2E-10	-	-
61	Promethium-148	W, see ^{141}Pm	4E+2 LLI wall (5E+2)	5E+2 -	2E-7 -	8E-10 -	- 7E-6	- 7E-5
		Y, see ^{141}Pm	-	5E+2	2E-7	7E-10	-	-
61	Promethium-148m	W, see ^{141}Pm	7E+2	3E+2	1E-7	4E-10	1E-5	1E-4
		Y, see ^{141}Pm	-	3E+2	1E-7	5E-10	-	-
61	Promethium-149	W, see ^{141}Pm	1E+3 LLI wall (1E+3)	2E+3 -	8E-7 -	3E-9 -	- 2E-5	- 2E-4
		Y, see ^{141}Pm	-	2E+3	8E-7	2E-9	-	-
61	Promethium-150	W, see ^{141}Pm	5E+3	2E+4	8E-6	3E-8	7E-5	7E-4
		Y, see ^{141}Pm	-	2E+4	7E-6	2E-8	-	-
61	Promethium-151	W, see ^{141}Pm	2E+3	4E+3	1E-6	5E-9	2E-5	2E-4
		Y, see ^{141}Pm	-	3E+3	1E-6	4E-9	-	-
91	Protactinium-227[2]	W, all compounds except those given for Y	4E+3	1E+2	5E-8	2E-10	5E-5	5E-4
		Y, oxides and hydroxides	-	1E+2	4E-8	1E-10	-	-
91	Protactinium-228	W, see ^{227}Pa	1E+3	1E+1 Bone surf (2E+1)	5E-9 -	- 3E-11	2E-5 -	2E-4 -
		Y, see ^{227}Pa	-	1E+1	5E-9	2E-11	-	-
91	Protactinium-230	W, see ^{227}Pa	6E+2 Bone surf (9E+2)	5E+0 -	2E-9 -	7E-12 -	- 1E-5	- 1E-4
		Y, see ^{227}Pa	-	4E+0	1E-9	5E-12	-	-
91	Protactinium-231	W, see ^{227}Pa	2E-1 Bone surf (5E-1)	2E-3 Bone surf (4E-3)	6E-13 -	- 6E-15	- 6E-9	- 6E-8
		Y, see ^{227}Pa	-	4E-3 Bone surf (6E-3)	2E-12 -	- 8E-15	- -	- -

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
91	Protactinium-232	W, see ^{227}Pa	1E+3	2E+1 Bone surf	9E-9	-	2E-5	2E-4
			-	(6E+1)	-	8E-11	-	-
		Y, see ^{227}Pa	-	6E+1 Bone surf	2E-8	-	-	-
			-	(7E+1)	-	1E-10	-	-
91	Protactinium-233	W, see ^{227}Pa	1E+3 LLI wall (2E+3)	7E+2	3E-7	1E-9	-	-
				-	-	-	2E-5	2E-4
		Y, see ^{227}Pa	-	6E+2	2E-7	8E-10	-	-
91	Protactinium-234	W, see ^{227}Pa	2E+3	8E+3	3E-6	1E-8	3E-5	3E-4
		Y, see ^{227}Pa	-	7E+3	3E-6	9E-9	-	-
88	Radium-223	W, all compounds	5E+0 Bone surf (9E+0)	7E-1	3E-10	9E-13	-	-
				-	-	-	1E-7	1E-6
88	Radium-224	W, all compounds	8E+0 Bone surf (2E+1)	2E+0	7E-10	2E-12	-	-
				-	-	-	2E-7	2E-6
88	Radium-225	W, all compounds	8E+0 Bone surf (2E+1)	7E-1	3E-10	9E-13	-	-
				-	-	-	2E-7	2E-6
88	Radium-226	W, all compounds	2E+0 Bone surf (5E+0)	6E-1	3E-10	9E-13	-	-
				-	-	-	6E-8	6E-7
88	Radium-227[2]	W, all compounds	2E+4 Bone surf (2E+4)	1E+4 Bone surf (2E+4)	6E-6	-	-	-
					-	3E-8	3E-4	3E-3
88	Radium-228	W, all compounds	2E+0 Bone surf (4E+0)	1E+0	5E-10	2E-12	-	-
				-	-	-	6E-8	6E-7
86	Radon-220	With daughters removed	-	2E+4	7E-6	2E-8	-	-
		With daughters present	-	2E+1 (or 12 working level months)	9E-9 (or 1.0 working level)	3E-11	-	-
86	Radon-222	With daughters removed	-	1E+4	4E-6	1E-8	-	-
		With daughters present	-	1E+2 (or 4 working level months)	3E-8 (or 0.33 working level)	1E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
75	Rhenium-177[2]	D, all compounds except those given for W	9E+4	3E+5	1E-4	4E-7	-	-
			St wall (1E+5)	-	-	-	2E-3	2E-2
		W, oxides, hydroxides, and nitrates	-	4E+5	1E-4	5E-7	-	-
75	Rhenium-178[2]	D, see ^{177}Re	7E+4	3E+5	1E-4	4E-7	-	-
			St wall (1E+5)	-	-	-	1E-3	1E-2
		W, see ^{177}Re	-	3E+5	1E-4	4E-7	-	-
75	Rhenium-181	D, see ^{177}Re	5E+3	9E+3	4E-6	1E-8	7E-5	7E-4
		W, see ^{177}Re	-	9E+3	4E-6	1E-8	-	-
75	Rhenium-182 (12.7 h)	D, see ^{177}Re	7E+3	1E+4	5E-6	2E-8	9E-5	9E-4
		W, see ^{177}Re	-	2E+4	6E-6	2E-8	-	-
75	Rhenium-182 (64.0 h)	D, see ^{177}Re	1E+3	2E+3	1E-6	3E-9	2E-5	2E-4
		W, see ^{177}Re	-	2E+3	9E-7	3E-9	-	-
75	Rhenium-184	D, see ^{177}Re	2E+3	4E+3	1E-6	5E-9	3E-5	3E-4
		W, see ^{177}Re	-	1E+3	6E-7	2E-9	-	-
75	Rhenium-184m	D, see ^{177}Re	2E+3	3E+3	1E-6	4E-9	3E-5	3E-4
		W, see ^{177}Re	-	4E+2	2E-7	6E-10	-	-
75	Rhenium-186	D, see ^{177}Re	2E+3	3E+3	1E-6	4E-9	3E-5	3E-4
		W, see ^{177}Re	-	2E+3	7E-7	2E-9	-	-
75	Rhenium-186m	D, see ^{177}Re	1E+3	2E+3	7E-7	-	-	-
			St wall (2E+3)	St wall (2E+3)	-	3E-9	2E-5	2E-4
		W, see ^{177}Re	-	2E+2	6E-8	2E-10	-	-
75	Rhenium-187	D, see ^{177}Re	6E+5	8E+5	4E-4	-	8E-3	8E-2
			St wall -	(9E+5)	-	1E-6	-	-
		W, see ^{177}Re	-	1E+5	4E-5	1E-7	-	-
75	Rhenium-188	D, see ^{177}Re	2E+3	3E+3	1E-6	4E-9	2E-5	2E-4
		W, see ^{177}Re	-	3E+3	1E-6	4E-9	-	-
75	Rhenium-188m[2]	D, see ^{177}Re	8E+4	1E+5	6E-5	2E-7	1E-3	1E-2
		W, see ^{177}Re	-	1E+5	6E-5	2E-7	-	-
75	Rhenium-189	D, see ^{177}Re	3E+3	5E+3	2E-6	7E-9	4E-5	4E-4
		W, see ^{177}Re	-	4E+3	2E-6	6E-9	-	-
45	Rhodium-100	D, see ^{99m}Rh	2E+3	5E+3	2E-6	7E-9	2E-5	2E-4
		W, see ^{99m}Rh	-	4E+3	2E-6	6E-9	-	-
		Y, see ^{99m}Rh	-	4E+3	2E-6	5E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
45	Rhodium-101	D, see ^{99m}Rh	2E+3	5E+2	2E-7	7E-10	3E-5	3E-4
		W, see ^{99m}Rh	-	8E+2	3E-7	1E-9	-	-
		Y, see ^{99m}Rh	-	2E+2	6E-8	2E-10	-	-
45	Rhodium-101m	D, see ^{99m}Rh	6E+3	1E+4	5E-6	2E-8	8E-5	8E-4
		W, see ^{99m}Rh	-	8E+3	4E-6	1E-8	-	-
		Y, see ^{99m}Rh	-	8E+3	3E-6	1E-8	-	-
45	Rhodium-102	D, see ^{99m}Rh	6E+2	9E+1	4E-8	1E-10	8E-6	8E-5
		W, see ^{99m}Rh	-	2E+2	7E-8	2E-10	-	-
		Y, see ^{99m}Rh	-	6E+1	2E-8	8E-11	-	-
45	Rhodium-102m	D, see ^{99m}Rh	1E+3 LLI wall (1E+3)	5E+2	2E-7	7E-10	-	-
				-	-	-	2E-5	2E-4
		W, see ^{99m}Rh	-	4E+2	2E-7	5E-10	-	-
		Y, see ^{99m}Rh	-	1E+2	5E-8	2E-10	-	-
45	Rhodium-103m[2]	D, see ^{99m}Rh	4E+5	1E+6	5E-4	2E-6	6E-3	6E-2
		W, see ^{99m}Rh	-	1E+6	5E-4	2E-6	-	-
		Y, see ^{99m}Rh	-	1E+6	5E-4	2E-6	-	-
45	Rhodium-105	D, see ^{99m}Rh	4E+3 LLI wall (4E+3)	1E+4	5E-6	2E-8	-	-
				-	-	-	5E-5	5E-4
		W, see ^{99m}Rh	-	6E+3	3E-6	9E-9	-	-
		Y, see ^{99m}Rh	-	6E+3	2E-6	8E-9	-	-
45	Rhodium-106m	D, see ^{99m}Rh	8E+3	3E+4	1E-5	4E-8	1E-4	1E-3
		W, see ^{99m}Rh	-	4E+4	2E-5	5E-8	-	-
		Y, see ^{99m}Rh	-	4E+4	1E-5	5E-8	-	-
45	Rhodium-107[2]	D, see ^{99m}Rh	7E+4 St wall (9E+4)	2E+5	1E-4	3E-7	-	-
				-	-	-	1E-3	1E-2
		W, see ^{99m}Rh	-	3E+5	1E-4	4E-7	-	-
		Y, see ^{99m}Rh	-	3E+5	1E-4	3E-7	-	-
45	Rhodium-99	D, see ^{99m}Rh	2E+3	3E+3	1E-6	4E-9	3E-5	3E-4
		W, see ^{99m}Rh	-	2E+3	9E-7	3E-9	-	-
		Y, see ^{99m}Rh	-	2E+3	8E-7	3E-9	-	-
45	Rhodium-99m	D, all compounds except those given for W and Y	2E+4	6E+4	2E-5	8E-8	2E-4	2E-3
		W, halides	-	8E+4	3E-5	1E-7	-	-
		Y, oxides and hydroxides	-	7E+4	3E-5	9E-8	-	-
37	Rubidium-79[2]	D, all compounds	4E+4 St wall (6E+4)	1E+5	5E-5	2E-7	-	-
				-	-	-	8E-4	8E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
37	Rubidium-81	D, all compounds	4E+4	5E+4	2E-5	7E-8	5E-4	5E-3
37	Rubidium-81m[2]	D, all compounds	2E+5	3E+5	1E-4	5E-7	-	-
			St wall (3E+5)	-	-	-	4E-3	4E-2
37	Rubidium-82m	D, all compounds	1E+4	2E+4	7E-6	2E-8	2E-4	2E-3
37	Rubidium-83	D, all compounds	6E+2	1E+3	4E-7	1E-9	9E-6	9E-5
37	Rubidium-84	D, all compounds	5E+2	8E+2	3E-7	1E-9	7E-6	7E-5
37	Rubidium-86	D, all compounds	5E+2	8E+2	3E-7	1E-9	7E-6	7E-5
37	Rubidium-87	D, all compounds	1E+3	2E+3	6E-7	2E-9	1E-5	1E-4
37	Rubidium-88[2]	D, all compounds	2E+4	6E+4	3E-5	9E-8	-	-
			St wall (3E+4)	-	-	-	4E-4	4E-3
37	Rubidium-89[2]	D, all compounds	4E+4	1E+5	6E-5	2E-7	-	-
			St wall (6E+4)	-	-	-	9E-4	9E-3
44	Ruthenium-103	D, see ^{94}Ru	2E+3	2E+3	7E-7	2E-9	3E-5	3E-4
		W, see ^{94}Ru	-	1E+3	4E-7	1E-9	-	-
		Y, see ^{94}Ru	-	6E+2	3E-7	9E-10	-	-
44	Ruthenium-105	D, see ^{94}Ru	5E+3	1E+4	6E-6	2E-8	7E-5	7E-4
		W, see ^{94}Ru	-	1E+4	6E-6	2E-8	-	-
		Y, see ^{94}Ru	-	1E+4	5E-6	2E-8	-	-
44	Ruthenium-106	D, see ^{94}Ru	2E+2	9E+1	4E-8	1E-10	-	-
			LLI wall (2E+2)	-	-	-	3E-6	3E-5
		W, see ^{94}Ru	-	5E+1	2E-8	8E-11	-	-
		Y, see ^{94}Ru	-	1E+1	5E-9	2E-11	-	-
44	Ruthenium-94[2]	D, all compounds except those given for W and Y	2E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		W, halides	-	6E+4	3E-5	9E-8	-	-
		Y, oxides and hydroxides	-	6E+4	2E-5	8E-8	-	-
44	Ruthenium-97	D, see ^{94}Ru	8E+3	2E+4	8E-6	3E-8	1E-4	1E-3
		W, see ^{94}Ru	-	1E+4	5E-6	2E-8	-	-
		Y, see ^{94}Ru	-	1E+4	5E-6	2E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
62	Samarium-141[2]	W, all compounds	5E+4	2E+5	8E-5	2E-7	-	-
			St wall (6E+4)	-	-	-	8E-4	8E-3
62	Samarium-141m[2]	W, all compounds	3E+4	1E+5	4E-5	1E-7	4E-4	4E-3
62	Samarium-142[2]	W, all compounds	8E+3	3E+4	1E-5	4E-8	1E-4	1E-3
62	Samarium-145	W, all compounds	6E+3	5E+2	2E-7	7E-10	8E-5	8E-4
62	Samarium-146	W, all compounds	1E+1	4E2	1E-11	-	-	-
			Bone surf (3E+1)	Bone surf (6E-2)	-	9E-14	3E-7	3E-6
62	Samarium-147	W, all compounds	2E+1	4E2	2E-11	-	-	-
			Bone surf (3E+1)	Bone surf (7E-2)	-	1E-13	4E-7	4E-6
62	Samarium-151	W, all compounds	1E+4	1E+2	4E-8	-	-	-
			LLI wall (1E+4)	Bone surf (2E+2)	-	2E-10	2E-4	2E-3
62	Samarium-153	W, all compounds	2E+3	3E+3	1E-6	4E-9	-	-
			LLI wall (2E+3)	-	-	-	3E-5	3E-4
62	Samarium-155[2]	W, all compounds	6E+4	2E+5	9E-5	3E-7	-	-
			St wall (8E+4)	-	-	-	1E-3	1E-2
62	Samarium-156	W, all compounds	5E+3	9E+3	4E-6	1E-8	7E-5	7E-4
21	Scandium-43	Y, all compounds	7E+3	2E+4	9E-6	3E-8	1E-4	1E-3
21	Scandium-44	Y, all compounds	4E+3	1E+4	5E-6	2E-8	5E-5	5E-4
21	Scandium-44m	Y, all compounds	5E+2	7E+2	3E-7	1E-9	7E-6	7E-5
21	Scandium-46	Y, all compounds	9E+2	2E+2	1E-7	3E-10	1E-5	1E-4
21	Scandium-47	Y, all compounds	2E+3	3E+3	1E-6	4E-9	-	-
			LLI wall (3E+3)	-	-	-	4E-5	4E-4
21	Scandium-48	Y, all compounds	8E+2	1E+3	6E-7	2E-9	1E-5	1E-4
21	Scandium-49[2]	Y, all compounds	2E+4	5E+4	2E-5	8E-8	3E-4	3E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
34	Selenium-70[2]	D, all compounds except those given for W	2E+4	4E+4	2E-5	5E-8	1E-4	1E-3
		W, oxides, hydroxides, carbides, and elemental Se	1E+4	4E+4	2E-5	6E-8	-	-
34	Selenium-73	D, see ^{70}Se	3E+3	1E+4	5E-6	2E-8	4E-5	4E-4
		W, see ^{70}Se	-	2E+4	7E-6	2E-8	-	-
34	Selenium-73m[2]	D, see ^{70}Se	6E+4	2E+5	6E-5	2E-7	4E-4	4E-3
		W, see ^{70}Se	3E+4	1E+5	6E-5	2E-7	-	-
34	Selenium-75	D, see ^{70}Se	5E+2	7E+2	3E-7	1E-9	7E-6	7E-5
		W, see ^{70}Se	-	6E+2	3E-7	8E-10	-	-
34	Selenium-79	D, see ^{70}Se	6E+2	8E+2	3E-7	1E-9	8E-6	8E-5
		W, see ^{70}Se	-	6E+2	2E-7	8E-10	-	-
34	Selenium-81[2]	D, see ^{70}Se	6E+4 St wall (8E+4)	2E+5 -	9E-5 -	3E-7 -	- 1E-3	- 1E-2
		W, see ^{70}Se	-	2E+5	1E-4	3E-7	-	-
34	Selenium-81m[2]	D, see ^{70}Se	4E+4	7E+4	3E-5	9E-8	3E-4	3E-3
		W, see ^{70}Se	2E+4	7E+4	3E-5	1E-7	-	-
34	Selenium-83[2]	D, see ^{70}Se	4E+4	1E+5	5E-5	2E-7	4E-4	4E-3
		W, see ^{70}Se	3E+4	1E+5	5E-5	2E-7	-	-
14	Silicon-31	D, all compounds except those given for W and Y	9E+3	3E+4	1E-5	4E-8	1E-4	1E-3
		W, oxides, hydroxides, carbides, and nitrates	-	3E+4	1E-5	5E-8	-	-
		Y, aluminosilicate glass	-	3E+4	1E-5	4E-8	-	-
14	Silicon-32	D, see ^{31}Si	2E+3 LLI wall (3E+3)	2E+2 -	1E-7 -	3E-10 -	- 4E-5	- 4E-4
		W, see ^{31}Si	-	1E+2	5E-8	2E-10	-	-
		Y, see ^{31}Si	-	5E+0	2E-9	7E-12	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
47	Silver-102[2]	D, all compounds except those given for W and Y	5E+4	2E+5	8E-5	2E-7	-	-
			St wall (6E+4)	-	-	-	9E-4	9E-3
		W, nitrates and sulfides	-	2E+5	9E-5	3E-7	-	-
		Y, oxides and hydroxides	-	2E+5	8E-5	3E-7	-	-
47	Silver-103[2]	D, see ^{102}Ag	4E+4	1E+5	4E-5	1E-7	5E-4	5E-3
		W, see ^{102}Ag	-	1E+5	5E-5	2E-7	-	-
		Y, see ^{102}Ag	-	1E+5	5E-5	2E-7	-	-
47	Silver-104[2]	D, see ^{102}Ag	2E+4	7E+4	3E-5	1E-7	3E-4	3E-3
		W, see ^{102}Ag	-	1E+5	6E-5	2E-7	-	-
		Y, see ^{102}Ag	-	1E+5	6E-5	2E-7	-	-
47	Silver-104m[2]	D, see ^{102}Ag	3E+4	9E+4	4E-5	1E-7	4E-4	4E-3
		W, see ^{102}Ag	-	1E+5	5E-5	2E-7	-	-
		Y, see ^{102}Ag	-	1E+5	5E-5	2E-7	-	-
47	Silver-105	D, see ^{102}Ag	3E+3	1E+3	4E-7	1E-9	4E-5	4E-4
		W, see ^{102}Ag	-	2E+3	7E-7	2E-9	-	-
		Y, see ^{102}Ag	-	2E+3	7E-7	2E-9	-	-
47	Silver-106[2]	D, see ^{102}Ag	6E+4	2E+5	8E-5	3E-7	-	-
			St. wall (6E+4)	-	-	-	9E-4	9E-3
		W, see ^{102}Ag	-	2E+5	9E-5	3E-7	-	-
		Y, see ^{102}Ag	-	2E+5	8E-5	3E-7	-	-
47	Silver-106m	D, see ^{102}Ag	8E+2	7E+2	3E-7	1E-9	1E-5	1E-4
		W, see ^{102}Ag	-	9E+2	4E-7	1E-9	-	-
		Y, see ^{102}Ag	-	9E+2	4E-7	1E-9	-	-
47	Silver-108m	D, see ^{102}Ag	6E+2	2E+2	8E-8	3E-10	9E-6	9E-5
		W, see ^{102}Ag	-	3E+2	1E-7	4E-10	-	-
		Y, see ^{102}Ag	-	2E+1	1E-8	3E-11	-	-
47	Silver-110m	D, see ^{102}Ag	5E+2	1E+2	5E-8	2E-10	6E-6	6E-5
		W, see ^{102}Ag	-	2E+2	8E-8	3E-10	-	-
		Y, see ^{102}Ag	-	9E+1	4E-8	1E-10	-	-
47	Silver-111	D, see ^{102}Ag	9E+2	2E+3	6E-7	-	-	-
			LLI wall (1E+3)	Liver (2E+3)	-	2E-9	2E-5	2E-4
		W, see ^{102}Ag	-	9E+2	4E-7	1E-9	-	-
		Y, see ^{102}Ag	-	9E+2	4E-7	1E-9	-	-
47	Silver-112	D, see ^{102}Ag	3E+3	8E+3	3E-6	1E-8	4E-5	4E-4
		W, see ^{102}Ag	-	1E+4	4E-6	1E-8	-	-
		Y, see ^{102}Ag	-	9E+3	4E-6	1E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				Monthly Average Concentration (μCi/ml)
			ALI (μCi)	ALI (μCi)	DAC (μCi/ml)	Air (μCi/ml)	Water (μCi/ml)	
47	Silver-115[2]	D, see ^{102}Ag	3E+4	9E+4	4E-5	1E-7	-	-
			St wall (3E+4)	-	-	-	4E-4	4E-3
		W, see ^{102}Ag	-	9E+4	4E-5	1E-7	-	-
		Y, see ^{102}Ag	-	8E+4	3E-5	1E-7	-	-
11	Sodium-22	D, all compounds	4E+2	6E+2	3E-7	9E-10	6E-6	6E-5
11	Sodium-24	D, all compounds	4E+3	5E+3	2E-6	7E-9	5E-5	5E-4
38	Strontium-80[2]	D, all soluble compounds except SrTiO	4E+3	1E+4	5E-6	2E-8	6E-5	6E-4
		Y, all insoluble compounds and SrTi0	-	1E+4	5E-6	2E-8	-	-
38	Strontium-81[2]	D, see ^{80}Sr	3E+4	8E+4	3E-5	1E-7	3E-4	3E-3
		Y, see ^{80}Sr	2E+4	8E+4	3E-5	1E-7	-	-
38	Strontium-82	D, see ^{80}Sr	3E+2	4E+2	2E-7	6E-10	-	-
			LLI wall (2E+2)	-	-	-	3E-6	3E-5
		Y, see ^{80}Sr	2E+2	9E+1	4E-8	1E-10	-	-
38	Strontium-83	D, see ^{80}Sr	3E+3	7E+3	3E-6	1E-8	3E-5	3E-4
		Y, see ^{80}Sr	2E+3	4E+3	1E-6	5E-9	-	-
38	Strontium-85	D, see ^{80}Sr	3E+3	3E+3	1E-6	4E-9	4E-5	4E-4
		Y, see ^{80}Sr	-	2E+3	6E-7	2E-9	-	-
38	Strontium-85m[2]	D, see ^{80}Sr	2E+5	6E+5	3E-4	9E-7	3E-3	3E-2
		Y, see ^{80}Sr	-	8E+5	4E-4	1E-6	-	-
38	Strontium-87m	D, see ^{80}Sr	5E+4	1E+5	5E-5	2E-7	6E-4	6E-3
		Y, see ^{80}Sr	4E+4	2E+5	6E-5	2E-7	-	-
38	Strontium-89	D, see ^{80}Sr	6E+2	8E+2	4E-7	1E-9	-	-
			LLI wall (6E+2)	-	-	-	8E-6	8E-5
		Y, see ^{80}Sr	5E+2	1E+2	6E-8	2E-10	-	-
38	Strontium-90	D, see ^{80}Sr	3E+1	2E+1	8E-9	-	-	-
			Bone surf (4E+1)	Bone surf (2E+1)	-	3E-11	5E-7	5E-6
		Y, see ^{80}Sr	-	4E+0	2E-9	6E-12	-	-
38	Strontium-91	D, see ^{80}Sr	2E+3	6E+3	2E-6	8E-9	2E-5	2E-4
		Y, see ^{80}Sr	-	4E+3	1E-6	5E-9	-	-
38	Strontium-92	D, see ^{80}Sr	3E+3	9E+3	4E-6	1E-8	4E-5	4E-4
		Y, see ^{80}Sr	-	7E+3	3E-6	9E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
16	Sulfur-35	Vapor	1E+4	6E-6	2E-8	-	-	
		D, sulfides and sulfates except those given for W	1E+4	2E+4	7E-6	2E-8	-	-
			LLI wall (8E+3)	-	-	-	1E-4	1E-3
		W, elemental sulfur, sulfides of Sr, Ba, Ge, Sn, Pb, As, Sb, Bi, Cu, Ag, Au, Zn, Cd, Hg, W, and Mo. Sulfates of Ca, Sr, Ba, Ra, As, Sb, and Bi	6E+3 -	2E+3	9E-7	3E-9	-	-
73	Tantalum-172[2]	W, all compounds except those given for Y	4E+4	1E+5	5E-5	2E-7	5E-4	5E-3
		Y, elemental Ta, oxides, hydroxides, halides, carbides, nitrates, and nitrides	-	1E+5	4E-5	1E-7	-	-
73	Tantalum-173	W, see ^{172}Ta	7E+3	2E+4	8E-6	3E-8	9E-5	9E-4
		Y, see ^{172}Ta	-	2E+4	7E-6	2E-8	-	-
73	Tantalum-174[2]	W, see ^{172}Ta	3E+4	1E+5	4E-5	1E-7	4E-4	4E-3
		Y, see ^{172}Ta	-	9E+4	4E-5	1E-7	-	-
73	Tantalum-175	W, see ^{172}Ta	6E+3	2E+4	7E-6	2E-8	8E-5	8E-4
		Y, see ^{172}Ta	-	1E+4	6E-6	2E-8	-	-
73	Tantalum-176	W, see ^{172}Ta	4E+3	1E+4	5E-6	2E-8	5E-5	5E-4
		Y, see ^{172}Ta	-	1E+4	5E-6	2E-8	-	-
73	Tantalum-177	W, see ^{172}Ta	1E+4	2E+4	8E-6	3E-8	2E-4	2E-3
		Y, see ^{172}Ta	-	2E+4	7E-6	2E-8	-	-
73	Tantalum-178	W, see ^{172}Ta	2E+4	9E+4	4E-5	1E-7	2E-4	2E-3
		Y, see ^{172}Ta	-	7E+4	3E-5	1E-7	-	-
73	Tantalum-179	W, see ^{172}Ta	2E+4	5E+3	2E-6	8E-9	3E-4	3E-3
		Y, see ^{172}Ta	-	9E+2	4E-7	1E-9	-	-
73	Tantalum-180	W, see ^{172}Ta	1E+3	4E+2	2E-7	6E-10	2E-5	2E-4
		Y, see ^{172}Ta	-	2E+1	1E-8	3E-11	-	-
73	Tantalum-180m	W, see ^{172}Ta	2E+4	7E+4	3E-5	9E-8	3E-4	3E-3
		Y, see ^{172}Ta	-	6E+4	2E-5	8E-8	-	-
73	Tantalum-182	W, see ^{172}Ta	8E+2	3E+2	1E-7	5E-10	1E-5	1E-4
		Y, see ^{172}Ta	-	1E+2	6E-8	2E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
73	Tantalum-182m[2]	W, see ^{172}Ta	2E+5	5E+5	2E-4	8E-7	-	-
			St wall (2E+5)	-	-	-	3E-3	3E-2
		Y, see ^{172}Ta	-	4E+5	2E-4	6E-7	-	-
73	Tantalum-183	W, see ^{172}Ta	9E+2	1E+3	5E-7	2E-9	-	-
			LLI wall (1E+3)	-	-	-	2E-5	2E-4
		Y, see ^{172}Ta	-	1E+3	4E-7	1E-9	-	-
73	Tantalum-184	W, see ^{172}Ta	2E+3	5E+3	2E-6	8E-9	3E-5	3E-4
		Y, see ^{172}Ta	-	5E+3	2E-6	7E-9	-	-
73	Tantalum-185[2]	W, see ^{172}Ta	3E+4	7E+4	3E-5	1E-7	4E-4	4E-3
		Y, see ^{172}Ta	-	6E+4	3E-5	9E-8	-	-
73	Tantalum-186[2]	W, see ^{172}Ta	5E+4	2E+5	1E-4	3E-7	-	-
			St wall (7E+4)	-	-	-	1E-3	1E-2
		Y, see ^{172}Ta	-	2E+5	9E-5	3E-7	-	-
43	Technetium-101[2]	D, see ^{93m}Tc	9E+4	3E+5	1E-4	5E-7	-	-
			St wall (1E+5)	-	-	-	2E-3	2E-2
		W, see ^{93m}Tc	-	4E+5	2E-4	5E-7	-	-
43	Technetium-104[2]	D, see ^{93m}Tc	2E+4	7E+4	3E-5	1E-7	-	-
			St wall (3E+4)	-	-	-	4E-4	4E-3
		W, see ^{93m}Tc	-	9E+4	4E-5	1E-7	-	-
43	Technetium-93	D, see ^{93m}Tc	3E+4	7E+4	3E-5	1E-7	4E-4	4E-3
		W, see ^{93m}Tc	-	1E+5	4E-5	1E-7	-	-
43	Technetium-93m[2]	D, all compounds except those given for W	7E+4	2E+5	6E-5	2E-7	1E-3	1E-2
		W, oxides, hydroxides, halides, and nitrates	-	3E+5	1E-4	4E-7	-	-
43	Technetium-94	D, see ^{93m}Tc	9E+3	2E+4	8E-6	3E-8	1E-4	1E-3
		W, see ^{93m}Tc	-	2E+4	1E-5	3E-8	-	-
43	Technetium-94m[2]	D, see ^{93m}Tc	2E+4	4E+4	2E-5	6E-8	3E-4	3E-3
		W, see ^{93m}Tc	-	6E+4	2E-5	8E-8	-	-
43	Technetium-95	D, see ^{93m}Tc	1E+4	2E+4	9E-6	3E-8	1E-4	1E-3
		W, see ^{93m}Tc	-	2E+4	8E-6	3E-8	-	-
43	Technetium-95m	D, see ^{93m}Tc	4E+3	5E+3	2E-6	8E-9	5E-5	5E-4
		W, see ^{93m}Tc	-	2E+3	8E-7	3E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
43	Technetium-96	D, see ^{93m}Tc	2E+3	3E+3	1E-6	5E-9	3E-5	3E-4
		W, see ^{93m}Tc	-	2E+3	9E-7	3E-9	-	-
43	Technetium-96m[2]	D, see ^{93m}Tc	2E+5	3E+5	1E-4	4E-7	2E-3	2E-2
		W, see ^{93m}Tc	-	2E+5	1E-4	3E-7	-	-
43	Technetium-97	D, see ^{93m}Tc	4E+4	5E+4	2E-5	7E-8	5E-4	5E-3
		W, see ^{93m}Tc	-	6E+3	2E-6	8E-9	-	-
43	Technetium-97m	D, see ^{93m}Tc	5E+3	7E+3	3E-6	-	6E-5	6E-4
			St wall -	(7E+3)	-	1E-8	-	-
		W, see ^{93m}Tc	-	1E+3	5E-7	2E-9	-	-
43	Technetium-98	D, see ^{93m}Tc	1E+3	2E+3	7E-7	2E-9	1E-5	1E-4
		W, see ^{93m}Tc	-	3E+2	1E-7	4E-10	-	-
43	Technetium-99	D, see ^{93m}Tc	4E+3	5E+3	2E-6	-	6E-5	6E-4
			-	St wall (6E+3)	-	8E-9	-	-
		W, see ^{93m}Tc	-	7E+2	3E-7	9E-10	-	-
43	Technetium-99m	D, see ^{93m}Tc	8E+4	2E+5	6E-5	2E-7	1E-3	1E-2
		W, see ^{93m}Tc	-	2E+5	1E-4	3E-7	-	-
52	Tellurium-116	D, all compounds except those given for W	8E+3	2E+4	9E-6	3E-8	1E-4	1E-3
		W, oxides, hydroxides, and nitrates	-	3E+4	1E-5	4E-8	-	-
52	Tellurium-121	D, see ^{116}Te	3E+3	4E+3	2E-6	6E-9	4E-5	4E-4
		W, see ^{116}Te	-	3E+3	1E-6	4E-9	-	-
52	Tellurium-121m	D, see ^{116}Te	5E+2	2E+2	8E-8	-	-	-
			Bone surf (7E+2)	Bone surf (4E+2)	-	5E-10	1E-5	1E-4
		W, see ^{116}Te	-	4E+2	2E-7	6E-10	-	-
52	Tellurium-123	D, see ^{116}Te	5E+2	2E+2	8E-8	-	-	-
			Bone surf (1E+3)	Bone surf (5E+2)	-	7E-10	2E-5	2E-4
		W, see ^{116}Te	-	4E+2	2E-7	-	-	-
			-	Bone surf (1E+3)	-	2E-9	-	-
52	Tellurium-123m	D, see ^{116}Te	6E+2	2E+2	9E-8	-	-	-
			Bone surf (1E+3)	Bone surf (5E+2)	-	8E-10	1E-5	1E-4
		W, see ^{116}Te	-	5E+2	2E-7	8E-10	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
52	Tellurium-125m	D, see ^{116}Te	1E+3 Bone surf (1E+3)	4E+2 Bone surf (1E+3)	2E-7 -	- 1E-9	- 2E-5	- 2E-4
		W, see ^{116}Te	-	7E+2	3E-7	1E-9	-	-
52	Tellurium-127	D, see ^{116}Te	7E+3	2E+4	9E-6	3E-8	1E-4	1E-3
		W, see ^{116}Te	-	2E+4	7E-6	2E-8	-	-
52	Tellurium-127m	D, see ^{116}Te	6E+2	3E+2 Bone surf (4E+2)	1E-7 -	- 6E-10	9E-6 -	9E-5 -
		W, see ^{116}Te	-	3E+2	1E-7	4E-10	-	-
52	Tellurium-129[2]	D, see ^{116}Te	3E+4	6E+4	3E-5	9E-8	4E-4	4E-3
		W, see ^{116}Te	-	7E+4	3E-5	1E-7	-	-
52	Tellurium-129m	D, see ^{116}Te	5E+2	6E+2	3E-7	9E-10	7E-6	7E-5
		W, see ^{116}Te	-	2E+2	1E-7	3E-10	-	-
52	Tellurium-131[2]	D, see ^{116}Te	3E+3 Thyroid (6E+3)	5E+3 Thyroid (1E+4)	2E-6 -	- 2E-8	- 8E-5	- 8E-4
		W, see ^{116}Te	- -	5E+3 Thyroid (1E+4)	2E-6 -	- 2E-8	- -	- -
52	Tellurium-131m	D, see ^{116}Te	3E+2 Thyroid (6E+2)	4E+2 Thyroid (1E+3)	2E-7 -	- 2E-9	- 8E-6	- 8E-5
		W, see ^{116}Te	- -	4E+2 Thyroid (9E+2)	2E-7 -	- 1E-9	- -	- -
52	Tellurium-132	D, see ^{116}Te	2E+2 Thyroid (7E+2)	2E+2 Thyroid (8E+2)	9E-8 -	- 1E-9	- 9E-6	- 9E-5
		W, see ^{116}Te	- -	2E+2 Thyroid (6E+2)	9E-8 -	- 9E-10	- -	- -
52	Tellurium-133[2]	D, see ^{116}Te	1E+4 Thyroid (3E+4)	2E+4 Thyroid (6E+4)	9E-6 -	- 8E-8	- 4E-4	- 4E-3
		W, see ^{116}Te	- -	2E+4 Thyroid (6E+4)	9E-6 -	- 8E-8	- -	- -
52	Tellurium-133m[2]	D, see ^{116}Te	3E+3 Thyroid (6E+3)	5E+3 Thyroid (1E+4)	2E-6 -	- 2E-8	- 9E-5	- 9E-4
		W, see ^{116}Te	- -	5E+3 Thyroid (1E+4)	2E-6 -	- 2E-8	- -	- -

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
52	Tellurium-134[2]	D, see ^{116}Te	2E+4 Thyroid (2E+4)	2E+4 Thyroid (5E+4)	1E-5 -	- 7E-8	- 3E-4	- 3E-3
		W, see ^{116}Te	- -	2E+4 Thyroid (5E+4)	1E-5 -	- 7E-8	- -	- -
65	Terbium-147[2]	W, all compounds	9E+3	3E+4	1E-5	5E-8	1E-4	1E-3
65	Terbium-149	W, all compounds	5E+3	7E+2	3E-7	1E-9	7E-5	7E-4
65	Terbium-150	W, all compounds	5E+3	2E+4	9E-6	3E-8	7E-5	7E-4
65	Terbium-151	W, all compounds	4E+3	9E+3	4E-6	1E-8	5E-5	5E-4
65	Terbium-153	W, all compounds	5E+3	7E+3	3E-6	1E-8	7E-5	7E-4
65	Terbium-154	W, all compounds	2E+3	4E+3	2E-6	6E-9	2E-5	2E-4
65	Terbium-155	W, all compounds	6E+3	8E+3	3E-6	1E-8	8E-5	8E-4
65	Terbium-156	W, all compounds	1E+3	1E+3	6E-7	2E-9	1E-5	1E-4
65	Terbium-156m (5.0 h)	W, all compounds	2E+4	3E+4	1E-5	4E-8	2E-4	2E-3
65	Terbium-156m (24.4 h)	W, all compounds	7E+3	8E+3	3E-6	1E-8	1E-4	1E-3
65	Terbium-157	W, all compounds	5E+4 LLI wall (5E+4)	3E+2 Bone surf (6E+2)	1E-7 -	- 8E-10	- 7E-4	- 7E-3
65	Terbium-158	W, all compounds	1E+3	2E+1	8E-9	3E-11	2E-5	2E-4
65	Terbium-160	W, all compounds	8E+2	2E+2	9E-8	3E-10	1E-5	1E-4
65	Terbium-161	W, all compounds	2E+3 LLI wall (2E+3)	2E+3 -	7E-7 -	2E-9 -	- 3E-5	- 3E-4
81	Thallium-194[2]	D, all compounds	3E+5 St wall (3E+5)	6E+5 -	2E-4 -	8E-7 -	- 4E-3	- 4E-2
81	Thallium-194m[2]	D, all compounds	5E+4 St wall (7E+4)	2E+5 -	6E-5 -	2E-7 -	- 1E-3	- 1E-2
81	Thallium-195[2]	D, all compounds	6E+4	1E+5	5E-5	2E-7	9E-4	9E-3

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
81	Thallium-197	D, all compounds	7E+4	1E+5	5E-5	2E-7	1E-3	1E-2
81	Thallium-198	D, all compounds	2E+4	3E+4	1E-5	5E-8	3E-4	3E-3
81	Thallium-198m[2]	D, all compounds	3E+4	5E+4	2E-5	8E-8	4E-4	4E-3
81	Thallium-199	D, all compounds	6E+4	8E+4	4E-5	1E-7	9E-4	9E-3
81	Thallium-200	D, all compounds	8E+3	1E+4	5E-6	2E-8	1E-4	1E-3
81	Thallium-201	D, all compounds	2E+4	2E+4	9E-6	3E-8	2E-4	2E-3
81	Thallium-202	D, all compounds	4E+3	5E+3	2E-6	7E-9	5E-5	5E-4
81	Thallium-204	D, all compounds	2E+3	2E+3	9E-7	3E-9	2E-5	2E-4
90	Thorium-226[2]	W, all compounds except those given for Y	5E+3 St wall (5E+3)	2E+2 -	6E-8 -	2E-10 -	- 7E-5	- 7E-4
		Y, oxides and hydroxides	-	1E+2	6E-8	2E-10	-	-
90	Thorium-227	W, see ^{226}Th	1E+2	3E-1	1E-10	5E-13	2E-6	2E-5
		Y, see ^{226}Th	-	3E-1	1E-10	5E-13	-	-
90	Thorium-228	W, see ^{226}Th	6E+0 Bone surf (1E+1)	1E-2 Bone surf (2E-2)	4E-12 -	- 3E-14	- 2E-7	- 2E-6
		Y, see ^{226}Th	-	2E-2	7E-12	2E-14	-	-
90	Thorium-229	W, see ^{226}Th	6E-1 Bone surf (1E+0)	9E-4 Bone surf (2E-3)	4E-13 -	- 3E-15	- 2E-8	- 2E-7
		Y, see ^{226}Th	- -	2E-3 Bone surf (3E-3)	1E-12 -	- 4E-15	- -	- -
90	Thorium-230	W, see ^{226}Th	4E+0 Bone surf (9E+0)	6E-3 Bone surf (2E-2)	3E-12 -	- 2E-14	- 1E-7	- 1E-6
		Y, see ^{226}Th	- -	2E-2 Bone surf (2E-2)	6E-12 -	- 3E-14	- -	- -
90	Thorium-231	W, see ^{226}Th	4E+3	6E+3	3E-6	9E-9	5E-5	5E-4
		Y, see ^{226}Th	-	6E+3	3E-6	9E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
90	Thorium-232	W, see ^{226}Th	7E-1	1E-3	5E-13	-	-	-
			Bone surf (2E+0)	Bone surf (3E-3)	-	4E-15	3E-8	3E-7
		Y, see ^{226}Th	-	3E-3	1E-12	-	-	-
			-	Bone surf (4E-3)	-	6E-15	-	-
90	Thorium-234	W, see ^{226}Th	3E+2	2E+2	8E-8	3E-10	-	-
			LLI wall (4E+2)	-	-	-	5E-6	5E-5
		Y, see ^{226}Th	-	2E+2	6E-8	2E-10	-	-
69	Thulium-162[2]	W, all compounds	7E+4	3E+5	1E-4	4E-7	-	-
			St wall (7E+4)	-	-	-	1E-3	1E-2
69	Thulium-166	W, all compounds	4E+3	1E+4	6E-6	2E-8	6E-5	6E-4
69	Thulium-167	W, all compounds	2E+3	2E+3	8E-7	3E-9	-	-
			LLI wall (2E+3)	-	-	-	3E-5	3E-4
69	Thulium-170	W, all compounds	8E+2	2E+2	9E-8	3E-10	-	-
			LLI wall (1E+3)	-	-	-	1E-5	1E-4
69	Thulium-171	W, all compounds	1E+4	3E+2	1E-7	-	-	-
			LLI wall (1E+4)	Bone surf (6E+2)	-	8E-10	2E-4	2E-3
69	Thulium-172	W, all compounds	7E+2	1E+3	5E-7	2E-9	-	-
			LLI wall (8E+2)	-	-	-	1E-5	1E-4
69	Thulium-173	W, all compounds	4E+3	1E+4	5E-6	2E-8	6E-5	6E-4
69	Thulium-175[2]	W, all compounds	7E+4	3E+5	1E-4	4E-7	-	-
			St wall (9E+4)	-	-	-	1E-3	1E-2
50	Tin-110	D, all compounds except those given for W	4E+3	1E+4	5E-6	2E-8	5E-5	5E-4
		W, sulfides, oxides, hydroxides, halides, nitrates, and stannic phosphate	-	1E+4	5E-6	2E-8	-	-
50	Tin-111[2]	D, see ^{110}Sn	7E+4	2E+5	9E-5	3E-7	1E-3	1E-2
		W, see ^{110}Sn	-	3E+5	1E-4	4E-7	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
50	Tin-113	D, see ^{110}Sn	2E+3	1E+3	5E-7	2E-9	-	-
			LLI wall (2E+3)	-	-	-	3E-5	3E-4
		W, see ^{110}Sn	-	5E+2	2E-7	8E-10	-	-
50	Tin-117m	D, see ^{110}Sn	2E+3	1E+3	5E-7	-	-	-
			LLI wall (2E+3)	Bone surf (2E+3)	-	3E-9	3E-5	3E-4
		W, see ^{110}Sn	-	1E+3	6E-7	2E-9	-	-
50	Tin-119m	D, see ^{110}Sn	3E+3	2E+3	1E-6	3E-9	-	-
			LLI wall (4E+3)	-	-	-	6E-5	6E-4
		W, see ^{110}Sn	-	1E+3	4E-7	1E-9	-	-
50	Tin-121	D, see ^{110}Sn	6E+3	2E+4	6E-6	2E-8	-	-
			LLI wall (6E+3)	-	-	-	8E-5	8E-4
		W, see ^{110}Sn	-	1E+4	5E-6	2E-8	-	-
50	Tin-121m	D, see ^{110}Sn	3E+3	9E+2	4E-7	1E-9	-	-
			LLI wall (4E+3)	-	-	-	5E-5	5E-4
		W, see ^{110}Sn	-	5E+2	2E-7	8E-10	-	-
50	Tin-123	D, see ^{110}Sn	5E+2	6E+2	3E-7	9E-10	-	-
			LLI wall (6E+2)	-	-	-	9E-6	9E-5
		W, see ^{110}Sn	-	2E+2	7E-8	2E-10	-	-
50	Tin-123m[2]	D, see ^{110}Sn	5E+4	1E+5	5E-5	2E-7	7E-4	7E-3
		W, see ^{110}Sn	-	1E+5	6E-5	2E-7	-	-
50	Tin-125	D, see ^{110}Sn	4E+2	9E+2	4E-7	1E-9	-	-
			LLI wall (5E+2)	-	-	-	6E-6	6E-5
		W, see ^{110}Sn	-	4E+2	1E-7	5E-10	-	-
50	Tin-126	D, see ^{110}Sn	3E+2	6E+1	2E-8	8E-11	4E-6	4E-5
		W, see ^{110}Sn	-	7E+1	3E-8	9E-11	-	-
50	Tin-127	D, see ^{110}Sn	7E+3	2E+4	8E-6	3E-8	9E-5	9E-4
		W, see ^{110}Sn	-	2E+4	8E-6	3E-8	-	-
50	Tin-128[2]	D, see ^{110}Sn	9E+3	3E+4	1E-5	4E-8	1E-4	1E-3
		W, see ^{110}Sn	-	4E+4	1E-5	5E-8	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
22	Titanium-44	D, all compounds except those given for W and Y	3E+2	1E+1	5E-9	2E-11	4E-6	4E-5
		W, oxides, hydroxides, carbides, halides, and nitrates	-	3E+1	1E-8	4E-11	-	-
		Y, SrTi0	-	6E+0	2E-9	8E-12	-	-
22	Titanium-45	D, see ^{44}Ti	9E+3	3E+4	1E-5	3E-8	1E-4	1E-3
		W, see ^{44}Ti	-	4E+4	1E-5	5E-8	-	-
		Y, see ^{44}Ti	-	3E+4	1E-5	4E-8	-	-
74	Tungsten-176	D, all compounds	1E+4	5E+4	2E-5	7E-8	1E-4	1E-3
74	Tungsten-177	D, all compounds	2E+4	9E+4	4E-5	1E-7	3E-4	3E-3
74	Tungsten-178	D, all compounds	5E+3	2E+4	8E-6	3E-8	7E-5	7E-4
74	Tungsten-179[2]	D, all compounds	5E+5	2E+6	7E-4	2E-6	7E-3	7E-2
74	Tungsten-181	D, all compounds	2E+4	3E+4	1E-5	5E-8	2E-4	2E-3
74	Tungsten-185	D, all compounds	2E+3	7E+3	3E-6	9E-9	-	-
			LLI wall (3E+3)	-	-	-	4E-5	4E-4
74	Tungsten-187	D, all compounds	2E+3	9E+3	4E-6	1E-8	3E-5	3E-4
74	Tungsten-188	D, all compounds	4E+2	1E+3	5E-7	2E-9	-	-
			LLI wall (5E+2)	-	-	-	7E-6	7E-5
92	Uranium-230	D, UF, UOF, UO(NO)	4E+0	4E-1	2E-10	-	-	-
			Bone surf (6E+0)	Bone surf (6E-1)	-	8E-13	8E-8	8E-7
		W, UO, UF, UCl	-	4E-1	1E-10	5E-13	-	-
		Y, UO, UO	-	3E-1	1E-10	4E-13	-	-
92	Uranium-231	D, see ^{230}U	5E+3	8E+3	3E-6	1E-8	-	-
			LLI wall (4E+3)	-	-	-	6E-5	6E-4
		W, see ^{230}U	-	6E+3	2E-6	8E-9	-	-
		Y, see ^{230}U	-	5E+3	2E-6	6E-9	-	-
92	Uranium-232	D, see ^{230}U	2E+0	2E-1	9E-11	-	-	-
			Bone surf (4E+0)	Bone surf (4E-1)	-	6E-13	6E-8	6E-7
		W, see ^{230}U	-	4E-1	2E-10	5E-13	-	-
		Y, see ^{230}U	-	8E-3	3E-12	1E-14	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
92	Uranium-233	D, see ^{230}U	1E+1 Bone surf (2E+1)	1E+0 Bone surf (2E+0)	5E-10	-	-	-
		W, see ^{230}U	-	7E-1	3E-10	3E-12	3E-7	3E-6
		Y, see ^{230}U	-	4E-2	2E-11	1E-12	-	-
92	Uranium-234[3]	D, see ^{230}U	1E+1 Bone surf (2E+1)	1E+0 Bone surf (2E+0)	5E-10	-	-	-
		W, see ^{230}U	-	7E-1	3E-10	3E-12	3E-7	3E-6
		Y, see ^{230}U	-	4E-2	2E-11	1E-12	-	-
92	Uranium-235[3]	D, see ^{230}U	1E+1 Bone surf (2E+1)	1E+0 Bone surf (2E+0)	6E-10	-	-	-
		W, see ^{230}U	-	8E-1	3E-10	3E-12	3E-7	3E-6
		Y, see ^{230}U	-	4E-2	2E-11	1E-12	-	-
92	Uranium-236	D, see ^{230}U	1E+1 Bone surf (2E+1)	1E+0 Bone surf (2E+0)	5E-10	-	-	-
		W, see ^{230}U	-	8E-1	3E-10	3E-12	3E-7	3E-6
		Y, see ^{230}U	-	4E-2	2E-11	1E-12	-	-
92	Uranium-237	D, see ^{230}U	2E+3 LLI wall (2E+3)	3E+3	1E-6	4E-9	-	-
		W, see ^{230}U	-	2E+3	7E-7	-	3E-5	3E-4
		Y, see ^{230}U	-	2E+3	6E-7	2E-9	-	-
92	Uranium-238[3]	D, see ^{230}U	1E+1 Bone surf (2E+1)	1E+0 Bone surf (2E+0)	6E-10	-	-	-
		W, see ^{230}U	-	8E-1	3E-10	3E-12	3E-7	3E-6
		Y, see ^{230}U	-	4E-2	2E-11	1E-12	-	-
92	Uranium-239[2]	D, see ^{230}U	7E+4	2E+5	8E-5	3E-7	9E-4	9E-3
		W, see ^{230}U	-	2E+5	7E-5	2E-7	-	-
		Y, see ^{230}U	-	2E+5	6E-5	2E-7	-	-
92	Uranium-240	D, see ^{230}U	1E+3	4E+3	2E-6	5E-9	2E-5	2E-4
		W, see ^{230}U	-	3E+3	1E-6	4E-9	-	-
		Y, see ^{230}U	-	2E+3	1E-6	3E-9	-	-
92	Uranium-natural[3]	D, see ^{230}U	1E+1 Bone surf (2E+1)	1E+0 Bone surf (2E+0)	5E-10	-	-	-
		W, see ^{230}U	-	8E-1	3E-10	3E-12	3E-7	3E-6
		Y, see ^{230}U	-	5E-2	2E-11	9E-13	-	-
						9E-14	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
23	Vanadium-47[2]	D, all compounds except those given for W	3E+4	8E+4	3E-5	1E-7	-	-
			St wall (3E+4)	-	-	-	4E-4	4E-3
		W, oxides, hydroxides, carbides, and halides	-	1E+5	4E-5	1E-7	-	-
23	Vanadium-48	D, see ^{47}V	6E+2	1E+3	5E-7	2E-9	9E-6	9E-5
		W, see ^{47}V	-	6E+2	3E-7	9E-10	-	-
23	Vanadium-49	D, see ^{47}V	7E+4	3E+4	1E-5	-	-	-
			LLI wall (9E+4)	Bone surf (3E+4)	-	5E-8	1E-3	1E-2
		W, see ^{47}V	-	2E+4	8E-6	2E-8	-	-
54	Xenon-120[2]	Submersion[1]	-	-	1E-5	4E-8	-	-
54	Xenon-121[2]	Submersion[1]	-	-	2E-6	1E-8	-	-
54	Xenon-122	Submersion[1]	-	-	7E-5	3E-7	-	-
54	Xenon-123	Submersion[1]	-	-	6E-6	3E-8	-	-
54	Xenon-125	Submersion[1]	-	-	2E-5	7E-8	-	-
54	Xenon-127	Submersion[1]	-	-	1E-5	6E-8	-	-
54	Xenon-129m	Submersion[1]	-	-	2E-4	9E-7	-	-
54	Xenon-131m	Submersion[1]	-	-	4E-4	2E-6	-	-
54	Xenon-133	Submersion[1]	-	-	1E-4	5E-7	-	-
54	Xenon-133m	Submersion[1]	-	-	1E-4	6E-7	-	-
54	Xenon-135	Submersion[1]	-	-	1E-5	7E-8	-	-
54	Xenon-135m[2]	Submersion[1]	-	-	9E-6	4E-8	-	-
54	Xenon-138[2]	Submersion[1]	-	-	4E-6	2E-8	-	-
70	Ytterbium-162[2]	W, all compounds except those given for Y	7E+4	3E+5	1E-4	4E-7	1E-3	1E-2
		Y, oxides, hydroxides, and fluorides	-	3E+5	1E-4	4E-7	-	-
70	Ytterbium-166	W, see ^{162}Yb	1E+3	2E+3	8E-7	3E-9	2E-5	2E-4
		Y, see ^{162}Yb	-	2E+3	8E-7	3E-9	-	-
70	Ytterbium-167[2]	W, see ^{162}Yb	3E+5	8E+5	3E-4	1E-6	4E-3	4E-2
		Y, see ^{162}Yb	-	7E+5	3E-4	1E-6	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (µCi)	ALI (µCi)	DAC (µCi/ml)	Air (µCi/ml)	Water (µCi/ml)	Monthly Average Concentration (µCi/ml)
70	Ytterbium-169	W, see ^{162}Yb	2E+3	8E+2	4E-7	1E-9	2E-5	2E-4
		Y, see ^{162}Yb	-	7E+2	3E-7	1E-9	-	-
70	Ytterbium-175	W, see ^{162}Yb	3E+3	4E+3	1E-6	5E-9	-	-
			LLI wall (3E+3)	-	-	-	4E-5	4E-4
		Y, see ^{162}Yb	-	3E+3	1E-6	5E-9	-	-
70	Ytterbium-177[2]	W, see ^{162}Yb	2E+4	5E+4	2E-5	7E-8	2E-4	2E-3
		Y, see ^{162}Yb	-	5E+4	2E-5	6E-8	-	-
70	Ytterbium-178[2]	W, see ^{162}Yb	1E+4	4E+4	2E-5	6E-8	2E-4	2E-3
		Y, see ^{162}Yb	-	4E+4	2E-5	5E-8	-	-
39	Yttrium-86	W, see ^{86m}Y	1E+3	3E+3	1E-6	5E-9	2E-5	2E-4
		Y, see ^{86m}Y	-	3E+3	1E-6	5E-9	-	-
39	Yttrium-86m[2]	W, all compounds except those given for Y	2E+4	6E+4	2E-5	8E-8	3E-4	3E-3
		Y, oxides and hydroxides	-	5E+4	2E-5	8E-8	-	-
39	Yttrium-87	W, see ^{86m}Y	2E+3	3E+3	1E-6	5E-9	3E-5	3E-4
		Y, see ^{86m}Y	-	3E+3	1E-6	5E-9	-	-
39	Yttrium-88	W, see ^{86m}Y	1E+3	3E+2	1E-7	3E-10	1E-5	1E-4
		Y, see ^{86m}Y	-	2E+2	1E-7	3E-10	-	-
39	Yttrium-90	W, see ^{86m}Y	4E+2	7E+2	3E-7	9E-10	-	-
			LLI wall (5E+2)	-	-	-	7E-6	7E-5
		Y, see ^{86m}Y	-	6E+2	3E-7	9E-10	-	-
39	Yttrium-90m	W, see ^{86m}Y	8E+3	1E+4	5E-6	2E-8	1E-4	1E-3
		Y, see ^{86m}Y	-	1E+4	5E-6	2E-8	-	-
39	Yttrium-91	W, see ^{86m}Y	5E+2	2E+2	7E-8	2E-10	-	-
			LLI wall (6E+2)	-	-	-	8E-6	8E-5
		Y, see ^{86m}Y	-	1E+2	5E-8	2E-10	-	-
39	Yttrium-91m[2]	W, see ^{86m}Y	1E+5	2E+5	1E-4	3E-7	2E-3	2E-2
		Y, see ^{86m}Y	-	2E+5	7E-5	2E-7	-	-
39	Yttrium-92	W, see ^{86m}Y	3E+3	9E+3	4E-6	1E-8	4E-5	4E-4
		Y, see ^{86m}Y	-	8E+3	3E-6	1E-8	-	-
39	Yttrium-93	W, see ^{86m}Y	1E+3	3E+3	1E-6	4E-9	2E-5	2E-4
		Y, see ^{86m}Y	-	2E+3	1E-6	3E-9	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (µCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (µCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (µCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (µCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (µCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (µCi/ml)
39	Yttrium-94[2]	W, see ^{86m}Y	2E+4 St wall (3E+4)	8E+4 -	3E-5 -	1E-7 -	- 4E-4	- 4E-3
		Y, see ^{86m}Y	-	8E+4	3E-5	1E-7	-	-
39	Yttrium-95[2]	W, see ^{86m}Y	4E+4 St wall (5E+4)	2E+5 -	6E-5 -	2E-7 -	- 7E-4	- 7E-3
		Y, see ^{86m}Y	-	1E+5	6E-5	2E-7	-	-
30	Zinc-62	Y, all compounds	1E+3	3E+3	1E-6	4E-9	2E-5	2E-4
30	Zinc-63[2]	Y, all compounds	2E+4 St wall (3E+4)	7E+4 -	3E-5 -	9E-8 -	- 3E-4	- 3E-3
30	Zinc-65	Y, all compounds	4E+2	3E+2	1E-7	4E-10	5E-6	5E-5
30	Zinc-69[2]	Y, all compounds	6E+4	1E+5	6E-5	2E-7	8E-4	8E-3
30	Zinc-69m	Y, all compounds	4E+3	7E+3	3E-6	1E-8	6E-5	6E-4
30	Zinc-71m	Y, all compounds	6E+3	2E+4	7E-6	2E-8	8E-5	8E-4
30	Zinc-72	Y, all compounds	1E+3	1E+3	5E-7	2E-9	1E-5	1E-4
40	Zirconium-86	D, all compounds except those given for W and Y	1E+3	4E+3	2E-6	6E-9	2E-5	2E-4
		W, oxides, hydroxides, halides, and nitrates	-	3E+3	1E-6	4E-9	-	-
		Y, carbide	-	2E+3	1E-6	3E-9	-	-
40	Zirconium-88	D, see ^{86}Zr	4E+3	2E+2	9E-8	3E-10	5E-5	5E-4
		W, see ^{86}Zr	-	5E+2	2E-7	7E-10	-	-
		Y, see ^{86}Zr	-	3E+2	1E-7	4E-10	-	-
40	Zirconium-89	D, see ^{86}Zr	2E+3	4E+3	1E-6	5E-9	2E-5	2E-4
		W, see ^{86}Zr	-	2E+3	1E-6	3E-9	-	-
		Y, see ^{86}Zr	-	2E+3	1E-6	3E-9	-	-
40	Zirconium-93	D, see ^{86}Zr	1E+3 Bone surf (3E+3)	6E+0 Bone surf (2E+1)	3E-9 -	- 2E-11	- 4E-5	- 4E-4
		W, see ^{86}Zr	-	2E+1 Bone surf (6E+1)	1E-8 -	- 9E-11	- -	- -
		Y, see ^{86}Zr	-	6E+1 Bone surf (7E+1)	2E-8 -	- 9E-11	- -	- -

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (μCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (μCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (μCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (μCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (μCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (μCi/ml)
40	Zirconium-95	D, see ^{86}Zr	1E+3	1E+2 Bone surf	5E-8	-	2E-5	2E-4
			-	(3E+2)	-	4E-10	-	-
		W, see ^{86}Zr	-	4E+2	2E-7	5E-10	-	-
		Y, see ^{86}Zr	-	3E+2	1E-7	4E-10	-	-
40	Zirconium-97	D, see ^{86}Zr	6E+2	2E+3	8E-7	3E-9	9E-6	9E-5
		W, see ^{86}Zr	-	1E+3	6E-7	2E-9	-	-
		Y, see ^{86}Zr	-	1E+3	5E-7	2E-9	-	-
-	Any single radionuclide not listed above with decay mode other than alpha emission or spontaneous fission and with radioactive half-life less than 2 hours	Submersion[1]	-	2E+2	1E-7	1E-9	-	-
-	Any single radionuclide not listed above with decay mode other than alpha emission or spontaneous fission and with radioactive half-life greater than 2 hour		-	2E-1	1E-10	1E-12	1E-8	1E-7
-	Any single radionuclide not listed above that decays by alpha emission or spontaneous fission, or any mixture for which either the identity or the concentration of any radionuclide in the mixture is not known		-	4E-4	2E-13	1E-15	2E-9	2E-8

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values Col. 1 Oral Ingestion ALI (μCi)	Table 4B1 Occupational Values Col. 2 Inhalation ALI (μCi)	Table 4B1 Occupational Values Col. 3 Inhalation DAC (μCi/ml)	Table 4B2 Effluent Concentrations Col. 1 Air (μCi/ml)	Table 4B2 Effluent Concentrations Col. 2 Water (μCi/ml)	Table 4B3 Releases to Sewers Monthly Average Concentration (μCi/ml)
NOTE:								
1.	If the identity of each radionuclide in a mixture is known but the concentration of one or more of the radionuclides in the mixture is not known, the DAC for the mixture shall be the most restrictive DAC of any radionuclide in the mixture.							
2.	If the identity of each radionuclide in the mixture is not known, but it is known that certain radionuclides specified in this appendix are not present in the mixture, the inhalation ALI, DAC, and effluent and sewage concentrations for the mixture are the lowest values specified in this appendix for any radionuclide that is not known to be absent from the mixture; or							
	If it is known that Ac-227-D and Cm-250-W are not present		-	7E-4	3E-13	-	-	-
	If, in addition, it is known that Ac-227-W,Y, Th-229-W,Y, Th-230-W, Th-232-W,Y, Pa-231-W,Y, Np-237-W, Pu-239-W, Pu-240-W, Pu-242-W, Am-241-W, Am-242m-W, Am-243-W, Cm-245-W, Cm-246-W, Cm-247-W, Cm-248-W, Bk-247-W, Cf-249-W, and Cf-251-W are not present		-	7E-3	3E-12	-	-	-
	If, in addition, it is known that Sm-146-W, Sm-147-W, Gd-148-D,W, Gd-152-D,W, Th-228-W,Y, Th-230-Y, U-232-Y, U-233-Y, U-234-Y, U-235-Y, U-236-Y, U-238-Y, Np-236-W, Pu-236-W,Y, Pu-238-W,Y, Pu-239-Y, Pu-240-Y, Pu-242-Y, Pu-244-W,Y, Cm-243-W, Cm-244-W, Cf-248-W, Cf-249-Y, Cf-250-W,Y, Cf-251-Y, Cf-252-W,Y, and Cf-254-W,Y are not present		-	7E-2	3E-11	-	-	-
	If, in addition, it is known that Pb-210-D, Bi-210m-W, Po-210-D,W, Ra-223-W, Ra-225-W, Ra-226-W, Ac-225-D,W,Y, Th-227-W,Y, U-230-D,W,Y, U-232-D,W, Pu-241-W, Cm-240-W, Cm-242-W, Cf-248-Y, Es-254-W, Fm-257-W, and Md-258-W are not present		-	7E-1	3E-10	-	-	-
	If, in addition, it is known that Si-32-Y, Ti-44-Y, Fe-60-D, Sr-90-Y, Zr-93-D, Cd-113m-D, Cd-113-D, In-115-D,W, La-138-D, Lu-176-W, Hf-178m-D,W, Hf-182-D,W, Bi-210m-D, Ra-224-W, Ra-228-W, Ac-226-D,W,Y, Pa-230-W,Y, U-233-D,W, U-234-D,W, U-235-D,W, U-236-D,W, U-238-D,W, Pu-241-Y, Bk-249-W, Cf-253-W,Y, and Es-253-W are not present		-	7E+0	3E-9	-	-	-

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (μCi)	ALI (μCi)	DAC (μCi/ml)	Air (μCi/ml)	Water (μCi/ml)	Monthly Average Concentration (μCi/ml)
	If it is known that Ac-227-D,W,Y, Th-229-W,Y, Th-232-W,Y, Pa-231-W,Y, Cm-248-W, and Cm-250-W are not present		-	-	-	1E-14	-	-
	If, in addition, it is known that Sm-146-W, Gd-148-D,W, Gd-152-D, Th-228-W,Y, Th-230-W,Y, U-232-Y, U-233-Y, U-234-Y, U-235-Y, U-236-Y, U-238-Y, U-Nat-Y, Np-236-W, Np-237-W, Pu-236-W,Y, Pu-238-W,Y, Pu-239-W,Y, Pu-240-W,Y, Pu-242-W,Y, Pu-244-W,Y, Am-241-W, Am-242m-W, Am-243-W, Cm-243-W, Cm-244-W, Cm-245-W, Cm-246-W, Cm-247-W, Bk-247-W, Cf-249-W,Y, Cf-250-W,Y, Cf-251-W,Y, Cf-252-W,Y, and Cf-254-W,Y are not present		-	-	-	1E-13	-	-
	If, in addition, it is known that Sm-147-W, Gd-152-W, Pb-210-D, Bi-210m-W, Po-210-D,W, Ra-223-W, Ra-225-W, Ra-226-W, Ac-225-D,W,Y, Th-227-W,Y, U-230-D,W,Y, U-232-D,W, U-Nat-W, Pu-241-W, Cm-240-W, Cm-242-W, Cf-248-W,Y, Es-254-W, Fm-257-W, and Md-258-W are not present				-	1E-12	-	-
	If, in addition it is known that Fe-60, Sr-90, Cd-113m, Cd-113, In-115, I-129, Cs-134, Sm-145, Sm-147, Gd-148, Gd-152, Hg-194 (organic), Bi-210m, Ra-223, Ra-224, Ra-225, Ac-225, Th-228, Th-230, U-233, U-234, U-235, U-236, U-238, U-Nat, Cm-242, Cf-248, Es-254, Fm-257, and Md-258 are not present-		-	-	-		1E-6	1E-5

3. If a mixture of radionuclides consists of uranium and its daughters in ore dust (10 μm AMAD particle distribution assumed) prior to chemical separation of the uranium from the ore, the following values may be used for the DAC of the mixture: 6E-11 μCi of gross alpha activity from uranium-238, uranium-234, thorium-230, and radium-226 per milliliter of air; 3E-11 μCi of natural uranium per milliliter of air; or 45 micrograms of natural uranium per cubic meter of air.

4. If the identity and concentration of each radionuclide in a mixture are known, the limiting values should be derived as follows: determine, for each radionuclide in the mixture, the ratio between the concentration present in the mixture and the concentration otherwise established in Appendix B to '' 20.1001 - 20.2401 for the specific radionuclide when not in a mixture. The sum of such ratios for all of the radionuclides in the mixture may not exceed "1" (i.e., "unity").

Example: If radionuclides "A," "B," and "C" are present in concentrations CA, CB, and CC, and if the applicable DACs are DAC_A, DAC_B, and DAC_C, respectively, then the concentrations shall be limited so that the following relationship exists:

$$\frac{C_A}{DAC_A} + \frac{C_B}{DAC_B} + \frac{C_C}{DAC_C} \leq 1$$

Atomic No.	Radionuclide	Class	Table 4B1 Occupational Values			Table 4B2 Effluent Concentrations		Table 4B3 Releases to Sewers
			Col. 1	Col. 2	Col. 3	Col. 1	Col. 2	
			Oral Ingestion	Inhalation				
			ALI (μCi)	ALI (μCi)	DAC (μCi/ml)	Air (μCi/ml)	Water (μCi/ml)	Monthly Average Concentration (μCi/ml)

FOOTNOTES:

[1]"Submersion" means that values given are for submersion in a hemispherical semi-infinite cloud of airborne material.

[2]These radionuclides have radiological half-lives of less than 2 hours. The total effective dose equivalent received during operations with these radionuclides might include a significant contribution from external exposure. The DAC values for all radionuclides, other than those designated Class "Submersion," are based upon the committed effective dose equivalent due to the intake of the radionuclide into the body and do NOT include potentially significant contributions to dose equivalent from external exposures. The licensee may substitute 1E-7 μCi/ml for the listed DAC to account for the submersion dose prospectively, but should use individual monitoring devices or other radiation measuring instruments that measure external exposure to demonstrate compliance with the limits. (See ' 20.1203.)

[3]For soluble mixtures of U-238, U-234, and U-235 in air, chemical toxicity may be the limiting factor (see ' 20.1201(e)). If the percent by weight (enrichment) of U-235 is not greater than 5, the concentration value for a 40-hour workweek is 0.2 milligrams uranium per cubic meter of air average. For any enrichment, the product of the average concentration and time of exposure during a 40-hour workweek shall not exceed 8E-3 (SA) μCi-hr/ml, where SA is the specific activity of the uranium inhaled. The specific activity for natural uranium is 6.77E-7 curies per gram U. The specific activity for other mixtures of U-238, U-235, and U-234, if not known, shall be:

SA = 3.6E-7 curies/gram U U-depleted

$SA = [0.4 + 0.38 (enrichment) + 0.0034 (enrichment)^2] E-6$, enrichment ≥ 0.72

where enrichment is the percentage by weight of U-235, expressed as percent.

PART 4, APPENDIX 4C: QUANTITIES OF LICENSED OR REGISTERED MATERIAL REQUIRING LABELING

QUANTITIES[j] OF LICENSED OR REGISTERED MATERIAL REQUIRING LABELING

~~* To convert µCi to kBq, multiply the µCi value by 37.~~

Comment [JJ10]: Due to a past typographical error in the spelling of the isotope "Gadolinium" in Table 4C and the complexity of formatting a single page, the Table 4C will be replaced in its entirety.

There are no changes to the table numerical values or isotopes in the table.

Comment [JJ11]: The revised table contains this information at the top of each table page.

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Actinium-224	1	Barium-126	1,000
Actinium-225	0.01	Barium-128	100
Actinium-226	0.1	Barium-131	100
Actinium-227	0.001	Barium-131m	1,000
Actinium-228	1	Barium-133	100
Aluminum-26	10	Barium-133m	100
Americium-237	1,000	Barium-135m	100
Americium-238	100	Barium-139	1,000
Americium-239	1,000	Barium-140	100
Americium-240	100	Barium-141	1,000
Americium-241	0.001	Barium-142	1,000
Americium-242	10	Berkelium-245	100
Americium-242m	0.001	Berkelium-246	100
Americium-243	0.001	Berkelium-247	0.001
Americium-244	10	Berkelium-249	0.1
Americium-244m	100	Berkelium-250	10
Americium-245	1,000	Beryllium-10	1
Americium-246	1,000	Beryllium-7	1,000
Americium-246	1,000	Bismuth-200	1,000
Antimony-115	1,000	Bismuth-201	1,000
Antimony-116	1,000	Bismuth-202	1,000
Antimony-116m	1,000	Bismuth-203	100
Antimony-117	1,000	Bismuth-205	100
Antimony-118m	1,000	Bismuth-206	100
Antimony-119	1,000	Bismuth-207	10

Antimony-120(16m)	1,000	.	Bismuth-210	1
Antimony-120(5.76d)	100	.	Bismuth-210m	0.1
Antimony-122	100	.	Bismuth-212	10
Antimony-124	10	.	Bismuth-213	10
Antimony-124m	1,000	.	Bismuth-214	100
Antimony-125	100	.	Bromine-74	1,000
Antimony-126	100	.	Bromine-74m	1,000
Antimony-126m	1,000	.	Bromine-75	1,000
Antimony-127	100	.	Bromine-76	100
Antimony-128(10.4m)	1,000	.	Bromine-77	1,000
Antimony-128(9.01 h)	100	.	Bromine-80	1,000
Antimony-129	100	.	Bromine-80m	1,000
Antimony-130	1,000	.	Bromine-82	100
Antimony-131	1,000	.	Bromine-83	1,000
Argon-39	1,000	.	Bromine-84	1,000
Argon-41	1,000	.	Cadmium-104	1,000
Arsenic-69	1,000	.	Cadmium-107	1,000
Arsenic-70	1,000	.	Cadmium-109	1
Arsenic-71	100	.	Cadmium-113	100
Arsenic-72	100	.	Cadmium-113m	0.1
Arsenic-73	100	.	Cadmium-115	100
Arsenic-74	100	.	Cadmium-115m	10
Arsenic-76	100	.	Cadmium-117	1,000
Arsenic-77	100	.	Cadmium-117m	1,000
Arsenic-78	1,000	.	Calcium-41	100
Astatine-207	100	.	Calcium-45	100

Astatine-211	10	.	Calcium-47	100
Californium-244	100	.	Curium-245	0.001
Californium-246	1	.	Curium-246	0.001
Californium-244	100	.	Curium-245	0.001
Californium-246	1	.	Curium-246	0.001
Californium-248	0.01	.	Curium-247	0.001
Californium-249	0.001	.	Curium-248	0.001
Californium-250	0.001	.	Curium-249	1,000
Californium-251	0.001	.	Dysprosium-155	1,000
Californium-252	0.001	.	Dysprosium-157	1,000
Californium-253	0.1	.	Dysprosium-159	100
Californium-254	0.001	.	Dysprosium-165	1,000
Carbon-11	1,000	.	Dysprosium-166	100
Carbon-14	1,000	.	Einsteinium-250	100
Cerium-134	100	.	Einsteinium-251	100
Cerium-135	100	.	Einsteinium-253	0.1
Cerium-137	1,000	.	Einsteinium-254	0.01
Cerium-137m	100	.	Einsteinium-254m	1
Cerium-139	100	.	Erbium-161	1,000
Cerium-141	100	.	Erbium-165	1,000
Cerium-143	100	.	Erbium-169	100
Cerium-144	1	.	Erbium-171	100
Cesium-125	1,000	.	Erbium-172	100
Cesium-127	1,000	.	Europium-145	100
Cesium-129	1,000	.	Europium-146	100
Cesium-130	1,000	.	Europium-147	100
Cesium-131	1,000	.	Europium-148	10

Cesium-132	100		Europium-149	100
Cesium-134	10		Europium-150 (12.62h)	100
Cesium-134m	1,000		Europium-150 (34.2y)	1
Cesium-135	100		Europium-152	1
Cesium-135m	1,000		Europium-152m	100
Cesium-136	10		Europium-154	1
Cesium-137	10		Europium-155	10
Cesium-138	1,000		Europium-156	100
Chlorine-36	10		Europium-157	100
Chlorine-38	1,000		Europium-158	1,000
Chlorine-39	1,000		Fermium-252	1
Chromium-48	1,000		Fermium-253	1
Chromium-49	1,000		Fermium-254	10
Chromium-51	1,000		Fermium-255	1
Cobalt-55	100		Fermium-257	0.01
Cobalt-56	10		Fluorine-18	1,000
Cobalt-57	100		Francium-222	100
Cobalt-58	100		Francium-223	100
Cobalt-58m	1,000		Gandolinium-145	1,000
Cobalt-60	1		Gandolinium-146	10
Cobalt-60m	1,000		Gandolinium-147	100
Cobalt-61	1,000		Gandolinium-148	0.001
Cobalt-62m	1,000		Gandolinium-149	100
Copper-60	1,000		Gandolinium-151	10
Copper-61	1,000		Gandolinium-152	100
Copper-64	1,000		Gandolinium-153	10
Copper-67	1,000		Gandolinium-159	100

215

Curium-238	100		Gallium-65	1,000
Curium-240	0.1		Gallium-66	100
Curium-241	1		Gallium-67	1,000
Curium-242	0.01		Gallium-68	1,000
Curium-243	0.001		Gallium-70	1,000
Curium-244	0.001		Gallium-72	100
Gallium-73	1,000		Indium-119m	1,000
Germanium-66	1,000		Iodine-120	100
Germanium-67	1,000		Iodine-120m	1,000
Germanium-68	10		Iodine-121	1,000
Germanium-69	1,000		Iodine-123	100
Germanium-71	1,000		Iodine-124	10
Germanium-75	1,000		Iodine-125	1
Germanium-77	1,000		Iodine-126	1
Germanium-78	1,000		Iodine-128	1,000
Gold-193	1,000		Iodine-129	1
Gold-194	100		Iodine-130	10
Gold-195	10		Iodine-131	1
Gold-198	100		Iodine-132	100
Gold-198m	100		Iodine-132m	100
Gold-199	100		Iodine-133	10
Gold-200	1,000		Iodine-134	1,000
Gold-200m	100		Iodine-135	100
Gold-201	1,000		Iridium-182	1,000
Hafnium-170	100		Iridium-184	1,000
Hafnium-172	1		Iridium-185	1,000
Hafnium-173	1,000		Iridium-186	100

Hafnium-175	100	.	Iridium-187	1,000
Hafnium-177m	1,000	.	Iridium-188	100
Hafnium-178m	0.1	.	Iridium-189	100
Hafnium-179m	10	.	Iridium-190	100
Hafnium-180m	1,000	.	Iridium-190m	1,000
Hafnium-181	10	.	Iridium-192 (73.8d)	1
Hafnium-182	0.1	.	Iridium-192m (1.4m)	10
Hafnium-182m	1,000	.	Iridium-194	100
Hafnium-183	1,000	.	Iridium-194m	10
Hafnium-184	100	.	Iridium-195	1,000
Holmium-155	1,000	.	Iridium-195m	1,000
Holmium-157	1,000	.	Iron-52	100
Holmium-159	1,000	.	Iron-55	100
Holmium-161	1,000	.	Iron-59	10
Holmium-162	1,000	.	Iron-60	1
Holmium-162m	1,000	.	Krypton-74	1,000
Holmium-164	1,000	.	Krypton-76	1,000
Holmium-164m	1,000	.	Krypton-77	1,000
Holmium-166	100	.	Krypton-79	1,000
Holmium-166m	1	.	Krypton-81	1,000
Holmium-167	1,000	.	Krypton-83m	1,000
Hydrogen-3	1,000	.	Krypton-85	1,000
Indium-109	1,000	.	Krypton-85m	1,000
Indium-110 (69.1m)	1,000	.	Krypton-87	1,000
Indium-110m (4.9h)	1,000	.	Krypton-88	1,000
Indium-111	100	.	Lanthanum-131	1,000
Indium-112	1,000	.	Lanthanum-132	100

217

Indium-113m	1,000	.	Lanthanum-135	1,000
Indium-114m	10	.	Lanthanum-137	10
Indium-115	100	.	Lanthanum-138	100
Indium-115m	1,000	.	Lanthanum-14	1,000
Indium-116m	1,000	.	Lanthanum-140	100
Indium-117	1,000	.	Lanthanum-141	100
Indium-117m	1,000	.	Lanthanum-143	1,000
Lead-195m	1,000	.	Neodymium-147	100
Lead-198	1,000	.	Neodymium-149	1,000
Lead-199	1,000	.	Neodymium-151	1,000
Lead-200	100	.	Neptunium-232	100
Lead-201	1,000	.	Neptunium-233	1,000
Lead-202	10	.	Neptunium-235	100
Lead-202m	1,000	.	Neptunium-236 (1.15E+5y)	0.001
Lead-203	1,000	.	Neptunium-236 (22.5h)	1
Lead-205	100	.	Neptunium-237	0.001
Lead-209	1,000	.	Neptunium-238	10
Lead-210	0.01	.	Neptunium-239	100
Lead-211	100	.	Neptunium-240	1,000
Lead-212	1	.	Neptunium-234	100
Lead-214	100	.	Nickel-56	100
Lutetium-169	100	.	Nickel-57	100
Lutetium-170	100	.	Nickel-59	100
Lutetium-171	100	.	Nickel-63	100
Lutetium-172	100	.	Nickel-65	1,000
Lutetium-173	10	.	Nickel-66	10
Lutetium-174	10	.	Niobium-88	1,000

Lutetium-174m	10	.	Niobium-89 (122 min)	1,000
Lutetium-176	100	.	Niobium-89m (66 min)	1,000
Lutetium-176m	1,000	.	Niobium-90	100
Lutetium-177	100	.	Niobium-93m	10
Lutetium-177m	10	.	Niobium-94	1
Lutetium-178	1,000	.	Niobium-95	100
Lutetium-178m	1,000	.	Niobium-95m	100
Lutetium-179	1,000	.	Niobium-96	100
Magnesium-28	100	.	Niobium-97	1,000
Manganese-51	1,000	.	Niobium-98	1,000
Manganese-52	100	.	Osmium-180	1,000
Manganese-52m	1,000	.	Osmium-181	1,000
Manganese-53	1,000	.	Osmium-182	100
Manganese-54	100	.	Osmium-185	100
Manganese-56	1,000	.	Osmium-189m	1,000
Mendelevium-257	10	.	Osmium-191	100
Mendelevium-258	0.01	.	Osmium-191m	1,000
Mercury-193	1,000	.	Osmium-193	100
Mercury-193m	100	.	Osmium-194	1
Mercury-194	1	.	Palladium-100	100
Mercury-195	1,000	.	Palladium-101	1,000
Mercury-195m	100	.	Palladium-103	100
Mercury-197	1,000	.	Palladium-107	10
Mercury-197m	100	.	Palladium-109	100
Mercury-199m	1,000	.	Phosphorus-32	10
Mercury-203	100	.	Phosphorus-33	100
Molybdenum-101	1,000	.	Platinum-186	1,000

Molybdenum-90	100		Platinum-188	100
Molybdenum-93	10		Platinum-189	1,000
Molybdenum-93m	100		Platinum-191	100
Molybdenum-99	100		Platinum-193	1,000
Neodymium-136	1,000		Platinum-193m	100
Neodymium-138	100		Platinum-195m	100
Neodymium-139	1,000		Platinum-197	100
Neodymium-139m	1,000		Platinum-197m	1,000
Neodymium-141	1,000			
Platinum-199	1,000		Radium-225	0.1
Platinum-200	100		Radium-226	0.1
Plutonium-234	10		Radium-227	1,000
Plutonium-235	1,000		Radium-228	0.1
Plutonium-236	0.001		Radon-220	1
Plutonium-237	100		Radon-222	1
Plutonium-238	0.001		Rhenium-177	1,000
Plutonium-239	0.001		Rhenium-178	1,000
Plutonium-240	0.001		Rhenium-181	1,000
Plutonium-241	0.01		Rhenium–182 (12.7h)	1,000
Plutonium-242	0.001		Rhenium–182 (64.0h)	100
Plutonium-243	1,000		Rhenium-184	100
Plutonium-244	0.001		Rhenium-184m	10
Plutonium-245	100		Rhenium-186	100
Polonium-203	1,000		Rhenium-186m	10
Polonium-205	1,000		Rhenium-187	1,000
Polonium-207	1,000		Rhenium-188	100
Polonium-210	0.1		Rhenium-188m	1,000

Potassium-40	100		Rhenium-189	100
Potassium-42	1,000		Rhodium-100	100
Potassium-43	1,000		Rhodium-101	10
Potassium-44	1,000		Rhodium-101m	1,000
Potassium-45	1,000		Rhodium-102	10
Praseodymium-136	1,000		Rhodium-102m	10
Praseodymium-137	1,000		Rhodium-103m	1,000
Praseodymium-138m	1,000		Rhodium-105	100
Praseodymium-139	1,000		Rhodium-106m	1,000
Praseodymium-142	100		Rhodium-107	1,000
Praseodymium-142m	1,000		Rhodium-99	100
Praseodymium-143	100		Rhodium-99m	1,000
Praseodymium-144	1,000		Rubidium-79	1,000
Praseodymium-145	100		Rubidium-81	1,000
Praseodymium-147	1,000		Rubidium-81m	1,000
Promethium-141	1,000		Rubidium-82m	1,000
Promethium-143	100		Rubidium-83	100
Promethium-144	10		Rubidium-84	100
Promethium-145	10		Rubidium-86	100
Promethium-146	1		Rudidium-87	100
Promethium-147	10		Rubidium-88	1,000
Promethium-148	10		Rubidium-89	1,000
Promethium-148m	10		Ruthenium-103	100
Promethium-149	100		Ruthenium-105	1,000
Promethium-150	1,000		Ruthenium-106	1
Promethium-151	100		Ruthenium-94	1,000
Protactinium-227	10		Ruthenium-97	1,000

Protactinium-228	1		Samarium-141	1,000
Protactinium-230	0.1		Samarium-141m	1,000
Protactinium-231	0.001		Samarium-142	1,000
Protactinium-232	1		Samarium-145	100
Protactinium-233	100		Samarium-146	1
Protactinium-234	100		Samarium-147	100
Radium-223	0.1		Samarium-151	10
Radium-224	0.1		Samarium-153	100
Samarium-155	1,000		Tantalum-182m	1,000
Samarium-156	1,000		Tantalum-183	100
Scandium-43	1,000		Tantalum-184	100
Scandium-44	100		Tantalum-185	1,000
Scandium-44m	100		Tantalum-186	1,000
Scandium-46	10		Technetium-101	1,000
Scandium-47	100		Technetium-104	1,000
Scandium-48	10		Technetium-93	1,000
Scandium-49	1,000		Technetium-93m	1,000
Selenium-70	1,000		Technetium-94	1,000
Selenium-73	100		Technetium-94m	1,000
Selenium-73m	1,000		Technetium-96	100
Selenium-75	100		Technetium-96m	1,000
Selenium-79	100		Technetium-97	1,000
Selenium-81	1,000		Technetium-97m	100
Selenium-81m	1,000		Technetium-98	10
Selenium-83	1,000		Technetium-99	100
Silicon-2	1		Technetium-99m	1,000
Silicon-31	1,000		Tellurium-116	1,000

Silver-102	1,000		Tellurium-121	100
Silver-103	1,000		Tellurium-121m	10
Silver-104	1,000		Tellurium-123	100
Silver-104m	1,000		Tellurium-123m	10
Silver-105	100		Tellurium-125m	10
Silver-106	1,000		Tellurium-127	1,000
Silver-106m	100		Tellurium-127m	10
Silver-108m	1		Tellurium-129	1,000
Silver-111	100		Tellurium-129m	10
Silver-112	100		Tellurium-131	100
Silver-115	1,000		Tellurium-131m	10
Silver-110m	10		Tellurium-132	10
Sodium-22	10		Tellurium-133	1,000
Sodium-24	100		Tellurium-133m	100
Strontium-80	100		Tellurium-134	1,000
Strontium-81	1,000		Terbium-147	1,000
Strontium-83	100		Terbium-149	100
Strontium-85	100		Terbium-150	1,000
Strontium-85m	1,000		Terbium-151	100
Strontium-87m	1,000		Terbium-153	1,000
Strontium-89	10		Terbium-154	100
Strontium-90	0.1		Terbium-155	1,000
Strontium-91	100		Terbium-156	100
Strontium-92	100		Terbium-156m (5.0h)	1,000
Sulfur-35	100		Terbium-156m (24.4h)	1,000
Tantalum-172	1,000		Terbium-157	10
Tantalum-173	1,000		Terbium-158	1

Tantalum-174	1,000		Terbium-160	10
Tantalum-175	1,000		Terbium-161	100
Tantalum-176	100		Thallium-194	1,000
Tantalum-177	1,000		Thallium-194m	1,000
Tantalum-178	1,000		Thallium-195	1,000
Tantalum-179	100		Thallium-197	1,000
Tantalum-180	100		Thallium-198	1,000
Tantalum-180m	1,000		Thallium-198m	1,000
Tantalum-182	10		Thallium-199	1,000
Thallium-200	1,000		Uranium-231	100
Thallium-201	1,000		Uranium-232	0.001
Thallium-202	100		Uranium-233	0.001
Thallium-204	100		Uranium-234	0.001
Thorium-226	10		Uranium-235	0.001
Thorium-227	0.01		Uranium-236	0.001
Thorium-228	0.001		Uranium-237	100
Thorium-229	0.001		Uranium-238	100
Thorium-230	0.001		Uranium-239	1,000
Thorium-231	100		Uranium-240	100
Thorium-232	100		Uranium-natural	100
Thorium-234	10		Vanadium-47	1,000
Thorium-natural	100		Vanadium-48	100
Thulium-162	1,000		Vanadium-49	1,000
Thulium-166	100		Xenon-120	1,000
Thulium-167	100		Xenon-121	1,000
Thulium-170	10		Xenon-122	1,000
Thulium-171	10		Xenon-123	1,000

224

Thulium-172	100	.	Xenon-125	1,000
Thulium-173	100	.	Xenon-127	1,000
Thulium-175	1,000	.	Xenon-129m	1,000
Tin-110	100	.	Xenon-131m	1,000
Tin-111	1,000	.	Xenon-133	1,000
Tin-113	100	.	Xenon-133m	1,000
Tin-117m	100	.	Xenon-135	1,000
Tin-119m	100	.	Xenon-135m	1,000
Tin-121	1,000	.	Xenon-138	1,000
Tin-121m	100	.	Ytterbium-162	1,000
Tin-123	10	.	Ytterbium-166	100
Tin-123m	1,000	.	Ytterbium-167	1,000
Tin-125	10	.	Ytterbium-169	100
Tin-126	10	.	Ytterbium-175	100
Tin-127	1,000	.	Ytterbium-177	1,000
Tin-128	1,000	.	Ytterbium-178	1,000
Titanium-44	1	.	Yttrium-86	100
Titanium-45	1,000	.	Yttrium-86m	1,000
Tungsten-176	1,000	.	Yttrium-87	100
Tungsten-177	1,000	.	Yttrium-88	10
Tungsten-178	1,000	.	Yttrium-90	10
Tungsten-179	1,000	.	Yttrium-90m	1,000
Tungsten-18	100	.	Yttrium-91	10
Tungsten-181	1,000	.	Yttrium-91m	1,000
Tungsten-187	100	.	Yttrium-92	100
Tungsten-188	10	.	Yttrium-93	100
Uranium-230	0.01	.	Yttrium-94	1,000

		Yttrium-95	1,000
Zinc-62	100		
Zinc-63	1,000		
Zinc-65	10		
Zinc-69	1,000		
Zinc-69m	100		
Zinc-71m	1,000		
Zinc-72	100		
Zirconium-86	100		
Zirconium-88	10		
Zirconium-89	100		
Zirconium-93	1		
Zirconium-95	10		
Zirconium-97	100		
Any alpha-emitting radionuclide not listed above or mixtures of alpha emitters of unknown composition	0.001	Any radionuclide other than alpha-emitting radionuclides not listed above, or mixtures of beta emitters of unknown composition	0.01

226

227

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
* To convert µCi to kBq, multiply the µCi value by 37.			
Actinium-224	1	Barium-126	1,000
Actinium-225	0.01	Barium-128	100
Actinium-226	0.1	Barium-131	100
Actinium-227	0.001	Barium-131m	1,000
Actinium-228	1	Barium-133	100
Aluminum-26	10	Barium-133m	100
Americium-237	1,000	Barium-135m	100
Americium-238	100	Barium-139	1,000
Americium-239	1,000	Barium-140	100
Americium-240	100	Barium-141	1,000
Americium-241	0.001	Barium-142	1,000
Americium-242	10	Berkelium-245	100
Americium-242m	0.001	Berkelium-246	100
Americium-243	0.001	Berkelium-247	0.001
Americium-244	10	Berkelium-249	0.1
Americium-244m	100	Berkelium-250	10
Americium-245	1,000	Beryllium-10	1

Comment [JJ12]:

This new table will replace Table 4C in its entirety to correct the typographical error with the isotope "Gadolinium".

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Americium-246	1,000	Beryllium-7	1,000
Americium-246	1,000	Bismuth-200	1,000
Antimony-115	1,000	Bismuth-201	1,000
Antimony-116	1,000	Bismuth-202	1,000
Antimony-116m	1,000	Bismuth-203	100
Antimony-117	1,000	Bismuth-205	100
Antimony-118m	1,000	Bismuth-206	100
Antimony-119	1,000	Bismuth-207	10
Antimony-120(16m)	1,000	Bismuth-210	1
Antimony-120(5.76d)	100	Bismuth-210m	0.1
Antimony-122	100	Bismuth-212	10
Antimony-124	10	Bismuth-213	10
Antimony-124m	1,000	Bismuth-214	100
Antimony-125	100	Bromine-74	1,000
Antimony-126	100	Bromine-74m	1,000
Antimony-126m	1,000	Bromine-75	1,000
Antimony-127	100	Bromine-76	100
Antimony-128(10.4m)	1,000	Bromine-77	1,000
Antimony-128(9.01 h)	100	Bromine-80	1,000
Antimony-129	100	Bromine-80m	1,000
Antimony-130	1,000	Bromine-82	100
Antimony-131	1,000	Bromine-83	1,000
Argon-39	1,000	Bromine-84	1,000
Argon-41	1,000	Cadmium-104	1,000
Arsenic-69	1,000	Cadmium-107	1,000
Arsenic-70	1,000	Cadmium-109	1
Arsenic-71	100	Cadmium-113	100
Arsenic-72	100	Cadmium-113m	0.1
Arsenic-73	100	Cadmium-115	100
Arsenic-74	100	Cadmium-115m	10
Arsenic-76	100	Cadmium-117	1,000
Arsenic-77	100	Cadmium-117m	1,000
Arsenic-78	1,000	Calcium-41	100
Astatine-207	100	Calcium-45	100
Astatine-211	10	Calcium-47	100
Californium-244	100	Curium-245	0.001
Californium-246	1	Curium-246	0.001
Californium-244	100	Curium-245	0.001
Californium-246	1	Curium-246	0.001
Californium-248	0.01	Curium-247	0.001
Californium-249	0.001	Curium-248	0.001
Californium-250	0.001	Curium-249	1,000
Californium-251	0.001	Dysprosium-155	1,000
Californium-252	0.001	Dysprosium-157	1,000

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Californium-253	0.1	Dysprosium-159	100
Californium-254	0.001	Dysprosium-165	1,000
Carbon-11	1,000	Dysprosium-166	100
Carbon-14	1,000	Einsteinium-250	100
Cerium-134	100	Einsteinium-251	100
Cerium-135	100	Einsteinium-253	0.1
Cerium-137	1,000	Einsteinium-254	0.01
Cerium-137m	100	Einsteinium-254m	1
Cerium-139	100	Erbium-161	1,000
Cerium-141	100	Erbium-165	1,000
Cerium-143	100	Erbium-169	100
Cerium-144	1	Erbium-171	100
Cesium-125	1,000	Erbium-172	100
Cesium-127	1,000	Europium-145	100
Cesium-129	1,000	Europium-146	100
Cesium-130	1,000	Europium-147	100
Cesium-131	1,000	Europium-148	10
Cesium-132	100	Europium-149	100
Cesium-134	10	Europium-150 (12.62h)	100
Cesium-134m	1,000	Europium-150 (34.2y)	1
Cesium-135	100	Europium-152	1
Cesium-135m	1,000	Europium-152m	100
Cesium-136	10	Europium-154	1
Cesium-137	10	Europium-155	10
Cesium-138	1,000	Europium-156	100
Chlorine-36	10	Europium-157	100
Chlorine-38	1,000	Europium-158	1,000
Chlorine-39	1,000	Fermium-252	1
Chromium-48	1,000	Fermium-253	1
Chromium-49	1,000	Fermium-254	10
Chromium-51	1,000	Fermium-255	1
Cobalt-55	100	Fermium-257	0.01
Cobalt-56	10	Fluorine-18	1,000
Cobalt-57	100	Francium-222	100
Cobalt-58	100	Francium-223	100
Cobalt-58m	1,000	Gadolinium-145	1,000
Cobalt-60	1	Gadolinium-146	10
Cobalt-60m	1,000	Gadolinium-147	100
Cobalt-61	1,000	Gadolinium-148	0.001
Cobalt-62m	1,000	Gadolinium-149	100
Copper-60	1,000	Gadolinium-151	10
Copper-61	1,000	Gadolinium-152	100
Copper-64	1,000	Gadolinium-153	10
Copper-67	1,000	Gadolinium-159	100

Comment [JJ13]: The isotope Gadolinium is is spelled incorrectly in the current Table 4C.

The proposed change corrects this typographical error.

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Curium-238	100	Gallium-65	1,000
Curium-240	0.1	Gallium-66	100
Curium-241	1	Gallium-67	1,000
Curium-242	0.01	Gallium-68	1,000
Curium-243	0.001	Gallium-70	1,000
Curium-244	0.001	Gallium-72	100
Gallium-73	1,000	Indium-119m	1,000
Germanium-66	1,000	Iodine-120	100
Germanium-67	1,000	Iodine-120m	1,000
Germanium-68	10	Iodine-121	1,000
Germanium-69	1,000	Iodine-123	100
Germanium-71	1,000	Iodine-124	10
Germanium-75	1,000	Iodine-125	1
Germanium-77	1,000	Iodine-126	1
Germanium-78	1,000	Iodine-128	1,000
Gold-193	1,000	Iodine-129	1
Gold-194	100	Iodine-130	10
Gold-195	10	Iodine-131	1
Gold-198	100	Iodine-132	100
Gold-198m	100	Iodine-132m	100
Gold-199	100	Iodine-133	10
Gold-200	1,000	Iodine-134	1,000
Gold-200m	100	Iodine-135	100
Gold-201	1,000	Iridium-182	1,000
Hafnium-170	100	Iridium-184	1,000
Hafnium-172	1	Iridium-185	1,000
Hafnium-173	1,000	Iridium-186	100
Hafnium-175	100	Iridium-187	1,000
Hafnium-177m	1,000	Iridium-188	100
Hafnium-178m	0.1	Iridium-189	100
Hafnium-179m	10	Iridium-190	100
Hafnium-180m	1,000	Iridium-190m	1,000
Hafnium-181	10	Iridium-192 (73.8d)	1
Hafnium-182	0.1	Iridium-192m (1.4m)	10
Hafnium-182m	1,000	Iridium-194	100
Hafnium-183	1,000	Iridium-194m	10
Hafnium-184	100	Iridium-195	1,000
Holmium-155	1,000	Iridium-195m	1,000
Holmium-157	1,000	Iron-52	100
Holmium-159	1,000	Iron-55	100
Holmium-161	1,000	Iron-59	10
Holmium-162	1,000	Iron-60	1
Holmium-162m	1,000	Krypton-74	1,000
Holmium-164	1,000	Krypton-76	1,000

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Holmium-164m	1,000	Krypton-77	1,000
Holmium-166	100	Krypton-79	1,000
Holmium-166m	1	Krypton-81	1,000
Holmium-167	1,000	Krypton-83m	1,000
Hydrogen-3	1,000	KryTpton-85	1,000
Indium-109	1,000	Krypton-85m	1,000
Indium-110 (69.1m)	1,000	Krypton-87	1,000
Indium-110m (4.9h)	1,000	Krypton-88	1,000
Indium-111	100	Lanthanum-131	1,000
Indium-112	1,000	Lanthanum-132	100
Indium-113m	1,000	Lanthanum-135	1,000
Indium-114m	10	Lanthanum-137	10
Indium-115	100	Lanthanum-138	100
Indium-115m	1,000	Lanthanum-14	1,000
Indium-116m	1,000	Lanthanum-140	100
Indium-117	1,000	Lanthanum-141	100
Indium-117m	1,000	Lanthanum-143	1,000
Lead-195m	1,000	Neodymium-147	100
Lead-198	1,000	Neodymium-149	1,000
Lead-199	1,000	Neodymium-151	1,000
Lead-200	100	Neptunium-232	100
Lead-201	1,000	Neptunium-233	1,000
Lead-202	10	Neptunium-235	100
Lead-202m	1,000	Neptunium-236 (1.15E+5y)	0.001
Lead-203	1,000	Neptunium-236 (22.5h)	1
Lead-205	100	Neptunium-237	0.001
Lead-209	1,000	Neptunium-238	10
Lead-210	0.01	Neptunium-239	100
Lead-211	100	Neptunium-240	1,000
Lead-212	1	Neptunium-234	100
Lead-214	100	Nickel-56	100
Lutetium-169	100	Nickel-57	100
Lutetium-170	100	Nickel-59	100
Lutetium-171	100	Nickel-63	100
Lutetium-172	100	Nickel-65	1,000
Lutetium-173	10	Nickel-66	10
Lutetium-174	10	Niobium-88	1,000
Lutetium-174m	10	Niobium-89 (122 min)	1,000
Lutetium-176	100	Niobium-89m (66 min)	1,000
Lutetium-176m	1,000	Niobium-90	100
Lutetium-177	100	Niobium-93m	10
Lutetium-177m	10	Niobium-94	1
Lutetium-178	1,000	Niobium-95	100
Lutetium-178m	1,000	Niobium-95m	100

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Lutetium-179	1,000	Niobium-96	100
Magnesium-28	100	Niobium-97	1,000
Manganese-51	1,000	Niobium-98	1,000
Manganese-52	100	Osmium-180	1,000
Manganese-52m	1,000	Osmium-181	1,000
Manganese-53	1,000	Osmium-182	100
Manganese-54	100	Osmium-185	100
Manganese-56	1,000	Osmium-189m	1,000
Mendelevium-257	10	Osmium-191	100
Mendelevium-258	0.01	Osmium-191m	1,000
Mercury-193	1,000	Osmium-193	100
Mercury-193m	100	Osmium-194	1
Mercury-194	1	Palladium-100	100
Mercury-195	1,000	Palladium-101	1,000
Mercury-195m	100	Palladium-103	100
Mercury-197	1,000	Palladium-107	10
Mercury-197m	100	Palladium-109	100
Mercury-199m	1,000	Phosphorus-32	10
Mercury-203	100	Phosphorus-33	100
Molybdenum-101	1,000	Platinum-186	1,000
Molybdenum-90	100	Platinum-188	100
Molybdenum-93	10	Platinum-189	1,000
Molybdenum-93m	100	Platinum-191	100
Molybdenum-99	100	Platinum-193	1,000
Neodymium-136	1,000	Platinum-193m	100
Neodymium-138	100	Platinum-195m	100
Neodymium-139	1,000	Platinum-197	100
Neodymium-139m	1,000	Platinum-197m	1,000
Neodymium-141	1,000		
Platinum-199	1,000	Radium-225	0.1
Platinum-200	100	Radium-226	0.1
Plutonium-234	10	Radium-227	1,000
Plutonium-235	1,000	Radium-228	0.1
Plutonium-236	0.001	Radon-220	1
Plutonium-237	100	Radon-222	1
Plutonium-238	0.001	Rhenium-177	1,000
Plutonium-239	0.001	Rhenium-178	1,000
Plutonium-240	0.001	Rhenium-181	1,000
Plutonium-241	0.01	Rhenium–182 (12.7h)	1,000
Plutonium-242	0.001	Rhenium–182 (64.0h)	100
Plutonium-243	1,000	Rhenium-184	100
Plutonium-244	0.001	Rhenium-184m	10
Plutonium-245	100	Rhenium-186	100
Polonium-203	1,000	Rhenium-186m	10

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Polonium-205	1,000	Rhenium-187	1,000
Polonium-207	1,000	Rhenium-188	100
Polonium-210	0.1	Rhenium-188m	1,000
Potassium-40	100	Rhenium-189	100
Potassium-42	1,000	Rhodium-100	100
Potassium-43	1,000	Rhodium-101	10
Potassium-44	1,000	Rhodium-101m	1,000
Potassium-45	1,000	Rhodium-102	10
Praseodymium-136	1,000	Rhodium-102m	10
Praseodymium-137	1,000	Rhodium-103m	1,000
Praseodymium-138m	1,000	Rhodium-105	100
Praseodymium-139	1,000	Rhodium-106m	1,000
Praseodymium-142	100	Rhodium-107	1,000
Praseodymium-142m	1,000	Rhodium-99	100
Praseodymium-143	100	Rhodium-99m	1,000
Praseodymium-144	1,000	Rubidium-79	1,000
Praseodymium-145	100	Rubidium-81	1,000
Praseodymium-147	1,000	Rubidium-81m	1,000
Promethium-141	1,000	Rubidium-82m	1,000
Promethium-143	100	Rubidium-83	100
Promethium-144	10	Rubidium-84	100
Promethium-145	10	Rubidium-86	100
Promethium-146	1	Rudidium-87	100
Promethium-147	10	Rubidium-88	1,000
Promethium-148	10	Rubidium-89	1,000
Promethium-148m	10	Ruthenium-103	100
Promethium-149	100	Ruthenium-105	1,000
Promethium-150	1,000	Ruthenium-106	1
Promethium-151	100	Ruthenium-94	1,000
Protactinium-227	10	Ruthenium-97	1,000
Protactinium-228	1	Samarium-141	1,000
Protactinium-230	0.1	Samarium-141m	1,000
Protactinium-231	0.001	Samarium-142	1,000
Protactinium-232	1	Samarium-145	100
Protactinium-233	100	Samarium-146	1
Protactinium-234	100	Samarium-147	100
Radium-223	0.1	Samarium-151	10
Radium-224	0.1	Samarium-153	100
Samarium-155	1,000	Tantalum-182m	1,000
Samarium-156	1,000	Tantalum-183	100
Scandium-43	1,000	Tantalum-184	100
Scandium-44	100	Tantalum-185	1,000
Scandium-44m	100	Tantalum-186	1,000
Scandium-46	10	Technetium-101	1,000

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Scandium-47	100	Technetium-104	1,000
Scandium-48	10	Technetium-93	1,000
Scandium-49	1,000	Technetium-93m	1,000
Selenium-70	1,000	Technetium-94	1,000
Selenium-73	100	Technetium-94m	1,000
Selenium-73m	1,000	Technetium-96	100
Selenium-75	100	Technetium-96m	1,000
Selenium-79	100	Technetium-97	1,000
Selenium-81	1,000	Technetium-97m	100
Selenium-81m	1,000	Technetium-98	10
Selenium-83	1,000	Technetium-99	100
Silicon-2	1	Technetium-99m	1,000
Silicon-31	1,000	Tellurium-116	1,000
Silver-102	1,000	Tellurium-121	100
Silver-103	1,000	Tellurium-121m	10
Silver-104	1,000	Tellurium-123	100
Silver-104m	1,000	Tellurium-123m	10
Silver-105	100	Tellurium-125m	10
Silver-106	1,000	Tellurium-127	1,000
Silver-106m	100	Tellurium-127m	10
Silver-108m	1	Tellurium-129	1,000
Silver-111	100	Tellurium-129m	10
Silver-112	100	Tellurium-131	100
Silver-115	1,000	Tellurium-131m	10
Silver-110m	10	Tellurium-132	10
Sodium-22	10	Tellurium-133	1,000
Sodium-24	100	Tellurium-133m	100
Strontium-80	100	Tellurium-134	1,000
Strontium-81	1,000	Terbium-147	1,000
Strontium-83	100	Terbium-149	100
Strontium-85	100	Terbium-150	1,000
Strontium-85m	1,000	Terbium-151	100
Strontium-87m	1,000	Terbium-153	1,000
Strontium-89	10	Terbium-154	100
Strontium-90	0.1	Terbium-155	1,000
Strontium-91	100	Terbium-156	100
Strontium-92	100	Terbium-156m (5.0h)	1,000
Sulfur-35	100	Terbium-156m (24.4h)	1,000
Tantalum-172	1,000	Terbium-157	10
Tantalum-173	1,000	Terbium-158	1
Tantalum-174	1,000	Terbium-160	10
Tantalum-175	1,000	Terbium-161	100
Tantalum-176	100	Thallium-194	1,000
Tantalum-177	1,000	Thallium-194m	1,000

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Tantalum-178	1,000	Thallium-195	1,000
Tantalum-179	100	Thallium-197	1,000
Tantalum-180	100	Thallium-198	1,000
Tantalum-180m	1,000	Thallium-198m	1,000
Tantalum-182	10	Thallium-199	1,000
Thallium-200	1,000	Uranium-231	100
Thallium-201	1,000	Uranium-232	0.001
Thallium-202	100	Uranium-233	0.001
Thallium-204	100	Uranium-234	0.001
Thorium-226	10	Uranium-235	0.001
Thorium-227	0.01	Uranium-236	0.001
Thorium-228	0.001	Uranium-237	100
Thorium-229	0.001	Uranium-238	100
Thorium-230	0.001	Uranium-239	1,000
Thorium-231	100	Uranium-240	100
Thorium-232	100	Uranium-natural	100
Thorium-234	10	Vanadium-47	1,000
Thorium-natural	100	Vanadium-48	100
Thulium-162	1,000	Vanadium-49	1,000
Thulium-166	100	Xenon-120	1,000
Thulium-167	100	Xenon-121	1,000
Thulium-170	10	Xenon-122	1,000
Thulium-171	10	Xenon-123	1,000
Thulium-172	100	Xenon-125	1,000
Thulium-173	100	Xenon-127	1,000
Thulium-175	1,000	Xenon-129m	1,000
Tin-110	100	Xenon-131m	1,000
Tin-111	1,000	Xenon-133	1,000
Tin-113	100	Xenon-133m	1,000
Tin-117m	100	Xenon-135	1,000
Tin-119m	100	Xenon-135m	1,000
Tin-121	1,000	Xenon-138	1,000
Tin-121m	100	Ytterbium-162	1,000
Tin-123	10	Ytterbium-166	100
Tin-123m	1,000	Ytterbium-167	1,000
Tin-125	10	Ytterbium-169	100
Tin-126	10	Ytterbium-175	100
Tin-127	1,000	Ytterbium-177	1,000
Tin-128	1,000	Ytterbium-178	1,000
Titanium-44	1	Yttrium-86	100
Titanium-45	1,000	Yttrium-86m	1,000
Tungsten-176	1,000	Yttrium-87	100
Tungsten-177	1,000	Yttrium-88	10
Tungsten-178	1,000	Yttrium-90	10

Radionuclide	Quantity (µCi)*	Radionuclide	Quantity (µCi)*
Tungsten-179	1,000	Yttrium-90m	1,000
Tungsten-18	100	Yttrium-91	10
Tungsten-181	1,000	Yttrium-91m	1,000
Tungsten-187	100	Yttrium-92	100
Tungsten-188	10	Yttrium-93	100
Uranium-230	0.01	Yttrium-94	1,000
		Yttrium-95	1,000
Zinc-62	100		
Zinc-63	1,000		
Zinc-65	10		
Zinc-69	1,000		
Zinc-69m	100		
Zinc-71m	1,000		
Zinc-72	100		
Zirconium-86	100		
Zirconium-88	10		
Zirconium-89	100		
Zirconium-93	1		
Zirconium-95	10		
Zirconium-97	100		
Any alpha-emitting radionuclide not listed above or mixtures of alpha emitters of unknown composition	0.001	Any radionuclide other than alpha-emitting radionuclides not listed above, or mixtures of beta emitters of unknown composition	0.01

Note: For purposes of 4.28.5, 4.31.1, and 4.51.1, where there is involved a combination of radionuclides in known amounts, the limit for the combination shall be derived as follows: determine, for each radionuclide in the combination, the ratio between the quantity present in the combination and the limit otherwise established for the specific radionuclide when not in combination. The sum of such ratios for all radionuclides in the combination may not exceed “1” - that is, unity.

j The quantities listed above were derived by taking 1/10th of the most restrictive ALI listed in Table 4B1, Columns 1 and 2, of Appendix 4B, rounding to the nearest factor of 10, and constraining the values listed between 37 Bq and 37 MBq (0.001 and 1,000 µCi). Values of 3.7 MBq (100 µCi) have been assigned for radionuclides having a radioactive half-life in excess of E+9 years, except Rhenium, 37 MBq (1,000 µCi), to take into account their low specific activity.

* * *

COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing

Scheduled for June 17, 2015

NOTICE is hereby given pursuant to the provisions of Section 24-4-103, C.R.S., that the Colorado Board of Health will conduct a public rule-making hearing on June 17, 2015 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive S., Denver, CO 80246 to consider the promulgation of amendments to 6 CCR 1007-1, Colorado Rules and Regulations Pertaining to Radiation Control, Part 4, Standards for Protection Against Radiation. The proposed rules have been developed by the Hazardous Materials and Waste Management Division of the Colorado Department of Public Health and Environment pursuant to Section 25-1.5-101(1)(k), 25-1.5(1)(l), 25-11-103, 25-11-104, and 25-1-108 C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, www.colorado.gov/cdphe/BoardOfHealth at least 7 days prior to the meeting. The proposed rules, together with the proposed statement of basis and purpose, specific statutory authority and regulatory analysis will be available for inspection at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 at least five working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Hazardous Materials and Waste Management Division, HMWM-RM-B2, 4300 Cherry Creek Drive S., Denver, CO 80246, (303) 692-3454.

The Board encourages all interested persons to participate in the hearing by providing written data, views, or comments, or by making oral comments at the hearing. At the discretion of the Chair, oral testimony at the hearing may be limited to three minutes or less depending on the number of persons wishing to comment. Pursuant to 6 CCR 1014-8, §3.02.1, written testimony must be submitted no later than five (5) calendar days prior to the rulemaking hearing. Written testimony is due by 5:00 p.m., Thursday, June 11, 2015. Persons wishing to submit written comments should submit them to: Colorado Board of Health, ATTN: Jamie L. Thornton, Program Assistant, Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 or by e-mail at: cdphe.bohrequests@state.co.us

Dated this 28th day of April, 2015.

Deborah Nelson
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2015-00227

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series) - by Colo Bd of Health

CCR number

6 CCR 1011-1 Chap 07

Rule title

CHAPTER 07 - ASSISTED LIVING RESIDENCES

Rulemaking Hearing

Date

06/17/2015

Time

10:00 AM

Location

Sabin-Cleere Conference Room, Colorado Department of Public Health and Environment, Bldg. A, 4300 Cherry Creek Drive, South, Denver, CO. 80246

Subjects and issues involved

The proposed rules concern initial and renewal license fees.

Statutory authority

Sections 25-27-107, 25-1.5-103, and 25-3-101 C.R.S.

Contact information

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COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

To: Members of the State Board of Health

From: Laurie Schoder, Policy Analyst, Health Facilities and Emergency Medical Services Division

Through: D. Randy Kuykendall, MLS; Director *DRK*

Date: April 15, 2015

Subject: Proposed Amendments to 6 CCR 1011-1, Standards for Hospitals and Health Facilities, Chapter 7, Assisted Living Residences, with a request for the Rulemaking Hearing to occur on June 17, 2015

The Health Facilities and Emergency Medical Services Division is proposing an amendment to the initial and renewal license fees for assisted living residences (ALRs).

License fees for ALRs were last raised in January of 2009 based upon House Bill 08-1038, which directed the Board of Health to promulgate rules establishing a schedule of fees sufficient to meet the direct and indirect costs of administration and enforcement of the ALR program. In January 2012, the ALR license renewal fees were reduced from $56 to $30 per bed primarily because the fund balance had risen above the target reserve amount and the division did not have the spending authority to spend down the fund balance.

Since adoption of the reduced renewal fee in 2009, the ALR fund balance has steadily decreased to the point that an increase is now necessary for the continued operation of the program. The estimated total fee revenue for FY 2014-15 is $957,662. The total increase needed is $286,000 to $290,000 annually. The ALR fund balances are as follows:

Current Fund balance as of June 30, 2014	$237,444
Projected fund balance June 30, 2015	$147,778
Projected fund balance June 30, 2016 (with fee increase effective July 2015).	$25,059

The current and estimated costs for operation of the program are:

FY 2014-15: Direct - $865,400, Indirect - $213,866
FY 2015-16: Direct - $1,120,541, Indirect - $277,964

During the 2015 legislative session, the Joint Budget committee authorized additional staff to support ALR licensing. The cost estimates for FY 2015-16 enable the department to survey all

facilities every three years and ensure that the survey process meets the increasing complex needs of ALR residents.

In January of this year the division presented stakeholders and the ALR advisory committee with several different proposals for raising the necessary revenue. Based upon feedback from the ALR community, the division narrowed those proposals to two options which were again presented to stakeholders and the ALR advisory committee on March 26th. The current proposed fee increase that raises initial license fees along with renewal license base fees and bed fees is the option agreed upon by the vast majority of stakeholders.

The number of assisted living facilities has continually risen over the last few years. In 2009, the division licensed 510 facilities. Today there are 605 licensed assisted living facilities, of which 167 are high Medicaid use facilities. A high Medicaid utilization facility is defined as an assisted living residence in which at least 35% of its beds are occupied by residents receiving Medicaid. The statute requires that the department's regulations set a lower fee for high Medicaid utilization facilities (HMUF).

In 2002, the statute set the license renewal fee for HMUFs at $150 per facility and $15 per bed. Although the statute changed in 2009 to give the Board of Health discretion in fee setting, the HMUF fees have remained unchanged for the last 13 years.

The department proposes to increase the license renewal fees. The current fees are $150 per facility and $30 per bed for non-HMUFs and $150 per facility and $15 per bed for HMUFs. The proposal increases the renewal fee to $180 per facility and $47 per bed for non-HMUFs and $180 per facility and $19 per bed for HMUFs. Increasing the renewal license fees is appropriate as the costs for initially licensing have increased. The department believes that adopting a $30 facility increase and a $4 increase per bed for HMUFs, compared to a $17 increase per bed for all other facilities, should not be overly burdensome for the high Medicaid utilization facilities.

Lastly, the department proposes to also raise the initial license fee for new assisted living residences, of which there are three categories. For facilities serving a disproportionate share of low income residents, there will be a $500 increase from the current $2,500 to $3,000 for an initial license. For small facilities with three to eight beds, there will be a $1,000 increase from the current $5,000 to $6,000. For facilities with nine or more beds, there will be a $1,200 increase from the current $6,000 to $7,200 for an initial license. The department anticipates one new application per year for the category serving a disproportionate share of low income residents; six new applications per year for the three to eight bed facilities; and four new applications per year for the nine or more bed category. Increasing the initial license fee is appropriate as the costs for initially licensing have increased.

The total anticipated revenue from the license fee increases is projected to be $282,265 annually, which comes close to the estimated amount of revenue that is necessary for continued operation of the program. The department recognizes that it will continue to rely upon the fund balance and that a fee increase likely will be necessary in a few years; however, the fees as proposed allows for an incremental increase and provide an opportunity to adjust the estimates without giving rise to a concern that the cash fund reserve will exceed the statutory authorization.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY

For Amendments to 6 CCR 1011-1, Standards for Hospitals and Health Facilities,
Chapter 7, Assisted Living Residences
April 15, 2015

Basis and Purpose:

The Department of Public Health and Environment is proposing raising the initial and renewal license fees for assisted living residences. Section 25-27-107, C.R.S. requires a schedule of fees for licensing assisted living residence that is sufficient to meet the direct and indirect costs of administration and enforcement of the licensing standards. In addition to regulatory and administration functions, the statute also requires that the department use the licensing fees to provide technical assistance and education to assisted living residences.

License fees for ALRs were last raised in January of 2009. In January 2012, the ALR license renewal fees were reduced from $56 to $30 per bed primarily because the fund balance had risen above the target reserve amount and the Health Facilities and Emergency Medical Services Division did not have the spending authority to spend down the fund balance.

Since adoption of the reduced renewal fee in 2009, the ALR fund balance has steadily decreased to the point that an increase is now necessary for the continued operation of the program. The total increase needed is $286,000 to $290,000 annually. The proposed fee increases that were negotiated with stakeholders are estimated to raise an additional $282,265 in revenue annually.

These rules are promulgated pursuant to the following statutes:

Section 25-27-107, C.R.S. (2014)
Section 25-1.5-103, C.R.S. (2014)
Section 25-3-101, C.R.S. (2014)

SUPPLEMENTAL QUESTIONS

Is this rulemaking due to a change in state statute?

_____ Yes
__X__ No

Is this rulemaking due to a federal statutory or regulatory change?

_____ Yes
__X__ No

Does this rule incorporate materials by reference?

_____ Yes
__X__ No

Does this rule create or modify fines or fees?

__X__ Yes
_____ No

REGULATORY ANALYSIS

For Amendments to 6 CCR 1011-1, Standards for Hospitals and Health Facilities,
Chapter 7, Assisted Living Residences
April 15, 2015

1. **A description of the classes of persons who will be affected by the rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the rule.**

   The classes of persons affected by the proposed rule will be the owners/operators of assisted living residences. Residents of assisted living residences could potentially be affected if a facility makes the business decision to increase resident rates as a result of the license fee increase. Both owner/operators and residents will benefit from the proposed rule, however, because the fee increase will ensure that the assisted living program is fully funded and able to continue administration and enforcement of the program along with providing technical assistance and education to assisted living residences.

2. **To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected class of persons.**

   As set forth above, the probable quantitative and qualitative impact of the proposed rule will be the continued operation of the assisted living program. Without the proposed fee increases, the program would be unable to fulfill its statutory obligations of administering and enforcing the assisted living standards and providing technical assistance and education to assisted living residences.

3. **The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.**

   The Department of Public Health and Environment will incur minor administrative costs associated with changing the fee amounts on application forms. No costs are anticipated for any other state agency regarding implementation and enforcement of the proposed rule.

4. **A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.**

   The probable costs and benefits of the proposed rule outweigh the probable costs and benefits of inaction since inaction would cause the assisted living program to not be fully operation due to lack of funds. The proposed fee increases enable the department to survey all facilities every three years and ensure that the survey process meets the increasing complex needs of ALR residents.

5. **A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.**

The determination is that there is no less costly or less intrusive method for achieving the purpose of the rule.

6. A description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule.

The department initially presented stakeholders with five different proposals for raising the revenue needed. The options ranged from no increase in initial license fees and no increase in license renewal base fees with a $21 per bed fee increase for non high Medicaid utilization facilities only, to raising initial fees for all facility types and a 10% base fee increase with a $20 per bed fee increase for non high Medicaid utilization facilities. Stakeholders reviewed these proposals and made suggestions which the department refined and narrowed down to two options. After further review of the two options, the vast majority of the stakeholders involved agreed upon the current proposal for raising all initial license fees along with a 20 percent increase in the license renewal base fee and a per bed increase -- $4 for high Medicaid utilization facilities and $17 for non high Medicaid utilization facilities.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

The department has determined that it currently needs $286,000 to $290,000 annually to operate the assisted living residence program. In addition to regulatory and administrative functions, the statute requires that the department use license fees to provide technical assistance and education to assisted living residences. The current and estimated costs are as follows:

FY 2014-15: Direct - $865,400, Indirect - $213,866
FY2015-16: Direct -$1,120,54, Indirect - $277,964

The ALR fund balances are as follows:

Fund balance as of June 30, 2014	$237,444
Projected fund balance June 30, 2015	$147,778
Projected fund balance June 30, 2016 (with fee increase effective 07/01/15)	$ 25,059

There are currently 604 licensed assisted living residences, of which 167 are high Medicaid utilization facilities. The department anticipates that there will be one facility serving a disproportionate share of low-income residents per year applying for an initial license, along with 6 small ALRs (3-8 beds) and four larger ALRs (9+ beds). The revenue from the increased initial fees is projected to be $11,300. The revenue from the increased renewal license base fees is projected to be $18,120, while the revenue from the increased renewal license bed fees is projected to be $252,845. The total anticipated annual revenue from all license fee increases is $282,265.

STAKEHOLDER Comment
For Amendments to 6 CCR 1011-1, Standards for Hospitals and Health Facilities,
Chapter 7, Assisted Living Residences

The following individuals and/or entities were included in the development of these proposed rules: The assisted living residence advisory group, Leading Age Colorado, Colorado Health Care Association and Colorado Assisted Living Association.

The following individuals and/or entities were notified that this rule-making was proposed for consideration by the Board of Health: The assisted living residence advisory group, all licensed assisted living residences, Leading Age Colorado, Colorado Health Care Association and Colorado Assisted Living Association.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

There were no major factual issues. The major policy issue was determining the most equitable method to structure the fee increases in order to raise the necessary amount of revenue.

Please identify health equity and environmental justice (HEEJ) impacts. Does this proposal impact Coloradoans equally or equitably? Does this proposal provide an opportunity to advance HEEJ? Are there other factors that influenced these rules?

The division attempted to ensure that the proposed rules impact all Coloradoans equally and equitably. In order to minimize the impact of fee increases on facilities that have a high percentage of Medicaid residents, the division offered several options with no fee increases for high Medicaid utilization facilities. Ultimately, the majority of stakeholders rejected these options and consensus was developed around a proposal with a small increase for high Medicaid utilization residents. Given that there have been no fee increases for these type of facilities for almost 14 years, the small increase is not expected to have any adverse health equity or environmental justice impact.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES

CHAPTER VII - ASSISTED LIVING RESIDENCES

6 CCR 1011-1 Chap 07

.....

1.103(2) ***License Fees***

Unless otherwise specified in this chapter, all licensing ~~and plan review~~ fees paid to the Department shall be deemed non-refundable.

103(2)(a) High Medicaid Utilization Facilities

(i) Fee. High Medicaid utilization facilities shall pay a modified license fee as set forth below.

(ii) Eligible facilities. Facilities identified as high Medicaid utilization are those that have:

(A) no less than 35 percent of the licensed beds occupied by Medicaid enrollees as indicated by complete and accurate fiscal year claims data; and

(B) served Medicaid clients and submitted claims data for a minimum of nine (9) months of the relevant fiscal year.

103(2)(b) Facilities Serving a Disproportionate Share of Low Income Residents

(i) Fee. Facilities serving a disproportionate share of low-income residents shall pay a reduced initial license fee of $~~2,500~~ 3,000.

(ii) Eligible facilities. Facilities eligible for the reduced initial license fee shall:

(A) have qualified for federal or state low income housing assistance;

(B) plan to serve low income residents with incomes at or below 80 percent of the area median income; and

(C) submit evidence of such qualification, as required by the Department.

103(2)(c) Initial License

(i) The appropriate fee, as set forth below, shall accompany a facility's application for initial license.

Three to eight licensed beds: $~~5,000~~ 6,000.

Nine beds or more: $~~6,000~~ 7,200.

103(2)(d) License Renewal

~~(i) For licenses with a renewal between December 31, 2009 and December 31, 2011, the appropriate fee, as set forth below, shall accompany the renewal application:~~

~~(A) $150 per facility plus $56 per bed.~~

~~(B) for a high Medicaid utilization facility, $150 per facility plus $15 per bed.~~

~~(ii) For licenses with a renewal date on or after January 1, 2012, the appropriate fee, as set forth below, shall accompany the renewal application:~~

~~(A) $150 per facility plus $30 per bed.~~

~~(B) $150 per facility plus $15 per bed for a high Medicaid utilization facility.~~

(i) FOR LICENSES THAT EXPIRE PRIOR TO SEPTEMBER 1, 2015, THE APPROPRIATE FEE, AS SET FORTH BELOW, SHALL ACCOMPANY THE RENEWAL APPLICATION.

(A) $150 PER FACILITY PLUS $30 PER BED.

(B) $150 PER FACILITY PLUS $15 PER BED FOR A HIGH MEDICAID UTILIZATION FACILITY.

(ii) FOR LICENSES THAT EXPIRE ON OR AFTER SEPTEMBER 1, 2015, THE APPROPRIATE FEE, AS SET FORTH BELOW, SHALL ACCOMPANY THE RENEWAL APPLICATION:

(A) $180 PER FACILITY PLUS $47 PER BED.

(B) $180 PER FACILITY PLUS $19 PER BED FOR A HIGH MEDICAID UTILIZATION FACILITY.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing

Scheduled for June 17, 2015

NOTICE is hereby given pursuant to the provisions of Section 24-4-103, C.R.S., that the Colorado Board of Health will conduct a public rule-making hearing on June 17, 2015 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the promulgation of amendments to 6 CCR 1011-1, Chapter 7, Assisted Living Residences. The proposed rules concern initial and renewal license fees. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Sections 25-27-107, 25-1.5-103, and 25-3-101 C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh at least 7 days prior to the meeting. The proposed rules, together with the proposed statement of basis and purpose, specific statutory authority and regulatory analysis will be available for inspection at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 at least five working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division HFEMSD-C1, 4300 Cherry Creek Drive S., Denver, CO 80246, (303) 692-2800.

The Board encourages all interested persons to participate in the hearing by providing written data, views, or comments, or by making oral comments at the hearing. At the discretion of the Chair, oral testimony at the hearing may be limited to three minutes or less depending on the number of persons wishing to comment. Pursuant to 6 CCR 1014-8, §3.02.1, written testimony must be submitted no later than five (5) calendar days prior to the rulemaking hearing. Written testimony is due by 5:00 p.m., Thursday, June 11, 2015. Persons wishing to submit written comments should submit them to: Colorado Board of Health, ATTN: Jamie L. Thornton, Program Assistant, Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 or by e-mail at: Jamie.thornton@state.co.us

Dated this 29th day of April, 2015.

Deborah Nelson
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2015-00240

Department

1100 - Department of Labor and Employment

Agency

1101 - Division of Oil and Public Safety

CCR number

7 CCR 1101-12

Rule title

AMUSEMENT RIDES AND DEVICES

Rulemaking Hearing

Date

06/05/2015

Time

10:00 AM

Location

633 17th Street; Denver, CO 80202

Subjects and issues involved

Amendments to Amusement Rides and Devices Regulations

Statutory authority

CRS § 8-20-1001 through 8-20-1004

Contact information

Name

Scott Narreau

Title

Program Manager

Telephone

303-318-8495

Email

scott.narreau@state.co.us

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT

DIVISION OF OIL AND PUBLIC SAFETY

AMUSEMENT RIDES AND DEVICES REGULATIONS

7 CCR 1101-12

EFFECTIVE: JULY 30, 2015

TABLE OF CONTENTS

ARTICLE 1 GENERAL PROVISIONS

Section 1-1 Basis and Purpose

This regulation is promulgated to establish reasonable standards for the construction, operation, repair and maintenance of amusement rides and devices located in Colorado in the interest and safety of the general public, to establish financial standards for the operation of amusement rides and devices in a public setting and to provide for a registration process for amusement rides and devices.

Section 1-2 Statutory Authority

The amendments to these regulations are created pursuant to CRS § 8-20-1001 through 8-20-1004 of the Colorado Revised Statutes. All prior rules for amusement rides and devices are hereby repealed.

Section 1-3 Effective Date

This regulation shall be effective July 30, 2015. The operators of previously unregistered amusement rides and devices shall have up to three months from the effective date of these regulations to comply with Section 2-3 (C).

Section 1-4 Scope

These rules and regulations shall apply to the construction, operation, repair and maintenance of amusement rides and devices located in Colorado by any individual, corporation, company, firm, partnership, association or state or local government agency.

These rules and regulations shall not apply to:

(A) Coin operated model horse and model rocket rides, mechanical horse or bull rides, and other coin activated or self-operated devices.

(B) Non-mechanized playground equipment including, but not limited: to swings, seesaws, stationary spring mounted animal features, rider-propelled merry-go-rounds, climbers, slides, swinging gates and physical fitness devices.

(C) Live animal rides or live animal shows.

(D) Climbing walls trampolines used for sport and fitness training, located in educational facilities, schools, gymnasiums, sport and public entity recreational facilities or other facilities solely devoted to sport and recreational activities, training and instruction.

(E) Institutional trampolines used for sport and fitness training, located in educational facilities, schools, gymnasiums, sport and public entity recreational facilities or other facilities solely devoted to sport and recreational activities, training and instruction.

(F) Race-karts owned and operated by individuals who compete against each other, or rental race-karts available for rent at competitive sport race-kart tracks solely used for sanctioned racing where drivers have attended and passed a practical driver safety training test to establish their competency or hold an applicable valid competition license from a recognized motor sport sanctioning body.

(G) Skating rides, arcades, laser paintball games, bowling alleys, miniature golf courses, inflatable devices, ball crawls, exercise equipment, jet skis, paddle boats, air boats, hot air balloons (whether tethered or untethered), batting cages, games and side shows.

(H) Any amusement ride or device operated at a private event that is not open to the general public and not subject to a separate admission charge or any amusement ride or device owned and operated by a non-profit organization who meets all the requirements in Sections 2-1 and 2-2 of these regulations and operates their rides less than 8 days in any calendar year.

(I) Any amusement ride or device operator who notifies the Division in writing that his or her ride or device is inspected and licensed or issued a permit by one of the following agencies where said agency inspects and issues a license or permit for the ride or device shall be exempt from the requirements of this subsection, provided that the requirements of said agency meet or exceed the requirements of this regulation.

(1) Any municipality or local government within the state of Colorado

(2) Another state agency within the state of Colorado

(3) Any federal government agency

(J) Any local government that has received a temporary or permanent waiver from the Division pursuant to Executive Order D 2011-005. To obtain a waiver the affected local government must demonstrate that the requirements in these regulations conflict with other statutes or regulations (including those of local governments) or are unduly burdensome. A cost benefit analysis or other supporting documentation should be included with the waiver request.

(K) Water slides less than 18 feet in elevation change from point of dispatch to the end of the slide.

Section 1-5 Codes and Standards

(A) The following codes of the American Society for Testing and Materials (ASTM) F24 Committee on Amusement Rides and Devices, National Fire Protection Association (NFPA) and the Association for Challenge Course Technology (ACCT) are incorporated by reference.

(B) All amusement rides and devices shall comply with these standards, including, but not limited to the following unless specifically exempted in these regulations. If there is no applicable standard for an amusement ride or device, operators shall comply with the manufacturer's recommendations.

(1) **ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959**

(i) Standard Terminology Relating to Amusement Rides and Devices: F747-06

(ii) Standard Practice for Ownership and Operation of Amusement Rides and Devices Designation: F 770-14

(iii) Standard Practice for Design and Manufacture of Patron Directed, Artificial Climbing Walls, Dry Slide, Coin Operated and Purposeful Water Immersion Amusement Rides and Devices and Air Supported Structures Designation: F 1159-11

(iv) Standard Practice for Quality, Manufacture, and Construction of Amusement Rides and Devices Designation: F1193-14

(v) Standard Practice for Design, Manufacture, and Operation of Concession Go-Karts and Facilities Designation: F2007-12

(vi) Standard Practice for Measuring the Dynamic Characteristics of Amusement Rides and Devices Designation: F 2137-13

(vii) Standard Practice for Design of Amusement Rides and Devices Designation: F 2291-14

(viii) Standard Practice for Design, Manufacture, Installation and Testing of Climbing Nets and Netting/Mesh used in Amusement Rides, Devices, Play Areas and Attractions: F2375-09

(ix) Standard Practice for Classification, Design, Manufacture, Construction, and Operation of Water Slide Systems Designation: F 2376-13

(x) Standard Practice for Special Requirements for Bumper Boats Designation: F 2460-11

(xi) Standard Practice for Special Requirements for Aerial Adventure Courses Designation: F 2959-14

(xii) Standard Practice for Permanent Amusement Railway Ride Tracks and Related Devices: F2960-14

(xiii) Standard Practice for Design, Manufacture, Installation, Operation, Maintenance, Inspection and Major Modification of Trampoline Courts: F2970-15

(xiv) Standard Guide for Auditing Amusement Rides and Devices: F2974-13

(2) **National Fire Protection Association, One Batterymarch Park, Quincy, MA 02169-7471**

(i) National Electrical Code 2014 Designation: NFPA 70

(3) **Association for Challenge Course Technology, PO Box 47, Deerfield, IL 60015**

(i) Challenge Course and Canopy/Zip Line Tour Standards, Eighth Edition

(C) Interested parties may inspect the referenced incorporated materials by contacting the Program Manager, Amusement Rides and Devices, 633 17th Street, Suite 500, Denver, CO 80202.

(D) This rule does not include later amendments to or editions of the incorporated material.

Section 1-6 Definitions

The following words when used in these rules and regulations shall mean:

AERIAL ADVENTURE COURSE: A patron participatory facility or facilities consisting of one or more elevated walkways, platform, zip lines, nets, ropes, or other elements that require the use of fall hazard Personal Safety Equipment (PSE).

AMUSEMENT RIDE OR DEVICE: Any mechanized device or combination of devices which carry or convey persons along, around or over a fixed or restricted course for the purpose of giving its passengers amusement, pleasure, thrills, excitement or the opportunity to experience the natural environment.

Amusement rides and devices include but are not limited to, an aggregation of amusement rides and devices in an amusement setting such as amusement parks, carnivals, fairs and festivals. Amusement rides and devices also include but are not limited to, bungee jumping, bungee trampolines, climbing walls in amusement settings, concession go-karts, bumper boats, gravity-propelled rides and devices, water slides and traditional amusement rides.

AMUSEMENT RIDE, CLASS A: An amusement ride designed primarily for use by children 12 years of age or younger, typically referred to as a “kiddie ride.”

AMUSEMENT RIDE, CLASS B: Any amusement ride not defined as a Class A amusement ride.

BRAKE, EMERGENCY: A brake located on a zip line that is engaged upon failure of the primary brake, with no input from the zip line participant, in order to prevent serious injury or death resulting from primary brake failure.

BRAKE SYSTEM: An arrangement of primary and emergency brakes that are designed to function together.

BUMPER BOATS: Boats that are used to bump into each other intentionally as directed by drivers as a form of entertainment.

BUNGEE TRAMPOLINES: A type of trampoline where the patron is assisted by a harness attached to bungee cords.

CERTIFICATE OF INSPECTION: The documentation of the annual amusement ride inspection conducted by a qualified Third-Party inspector. Certificates of Inspection are valid for 12 months from the date of inspection.

CLIMBING WALL: An artificially constructed wall with holds for hands and feet used for climbing. Regulated climbing walls include climbing walls located in amusement settings and fixed or portable climbing walls for use by the general public as amusement devices and not for sport or fitness training.

CONCESSION GO-KARTS: A single vehicle which is powered without connection to a common energy source, which is driver controlled with respect to acceleration, speed, braking and steering, which operates within the containment system of a defined track, which simulates competitive motor sports, and which is used by the general public. Concession go-karts typically operate at speeds of up to 25 miles per hour.

DIVISION: The Director of the Division of Oil and Public Safety of the Department of Labor and Employment or any designees thereof which may include certain employees of the Division of Oil and Public Safety or other persons.

INFORMATION PLATE: A manufacturer-issued information plate, printed in English, which is permanently affixed to a ride or device in a visible location, and is designed to remain legible for the expected life of a ride or device. The plate shall include, but not be restricted to, the following applicable items:

Ride Serial Number - A manufacturer-issued unique identifying number or code affixed to the ride in a permanent fashion.

Ride Name and Manufacturer - A manufacturer-issued unique identifying ride name, including the name of the manufacturer by city, state, and country.

Ride Model Number - A manufacturer-issued unique identifying number or code assigned to each manufactured type of ride having the same structural design or components.

Date of Manufacture - The date (month and year) determined by the manufacturer that the given ride or device met his required construction specifications.

Ride Speed - Maximum and minimum revolutions per minute, feet per second, or miles per hour, as applicable.

Direction of Travel - When the proper direction of travel is essential to the design operation of the ride, the manufacturer shall designate the direction of travel, including reference point for this designation.

Passenger Capacity by Weight - Maximum total passenger weight per passenger position.

Passenger Capacity by Number - Maximum total number of adult or child passengers per passenger position and per ride.

INJURY: Means an injury that results in death or requires medical treatment administered by a physician or by registered professional personnel under the standing orders of a physician. Medical treatment does not include first aid treatment or one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters, or other minor injuries that do not ordinarily require medical care even though treatment is provided by a physician or by registered professional personnel.

INSPECTION: A procedure to be conducted by a Third-Party inspector to determine whether an amusement ride or device is being constructed, assembled, maintained, tested, operated, and inspected in accordance with the standards adopted by these regulations and the manufacturer's recommendations, as applicable, and that determines the current operational safety of the ride or device. All inspections shall be documented by a written inspection report to be filed with the operator.

INSPECTOR: A third party qualified by training, such as attainment of Level II certification from the National Association of Amusement Ride Safety Officials (NAARSO), attainment of Level II certification from the Amusement Industry Manufacturers and Suppliers International (AIMS), attainment of a Qualified Inspector certification from the Association for Challenge Course Technology (ACCT), Pennsylvania Department of Agriculture – General Qualified Inspector status or other similar qualification from another nationally recognized organization; or education, such as registration as a Professional Engineer; or experience evaluated and approved in advance, by the Division, to conduct inspections of amusement rides or devices in accordance with the standards adopted by these regulations and the manufacturer's recommendations and criteria.

MAJOR MODIFICATION: Any change in either the structural or operational characteristics of the ride or device which will alter its performance from that specified in the manufacturer's design criteria.

OPERATOR: A person or the agent of a person, corporation or company who owns, controls or has the duty to control the operation of an amusement ride or device.

PERMIT YEAR: The time during which an operator is registered that begins on the registration effective date and ends 12 months from the effective date. These dates appear on the signed permit that an operator receives once the registration application has been approved.

RACE-KARTS: A go-kart designed for competitive sport racing use in either sanctioned racing on tracks or other areas of competition, or in a racing school facility, and not to be used by the general public in an amusement facility. Race-kart drivers must wear approved safety equipment, consisting of a minimum of a Snell or DOT approved helmet and closed-toed shoes. Race-karts regularly reach maximum speeds in excess of 25 miles per hour.

REGISTRATION: The filing of a properly completed application with the Division and approval of the application by the Division.

REPORTABLE INJURY: Any injury (as defined) caused by a malfunction or failure of an amusement ride or device, or any injury (as defined) caused by a ride operator or patron error which impairs the function of an amusement ride or device.

RIDE OPERATOR: The person that has control of the amusement ride or device at all times or is supervising a patron-directed device when it is being operated for the public's use. This person must be trained in accordance with the standards adopted by these regulations and in accordance with an operator training program or specifications provided by the amusement ride or device designer, engineer or manufacturer.

TRAMPOLINE, INSTITUTIONAL: a trampoline intended for use in a commercial or institutional facility.

TRAMPOLINE COURT OR TC: A defined area comprising one or more institutional trampolines or a series of institutional trampolines.

TRAMPOLINE COURT FOAM PIT OR TC FOAM PIT: A combination style dismount pit designed with a rebound device, covered with loose impact absorbing blocks.

WATER SLIDES: Rides intended for use by riders in bathing attire where the action of the ride involves possible and purposeful immersion of the rider's body either in whole or in part in water and uses circulating water to mobilize or lubricate the rider's transportation along a purpose-built path.

ZIP LINE: A concession, commercial amusement device where participants attached to a pulley traverse by gravity from one point to another by use of a cable or rope line suspended between support structures.

ZIP LINE TOUR OR ZIP LINE COURSE: A guided aerial exploration or transit of a landscape by means of a series of zip lines and platforms generally supported by man-made structures.

ARTICLE 2 GENERAL REQUIREMENTS

Amusement rides and devices may not open to the public within the State of Colorado unless the operator has registered with the Division, received a permit from the Division and has satisfied and is continuing to satisfy the requirements as provided herein.

Section 2-1 Financial Standards

(A) Any person who operates an amusement ride must have currently in force an insurance policy written by an insurance company authorized to do business in this state, or by a surplus lines insurer, in an amount of not less than $100,000 per occurrence with a $300,000 annual aggregate for Class A amusement rides and devices, and an amount of not less than $1 million per occurrence for Class B amusement rides and devices insuring the owner or operator against liability for injury to persons arising out of the use of the amusement ride.

(B) For governmental entities, insurance or self-insurance in accordance with §24-10-115 of The Governmental Immunity Act, or participation in a public entity self-insurance pool pursuant to §24-10-115.5 of The Governmental Immunity Act shall be deemed to meet the financial standards of this section.

Section 2-2 Technical Standards

Amusement rides shall be constructed, maintained, operated and repaired subject to the following standards.

2-2-1 General

(A) Amusement rides or devices or any part thereof shall be constructed, maintained, operated and repaired in accordance with the standards adopted by these regulations and the manufacturer's recommendations, as applicable, in order to provide for an operation free from recognized safety hazards.

(B) Amusement rides and devices shall be constructed, maintained, operated and repaired in accordance with all otherwise applicable federal, state and local safety, fire, health or building codes or standards.

(C) Amusement rides and devices of site-specific or prototype construction shall be constructed, maintained and repaired as certified by a Professional Engineer. These certifications must be available for review by the Division.

2-2-2 Bungee Jumping

(A) A system review (structures, cords, harnesses, attachment components, etc.) that includes evaluation and inspection by a Colorado registered Professional Engineer, with his/her certification/stamp that the system design is adequate for the intended application, shall be provided to the Public Safety Section.

(B) All elements of the ASTM - Standards on Amusement Rides and Devices (2014 Edition), excluding the subsequent addenda incorporated by the code forward, are to be conformed to as a minimum standard. Documentation of this conformity shall be provided to the Division.

(C) Where the facility incorporates a crane structure for hoisting customers and/or staff members, the mechanism must conform to national standards. These standards include both the Occupational Safety and Health Administration Standards (OSHA) - 1926.1501 - July 1, 2011, excluding the subsequent addenda incorporated by the code forward, and the American Society of Mechanical Engineers (ASME) B30.5 – 2011. Documentation of this conformity shall be provided to the Division.

(D) Where the facility incorporates a hot air balloon for elevation purposes, copies of the current, valid Standard Airworthiness Certificate and Special Airworthiness Certificate issued by the Federal Aviation Administration (FAA), and records showing that all maintenance and alterations have been performed in accordance with Parts 21, 43, and 91 of the Federal Aviation Regulations excluding the subsequent addenda, shall be provided to the Division.

Section 2-3 Registration

No person shall open to the public and operate any amusement ride or device on property owned or leased by such person until the operator of the amusement ride or device has first registered and obtained a permit for operation from the Division.

2-3-1 Application Submission and Processing

(A) The Amusement Rides and Devices application shall be submitted annually on the form prescribed by the Division and shall include the following registration requirements.

(1) The name and address of the operator.

(2) The trade name of the manufacturer, and the serial number of all rides and devices.

(3) A report of any injury occurring in any state that meets the definition of a reportable injury as defined in this regulation.

(4) A list of the dates and locations of operation of the amusement rides or devices within the state for the upcoming permit year, including the dates at each location. This list may be updated throughout the permit year, provided that notification is received by the Division prior to operation.

(5) The name of all liability insurance carriers and the insurance policy numbers.

(6) An original amusement ride Certificate of Inspection for each amusement ride or device showing the name, serial number, manufacturer of the ride, the inspector's name, the owner/operator name and other information as required by 2-4 of these rules.

(7) Any other information reasonably related to the standards set forth in Article 2.

(8) A certificate of liability insurance for the registration period in an amount of not less than $100,000 per occurrence with a $300,000 annual aggregate for Class A amusement rides and devices and an amount of not less than $1 million per occurrence for Class B amusement rides and devices insuring the owner or operator against liability for injury to persons arising out of the use of the amusement ride or device. For governmental entities, insurance or self-insurance in accordance with §24-10-115 of The Governmental Immunity Act, or participation in a public entity self-insurance pool pursuant to §24-10-115.5 of The Governmental Immunity Act shall be deemed to meet the financial standards of this section.

(B) Upon receipt of an application, the Division shall review the application, and upon determining that the provisions of these rules have been met, shall approve the application, register the amusement rides or devices and issue a permit to operate.

(C) The submittal of a registration application does not guarantee the registration of any amusement ride or device. The owner/operator must obtain a permit from the Division prior to opening any ride or device to the public.

2-3-2 Application Fees

Table 2-3-2	Annual Registration Fees		
Fee Category	Registration Fee Per Amusement Ride or Device Operator	**+ (and)**	Registration Fee Per Amusement Ride or Device
Fee Amount	$500	**+ (and)**	$130

2-3-3 Incomplete Applications

(A) Upon receipt of an incomplete application or an application requiring additional information, the applicant will be notified of the deficiency or additional requirements.

(B) If the deficiency is not corrected or if the Division does not receive the additional information within 180 days following the date of notification, the application shall be considered abandoned and the Division shall not retain the application.

2-3-4 Aerial Adventure Courses

(A) Each aerial adventure course is generally considered to be one ride or device based on the information plate.

(B) If an information plate is not provided, and the owner/operator registers multiple aerial adventure courses as one device, the following will apply:

(1) All aerial adventure courses registered as one device shall be inspected and listed on the Certificate of Inspection as one device by the Third-Party inspector.

(2) When any one aerial adventure course registered in the device is shut down or inoperative, all other aerial adventure courses included in the device must also be shut down.

(C) It is the responsibility of the aerial adventure course owner/operator to correctly register each device being operated.

2-3-5 Trampoline Courts

(A) Each trampoline court is generally considered to be one ride or device based on the information plate.

2-3-6 Zip Lines

(A) Each zip line is generally considered to be one ride or device based on the information plate.

(B) If an information plate is not provided and the owner/operator registers multiple zip lines as one device, the following will apply:

(1) All zip lines registered as one device shall be inspected and listed on the Certificate of Inspection as one device by the Third-Party inspector.

(2) When any one zip line registered in the device is shut down or inoperative, all other zip lines included in the device must also be shut down.

(C) It is the responsibility of the zip line owner/operator to correctly register each device being operated.

Section 2-4 Inspections

2-4-1 Annual Inspections

(A) An annual inspection by a Third-Party inspector must be conducted on each amusement ride.

(1) The inspection shall be conducted with the amusement ride or device in an operable state prior to opening to the public and include an evaluation of the ride or device for a minimum of one complete operating cycle, where applicable.

(2) The inspection shall also include a review of the operator's daily inspection records, inspection and maintenance program records and training records in accordance with the standards adopted by these regulations and the manufacturer's recommendations, as applicable.

(B) Any amusement ride or device open to the public in the state of Colorado must have a valid Certificate of Inspection on file with the Division.

(1) Each item number on the Certificate of Inspection is considered to represent one ride or device.

(2) The ride owner/operator shall be responsible for submitting a completed and signed Certificate of Inspection to the Division for all rides or devices being opened to the public.

(3) A grace period of 30 days immediately following the expiration date of a Certificate of Inspection shall exist and that Certificate of Inspection shall continue to be valid during that time period.

(4) An inspection report for each amusement ride or device shall be made available to the Division at reasonable times, including during an inspection, upon the Division's request.

(C) The inspection certificate shall not be submitted to the Division until all discrepancies have been resolved and all necessary repair(s) or replacement(s) required in accordance with the standards of Section 2-2 have been made.

(1) Resolution of discrepancies, repairs and replacements may be documented in writing by the owner/operator and delivered to the inspector.

(2) The inspector may corroborate such letter by review thereof, subsequent re-inspection, receipt of additional documentation or by other means which the inspector deems appropriate.

(3) Corroborated discrepancies, repairs and replacements shall not require further inspection and such resolution shall be deemed to be in accordance with the standards of Section 2-2.

(D) No person shall open to the public an amusement ride or device that has been inspected by a qualified inspector or by the Division according to Section 2-2 of these regulations and found to be unsafe unless:

(1) All necessary repairs and modifications to the ride have been completed and certified as completed by a qualified inspector and

(2) A valid Certificate of Inspection is on file with the Division.

2-4-2 Daily Inspections

(A) In addition to the annual inspection required under this section, the owner/operator who operates an amusement ride or device must perform and record daily inspections of each amusement ride or

device.

(B) Records of the daily inspections must be available for inspection at the location where the amusement ride or device is operated, and the records must be maintained with the amusement ride or device for a period of three years.

(C) The daily inspection records must include an inspection of equipment identified for daily inspection in accordance with the applicable codes and the manufacturer's recommendations.

Section 2-5 Ride Operations

2-5-1 General

(A) Amusement ride and device owners/operators are required to operate each ride or device in accordance with these regulations, adopted codes and all manufacturers' recommendations as applicable.

(B) Consideration shall be given to environmental factors, including humidity, precipitation, temperature and wind effects on patron safety, where applicable.

(C) Operators shall have a reasonable written plan in place for the management of emergencies, including, but not limited to the following, where applicable:

(1) Prevention strategies;

(2) Emergency preparedness;

(3) Administrative response to emergencies;

(4) Field response to medical emergencies;

(5) Field response to incidents/accidents and fatalities;

(6) Technical rescues;

(7) Activating the emergency medical system;

(8) Evacuations; and

(9) Addressing severe weather.

2-5-2 Zip Lines

(A) For zip line operations, the operator shall:

(1) Have a full understanding of and proficiency in the setup, operation and ongoing monitoring requirements of the braking system in effect when operating zip lines.

(2) Ensure that the departure of patrons from dispatch zones is performed in a controlled manner and only when the zip line is clear of other persons.

(3) Ensure that the deceleration and arrest of patrons arriving at landing zones is performed in a controlled manner.

(4) Ensure that padding used as a protective element in the landing area is not used as a brake component.

ARTICLE 3 RECORDS

Section 3-1 Records Requirements

(A) Every amusement ride or device operator shall maintain detailed records relating to the construction, repair and maintenance of its operation, including safety, inspection, maintenance records and ride operator training activities.

(B) Records shall be made available to the Division at reasonable times, including during an inspection upon the Division's request.

(C) Records of daily inspections must be available for inspection at the location where the ride or device is operated.

(D) All records must be maintained for a period of three years.

ARTICLE 4 INJURY REPORTING

Section 4-1 Reportable Injury

(A) State of Colorado regulations require that amusement ride and device operators notify the Division of any reportable injury.

(B) A reportable injury is any injury (as defined) caused by a malfunction or failure of an amusement ride or device, or any injury (as defined) caused by an operator or patron error which impairs the function of an amusement ride or device.

(C) A reportable injury as defined must be reported to the Division by:

(1) Calling 303-514-3281 within 24 hours of the time that the ride operator or operator becomes aware of the injury; and

(2) Submitting an injury report to the Division within 72 hours of the time that the ride operator or operator becomes aware of the injury

(D) Complete injury reports should be emailed to cdle_amusements@state.co.us or faxed to 303-318-8488.

Section 4-2 Reportable Injury Scene Preservation

If a reportable injury occurs, the equipment or conditions that caused the accident shall be preserved for the purpose of an investigation by the Division unless an investigation is deemed unnecessary by the Division.

ARTICLE 5 PATRON RESPONSIBILITY

A patron is required to follow any written or verbal instructions that are given to him regarding the use of amusement rides and devices.

ARTICLE 6 ENFORCEMENT

Section 6-1 Enforcement Program

The Division provides these regulations to assist operators with safe and proper operation of amusement rides and devices. The Division may inspect the premises and operation of the amusement ride or device to insure that the financial and safety standards in this regulation have been met. When an amusement ride or device is found to be out of compliance with these regulations, the Division will pursue enforcement actions against the operator.

The enforcement process will include requiring the operator to make repairs and/or upgrades, perform system tests, provide records and complete other actions to bring the amusement ride or device back into compliance. During and following the enforcement process, the Division will continue to assist the operator to remain in compliance. The enforcement process may include monetary penalties of up to one thousand dollars ($1,000) per violation per day according to statute (CRS 8-20-104) if the enforcement obligations are not implemented according to the required schedule.

6-1-1 Notice of Violation

(A) A notice of violation (NOV) may be issued when an amusement ride or device is found to be out of compliance with these regulations and/or statutes (C.R.S. §8-20). The notice of violation may include an order to cease and desist operation of the specific amusement ride or device until all violations are satisfactorily corrected.

(B) Within ten working days after an NOV has been issued, the person issued the NOV may file a written request with the Division for an informal conference regarding the NOV. If the person issued the NOV does not request an informal conference within this time frame, all provisions of the NOV shall become final and not subject to further discussion. If the NOV is not resolved within the prescribed time frame, the Division may then seek judicial enforcement of the NOV, or an enforcement order may be issued.

6-1-2 Enforcement Order

(A) An enforcement order may be issued when the violations included within an NOV are not resolved within the prescribed time frame. The enforcement order may include increased fines of up to one thousand dollars ($1,000) per violation for each day of violation. In addition, the enforcement order may include shut-down of the amusement ride or device.

(B) Within ten working days after an enforcement order has been issued, the operator may file a written request with the Executive Director for an informal conference regarding the enforcement order. If the operator does not request an informal conference within this time frame, all provisions of the enforcement order shall become final and not subject to further discussion. If the enforcement order is not resolved within the prescribed time frame, the Division may then seek judicial enforcement of the enforcement order.

6-1-3 Informal Conference

(A) Upon receipt of the request, the Division shall provide the operator with notice of the date, time and place of the informal conference. The Division shall preside at the informal conference, during which the operator and Division personnel may present information and arguments regarding the allegations and requirements of the NOV or the enforcement order.

(B) Within twenty days after the informal conference, the Division shall issue a settlement agreement in which the violations from the NOV and/or enforcement order will be upheld, modified or stricken. The settlement agreement will include a schedule of required activity for resolution of the violations. If the terms and/or schedule in the settlement agreement are not satisfied, an enforcement order will be issued, re-issued or the Division may seek judicial enforcement.

- - - THIS PAGE INCLUDES NOTES TO STAKEHOLDERS FOR REVIEW OF THE PROPOSED REGULATIONS AND WILL BE REMOVED PRIOR TO RULE ADOPTION - - -

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Proposed Revisions to the Amusement Rides and Devices Regulations

The Amusement Rides and Devices Program hosted a 2nd stakeholder meeting on April 28, 2015, to further discuss proposed changes to our regulations. We addressed the following topics during the meeting:

- Adding ride information plate language;
- Clarifying reportable injury language;
- Reconsideration of patron responsibility language;
- Clarifying exemption language in Article 1 Section 1-4 (D)
- Updating trampoline standards language

Changes made based on the feedback we received are highlighted in yellow in the attached proposed revision to our regulations. As usual, your comments and feedback are welcome at any time during our regulation change process. If you feel major changes are need to these rules, please submit your feedback to Scott Narreau by 3:00 pm on April 30, 2015.

Review and Feedback to OPS

The proposed changes within this DRAFT document are identified as follows:

- All language added is **red** without underline.
- All deleted language is ~~**red**~~ with strikethrough.
- Language in **blue** indicates existing language that has been moved to a different section of the regulations.

Questions During Document Review

Questions during the review process can be communicated to the following OPS staff:

Scott Narreau, Explosives Program Manager
scott.narreau@state.co.us
303-318-8495

Submission of Public Comment

Please communicate comments in writing to OPS at:

Division of Oil and Public Safety
633 17th Street, Suite 500
Denver, CO 80202-3610

or

scott.narreau@state.co.us

- - - THIS PAGE INCLUDES NOTES TO STAKEHOLDERS FOR REVIEW OF THE PROPOSED REGULATIONS AND WILL BE REMOVED PRIOR TO RULE ADOPTION - - -

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT

DIVISION OF OIL AND PUBLIC SAFETY

AMUSEMENT RIDES AND DEVICES REGULATIONS

7 CCR 1101-12

EFFECTIVE: ~~MAY~~ JULY ~~7~~30, ~~2014~~2015

TABLE OF CONTENTS

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ARTICLE 1 GENERAL PROVISIONS

Section 1-1 Basis and Purpose

This regulation is promulgated to establish reasonable standards for the construction, operation, repair and maintenance of amusement rides and devices located in Colorado in the interest and safety of the general public, to establish financial standards for the operation of amusement rides and devices in a public setting and to provide for a registration process for amusement rides and devices.

Section 1-2 Statutory Authority

The amendments to these regulations are created pursuant to CRS § 8-20-1001 through 8-20-1004 of the Colorado Revised Statutes. All prior rules for amusement rides and devices are hereby repealed.

Section 1-3 Effective Date

This regulation shall be effective ~~May~~ July ~~7~~30, ~~2014~~2015. The operators of previously unregistered amusement rides and devices shall have up to three months from the effective date of these regulations to comply with Section 2-~~3~~2 (C).

Section 1-4 Scope

These rules and regulations shall apply to the construction, operation, repair and maintenance of amusement rides and devices located in Colorado by any individual, corporation, company, firm, partnership, association or state or local government agency.

These rules and regulations shall not apply to:

(A) Coin operated model horse and model rocket rides, mechanical horse or bull rides, and other coin activated or self-operated devices.

(B) Non-mechanized playground equipment including, but not limited: to swings, seesaws, stationary spring mounted animal features, rider-propelled merry-go-rounds, climbers, slides, ~~trampolines,~~ swinging gates and physical fitness devices.

(C) Live animal rides or live animal shows.

(D) Climbing walls used for sport and fitness training, located in educational facilities, schools, gymnasiums, sport and public entity recreational facilities or other facilities solely devoted to sport and recreational activities, training and instruction.

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(E) Institutional trampolines used for sport and fitness training, located in educational facilities, schools, gymnasiums, sport and public entity recreational facilities or other facilities solely devoted to sport and recreational activities, training and instruction.

~~(E)~~(F) Race-karts owned and operated by individuals who compete against each other, or rental race-karts available for rent at competitive sport race-kart tracks solely used for sanctioned racing where drivers have attended and passed a practical driver safety training test to establish their competency or hold an applicable valid competition license from a recognized motor sport sanctioning body.

~~(F)~~(G) Skating rides, arcades, laser paintball games, bowling alleys, miniature golf courses, inflatable devices, ball crawls, exercise equipment, jet skis, paddle boats, air boats, hot air balloons (whether tethered or untethered), batting cages, games and side shows.

~~(G)~~(H) Any amusement ride or device operated at a private event that is not open to the general public and not subject to a separate admission charge or any amusement ride or device owned and operated by a non-profit organization who meets all the requirements in Sections 2-1 and ~~,~~2-2~~(A), 2-2 (G), 2-2 (H), and 2-2 (I)~~ of these regulations and operates their rides less than 8 days in any calendar year.

~~(H)~~(I) Any amusement ride or device operator who notifies the Division in writing that his or her ride or device is inspected and licensed or issued a permit by one of the following agencies where said agency inspects and issues a license or permit for the ride or device shall be exempt from the requirements of this subsection, provided that the requirements of said agency meet or exceed the requirements of this regulation.

(1) Any municipality or local government within the state of Colorado

(2) Another state agency within the state of Colorado

(3) Any federal government agency

~~(I)~~(J) Any local government that has received a temporary or permanent waiver from the Division pursuant to Executive Order D 2011-005. To obtain a waiver the affected local government must demonstrate that the requirements in these regulations conflict with other statutes or regulations (including those of local governments) or are unduly burdensome. A cost benefit analysis or other supporting documentation should be included with the waiver request.

~~(J)~~(K) Water slides less than 18 feet in elevation change from point of dispatch to the end of the slide.

Section 1-5 Codes and Standards

(A) The following codes of the American Society for Testing and Materials (ASTM) F24 Committee on Amusement Rides and Devices, National Fire Protection Association (NFPA) and the Association for Challenge Course Technology (ACCT) are incorporated by reference.

(B) All amusement rides and devices shall comply with these standards, including, but not limited to the following unless specifically exempted in these regulations. If there is no applicable standard for an amusement ride or device, operators shall comply with the manufacturer's recommendations.

(1) **ASTM International, 100 Barr Harbor Drive, West Conshohocken, PA 19428-2959**

(i) Standard Terminology Relating to Amusement Rides and Devices: F747-06

(ii) Standard Practice for Ownership and Operation of Amusement Rides and Devices Designation: F 770-~~11~~14

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

~~Standard Guide for Testing Performance of Amusement Rides and Devices Designation: F 846-92 (reapproved 2009)~~
~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

~~Standard Practice for Maintenance Procedures for Amusement Rides and Devices Designation: F 853-05~~
~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

~~Standard Guide for Auditing Amusement Rides and Devices Designation: F 893-10~~

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~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(iii) Standard Practice for Design and Manufacture of Patron Directed, Artificial Climbing Walls, Dry Slide, Coin Operated and Purposeful Water Immersion Amusement Rides and Devices and Air Supported Structures Designation: F 1159-11

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(iv) Standard Practice for Quality, Manufacture, and Construction of Amusement Rides and Devices Designation: F1193-~~06~~14

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

~~Standard Guide for Classification of Amusement Ride and Device Related Injuries and Illnesses Designation: F 1305-94 (Reapproved 2002)~~
~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(v) Standard Practice for Design, Manufacture, and Operation of Concession Go-Karts and Facilities Designation: F2007-12

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(vi) Standard Practice for Measuring the Dynamic Characteristics of Amusement Rides and Devices Designation: F 2137-~~11~~13

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(vii) Standard Practice for Design of Amusement Rides and Devices Designation: F 2291-~~11~~14

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(viii) Standard Practice for Design, Manufacture, Installation and Testing of Climbing Nets and Netting/Mesh used in Amusement Rides, Devices, Play Areas and Attractions: F2375-09

(ix) Standard Practice for Classification, Design, Manufacture, Construction, and Operation of Water Slide Systems Designation: F 2376-~~08~~13

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(x) Standard Practice for Special Requirements for Bumper Boats Designation: F 2460-11

~~ASTM International 100 Barr Harbor Drive~~
~~West Conshohocken, PA 19428-2959~~

(xi) Standard Practice for Special Requirements for Aerial Adventure Courses Designation: F 2959-~~12~~14

~~ASTM International 100 Barr Harbor Drive~~

~~West Conshohocken, PA 19428-2959~~

(xii) Standard Practice for Permanent Amusement Railway Ride Tracks and Related Devices: F2960-14

(xiii) Standard Practice for Design, Manufacture, Installation, Operation, Maintenance, Inspection and Major Modification of Trampoline Courts: F2970-15

(xiv) Standard Guide for Auditing Amusement Rides and Devices: F2974-13

(2) **National Fire Protection Association, One Batterymarch Park, Quincy, MA 02169-7471**

(i) National Electrical Code ~~2011~~ 2014 Designation: NFPA 70

~~National Fire Protection Association One Batterymarch Park~~
~~Quincy, MA 02169-7471~~

(3) **Association for Challenge Course Technology, PO Box 47, Deerfield, IL 60015**

(i) Challenge Course and Canopy/Zip Line Tour Standards, Eighth Edition

~~Association for Challenge Course Technology Po Box 47~~
~~Deerfield, IL 60015~~

(C) Interested parties may inspect the referenced incorporated materials by contacting the Program Manager, Amusement Rides and Devices, 633 17th Street, Suite 500, Denver, CO 80202~~ and/or The State Depository Libraries~~.

(D) This rule does not include later amendments to or editions of the incorporated material.

Section 1-6 Definitions

The following words when used in these rules and regulations shall mean:

AERIAL ADVENTURE COURSE: A patron participatory facility or facilities consisting of one or more elevated walkways, platform, zip lines, nets, ropes, or other elements that require the use of fall hazard Personal Safety Equipment (PSE).

AMUSEMENT RIDE OR DEVICE: Any mechanized device or combination of devices which carry or convey persons along, around or over a fixed or restricted course for the purpose of giving its passengers amusement, pleasure, thrills, excitement or the opportunity to experience the natural environment.

Amusement rides and devices include but are not limited to, an aggregation of amusement rides and devices in an amusement setting such as amusement parks, carnivals, fairs and festivals. Amusement rides and devices also include but are not limited to, bungee jumping, bungee trampolines, climbing walls in amusement settings, concession go-karts, bumper boats, gravity-propelled rides and devices, water slides and traditional amusement rides.

~~**CLASS A AMUSEMENT RIDE**~~**, CLASS A**: An amusement ride designed primarily for use by children 12 years of age or younger, typically referred to as a "kiddie ride."

~~**CLASS B AMUSEMENT RIDE**~~**, CLASS B**: Any amusement ride not defined as a Class A amusement ride.

BRAKE, EMERGENCY: A brake located on a zip line that is engaged upon failure of the primary brake, with no input from the zip line participant, in order to prevent serious injury or death resulting from primary brake failure.

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BRAKE SYSTEM: An arrangement of primary and emergency brakes that are designed to function together.

BUMPER BOATS: Boats that are used to bump into each other intentionally as directed by drivers as a form of entertainment.

BUNGEE TRAMPOLINES: A type of trampoline where the patron is assisted by a harness attached to bungee cords.

CERTIFICATE OF INSPECTION: The documentation of the annual amusement ride inspection conducted by a qualified Third-Party inspector. Certificates of Inspection are valid for 12 months from the date of inspection.

~~**CLASS A AMUSEMENT RIDE:** An amusement ride designed primarily for use by children 12 years of age or younger, typically referred to as a "kiddie ride."~~

~~**CLASS B AMUSEMENT RIDE**: Any amusement ride not defined as a Class A amusement ride.~~

CLIMBING WALL: An artificially constructed wall with holds for hands and feet used for climbing. Regulated climbing walls include climbing walls located in amusement settings and fixed or portable climbing walls for use by the general public as amusement devices and not for sport or fitness training.

CONCESSION GO-KARTS: A single vehicle which is powered without connection to a common energy source, which is driver controlled with respect to acceleration, speed, braking and steering, which operates within the containment system of a defined track, which simulates competitive motor sports, and which is used by the general public. Concession go-karts typically operate at speeds of up to 25 miles per hour.

DIVISION: The Director of the Division of Oil and Public Safety of the Department of Labor and Employment or any designees thereof which may include certain employees of the Division of Oil and Public Safety or other persons.

INFORMATION PLATE: A manufacturer-issued information plate, printed in English, which is permanently affixed to a ride or device in a visible location, and is designed to remain legible for the expected life of a ride or device. The plate shall include, but not be restricted to, the following applicable items:

Ride Serial Number - A manufacturer-issued unique identifying number or code affixed to the ride in a permanent fashion.

Ride Name and Manufacturer - A manufacturer-issued unique identifying ride name, including the name of the manufacturer by city, state, and country.

Ride Model Number - A manufacturer-issued unique identifying number or code assigned to each manufactured type of ride having the same structural design or components.

Date of Manufacture - The date (month and year) determined by the manufacturer that the given ride or device met his required construction specifications.

Ride Speed - Maximum and minimum revolutions per minute, feet per second, or miles per hour, as applicable.

Direction of Travel - When the proper direction of travel is essential to the design operation of the ride, the manufacturer shall designate the direction of travel, including reference point for this designation.

Passenger Capacity by Weight - Maximum total passenger weight per passenger position.

Passenger Capacity by Number - Maximum total number of adult or child passengers per passenger position and per ride.

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INJURY: Means an injury that results in death or requires medical treatment administered by a physician or by registered professional personnel under the standing orders of a physician. Medical treatment does not include first aid treatment or one-time treatment and subsequent observation of minor scratches, cuts, burns, splinters, or other minor injuries that do not ordinarily require medical care even though treatment is provided by a physician or by registered professional personnel.

INSPECTION: A procedure to be conducted by a Third-Party inspector to determine whether an amusement ride or device is being constructed, assembled, maintained, tested, operated, and inspected in accordance with the standards adopted by these regulations and the manufacturer's recommendations, as applicable, and that determines the current operational safety of the ride or device. All inspections shall be documented by a written inspection report to be filed with the operator.

INSPECTOR: A third party qualified by training, such as attainment of Level II certification from the National Association of Amusement Ride Safety Officials (NAARSO), attainment of Level II certification from the Amusement Industry Manufacturers and Suppliers International (AIMS), attainment of a Qualified Inspector certification from the Association for Challenge Course Technology (ACCT), Pennsylvania Department of Agriculture – General Qualified Inspector status or other similar qualification from another nationally recognized organization; or education, such as registration as a Professional Engineer; or experience evaluated and approved in advance, by the Division, to conduct inspections of amusement rides or devices in accordance with the standards adopted by these regulations and the manufacturer's recommendations and criteria.

MAJOR MODIFICATION: Any change in either the structural or operational characteristics of the ride or device which will alter its performance from that specified in the manufacturer's design criteria.

OPERATOR: A person or the agent of a person, corporation or company who owns, ~~or~~ controls or has the duty to control the operation of an amusement ride or device.

PERMIT YEAR: The time during which an operator is registered that begins on the registration effective date and ends 12 months from the effective date. These dates appear on the signed ~~registration~~ permit that an operator receives once the registration application has been approved.

RACE-KARTS: A go-kart designed for competitive sport racing use in either sanctioned racing on tracks or other areas of competition, or in a racing school facility, and not to be used by the general public in an amusement facility. Race-kart drivers must wear approved safety equipment, consisting of a minimum of a Snell or DOT approved helmet and closed-toed shoes. Race-karts regularly reach maximum speeds in excess of 25 miles per hour.

REGISTRATION: The filing of a properly completed application with the Division and approval of the application by the ~~Director~~Division.

REPORTABLE INJURY: Any injury (as defined) caused by a malfunction or failure of an amusement ride or device, or any injury (as defined) caused by a ride operator or patron error which impairs the function of an amusement ride or device.~~Any injury caused by a possible malfunction or failure of an amusement ride or device which results in death, dismemberment, significant disfigurement, permanent loss of the use of a body organ, member, function or system, a compound fracture or other significant injury/illness.Injuries do not include treatment with first aid even if performed by a physician unless treatment is a result of any reason listed above.~~

RIDE OPERATOR: The person that has control of the amusement ride or device at all times or is supervising a patron-directed device when it is being operated for the public's use. This person must be trained in accordance with the standards adopted by these regulations and in accordance with an operator training program or specifications provided by the amusement ride or device designer, engineer or manufacturer.

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TRAMPOLINE, INSTITUTIONAL: a trampoline intended for use in a commercial or institutional facility.

TRAMPOLINE COURT OR TC: A defined area comprising one or more institutional trampolines or a series of institutional trampolines.

TRAMPOLINE COURT FOAM PIT OR TC FOAM PIT: A combination style dismount pit designed with a rebound device, covered with loose impact absorbing blocks.

WATER SLIDES: Rides intended for use by riders in bathing attire where the action of the ride involves possible and purposeful immersion of the rider's body either in whole or in part in water and uses circulating water to mobilize or lubricate the rider's transportation along a purpose-built path.

ZIP LINE: A concession, commercial amusement device where participants attached to a pulley traverse by gravity from one point to another by use of a cable or rope line suspended between support structures.

ZIP LINE TOUR OR ZIP LINE COURSE: A guided aerial exploration or transit of a landscape by means of a series of zip lines and platforms generally supported by man-made structures.

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ARTICLE 2 ~~STANDARDS~~GENERAL REQUIREMENTS

Amusement rides and devices may not ~~operate~~ open to the public within the State of Colorado unless the operator has registered with the Division, received a permit from the Division and has satisfied and is continuing to satisfy the ~~following standards~~requirements as provided herein.

Section 2-1 Financial Standards

(A) Any person who operates an amusement ride must have currently in force an insurance policy written by an insurance company authorized to do business in this state, or by a surplus lines insurer, in an amount of not less than $100,000 per occurrence with a $300,000 annual aggregate for Class A amusement rides and devices, and an amount of not less than $1 million per occurrence for Class B amusement rides and devices insuring the owner or operator against liability for injury to persons arising out of the use of the amusement ride.

(B) For governmental entities, insurance or self-insurance in accordance with ~~S~~section 24-10-115 of The Governmental Immunity Act, or participation in a public entity self-insurance pool pursuant to ~~S~~section 24-10-115.5 of The Governmental Immunity Act shall be deemed to meet the financial standards of this section.

Section 2-2 ~~Safety and Health~~Technical Standards

Amusement rides shall be constructed, maintained, operated and repaired subject to the following standards.

2-2-1 General

(A) Amusement rides or devices or any part thereof shall be constructed, maintained, operated and repaired in accordance with the standards adopted by these regulations and the manufacturer's recommendations, as applicable, in order to provide for an operation free from recognized safety hazards.

(B) Amusement rides and devices shall be constructed, maintained, operated and repaired ~~and operated~~ in accordance with all otherwise applicable federal, state and local safety, fire, health or building codes or standards.

(C) Amusement rides and devices of site-specific or prototype construction shall be constructed, maintained and repaired as certified by a Professional Engineer. These certifications must be available for review by the ~~Director~~Division. ~~All such devices must comply with all applicable building and fire codes.~~

~~Section 3-5~~2-2-2 Bungee Jumping

(A) A system review (structures, cords, harnesses, attachment components, etc.) that includes evaluation and inspection by a Colorado registered Professional Engineer, with his/her certification/stamp that the system design is adequate for the intended application, shall be provided to the Public Safety Section.

(B) All elements of the ~~American Society for Testing and Materials~~ASTM - Standards on Amusement Rides and Devices (~~2010~~2014 Edition), excluding the subsequent addenda incorporated by the code forward, are to be conformed to as a minimum standard. Documentation of this conformity shall be provided to the ~~Public Safety Section~~Division.

(C) Where the facility incorporates a crane structure for hoisting customers and/or staff members, the mechanism must conform to national standards. These standards include both the Occupational Safety and Health Administration Standards (OSHA) - 1926.~~550~~1501 - ~~August~~July ~~9~~1, ~~2010~~2011,

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excluding the subsequent addenda incorporated by the code forward, and the American Society of Mechanical Engineers (ASME) B30.5 – ~~2007~~2011. Documentation of this conformity shall be provided to the ~~Public Safety Section~~Division.

(D) Where the facility incorporates a hot air balloon for elevation purposes, copies of the current, valid Standard Airworthiness Certificate and Special Airworthiness Certificate issued by the Federal Aviation Administration (FAA), and records showing that all maintenance and alterations have been performed in accordance with Parts 21, 43, and 91 of the Federal Aviation Regulations excluding the subsequent addenda, shall be provided to the ~~Public Safety Section~~Division.

(D) ~~An annual inspection by a third party inspector must be conducted on each amusement ride. The inspection shall be conducted with the amusement ride or device in an operable state prior to opening to the public and include an evaluation of the ride or device for a minimum of one complete operating cycle where applicable. The inspection shall also include a review of the operator's daily inspection records, inspection and maintenance program records and training records in accordance with the standards adopted by these regulations and the manufacturer's recommendations, as applicable.~~

(E) ~~A separate certificate of inspection shall be completed and signed by the inspector for each amusement ride or device and shall be submitted with the operator's application for registration. An inspection report for each amusement ride or device shall be made available to the Director or his agent and auditors/inspectors, at reasonable times, including during an inspection upon the auditor's/inspector's request.~~

(F) ~~The inspection certificate shall not be submitted to the Division until all discrepancies have been resolved and all necessary repair(s) or replacement(s) required in accordance with the standards of Section 2-2(A) have been made. Resolution of discrepancies, repairs and replacements may be documented in writing by the owner/operator and delivered to the inspector. The inspector may corroborate such letter by review thereof, subsequent re-inspection, receipt of additional documentation, or by other means which the inspector deems appropriate. Corroborated discrepancies, repairs and replacements shall not require further inspection and such resolution shall be deemed to be in accordance with the standards of Section 2-2(A).~~

(G) ~~If the amusement ride or device does not meet the standards of Section 2-2(A), the amusement ride shall not be opened to the public until all necessary repair(s) and/or replacement(s) have been made and a certificate of inspection has been issued.~~

(H) ~~In addition to the annual inspection required under this section, the owner/operator who operates an amusement ride or device must perform and record daily inspections of each amusement ride or device.~~

(I) ~~Records of the daily inspections must be available for inspection at the location where the amusement ride or device is operated, and the records must be maintained with the amusement ride or device for a period of three years.~~

(J) ~~The daily inspection record must include an inspection of equipment identified for daily inspection in accordance with the applicable codes and the manufacturer's recommendations. Where applicable, the inspection shall include:~~

(1) ~~Safety belts, bars, locks and other passenger restraints;~~

(2) ~~All automatic and manual safety devices;~~

(3) ~~Signal systems, brakes and control devices;~~

(4) ~~Safety pins and keys;~~

(5) ~~Fencing, guards, barricades, stairways and ramps;~~

(6) ~~Ride structure and moving parts;~~

(7) ~~Tightness of bolts and nuts;~~

(8) ~~Blocking, support braces and jackstands;~~

(9) ~~Electrical equipment;~~

(10) ~~Lubrication as per manufacturer's instructions;~~

(11) ~~Hydraulic and/or pneumatic equipment;~~

(12) ~~Check communication equipment necessary for operation;~~

(13) ~~Prior to opening, operate ride through one complete cycle of proper functioning; and~~

(14) ~~Any other component that is included in the manufacturer's specific ride maintenance and safety checks or standards adopted by these regulations, or that the operator or person performing the daily inspection deems necessary for inspection.~~

(K) ~~No person shall open to the public an amusement ride or device that has been inspected by a qualified inspector or by the Division and found to be unsafe, unless all necessary repairs and modifications to the ride have been completed and certified as completed by a qualified inspector.~~

(L) ~~Amusement rides and devices of site specific or prototype construction shall be constructed, maintained, and repaired as certified by a Professional Engineer. The certifications must be available for review by the Director. All such devices must comply with all applicable building and fire codes.~~

~~ARTICLE~~ Section 2-3 Registration

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~~No amusement ride or device shall operate within the State of Colorado without first becoming registered as provided herein. Each operator of an amusement ride or device must register and obtain a permit by filing an application with the Division, prior to opening rides to the public.~~

No person shall open to the public and operate any amusement ride or device on property owned or leased by such person until the operator of the amusement ride or device has first registered and obtained a permit for operation from the Division.

~~Section 3-3~~2-3-1 Application~~s~~ Submission and Processing

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(A) The Amusement Rides and Devices application shall be submitted annually on the form prescribed by the ~~Director~~ Division and shall include the following registration requirements.

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~~(A)~~(1) The name and address of the operator.

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~~(B)~~(2) The trade name of the manufacturer, and the serial number of all rides and devices.

~~(C)~~(3) A report of any injury occurring in any state that meets the definition of a reportable injury as defined in this regulation.~~caused by an amusement ride which results in death or requires medical treatment. An injury is caused by the ride if the injury occurs on the ride or is in any way associated with the ride.~~

~~(D)~~(4) A list of the dates and locations of operation of the amusement rides or devices within the state for the upcoming permit year, including the dates at each location. This list may be updated throughout the permit year, provided that notification is received by the ~~d~~Division prior to operation.

~~(E)~~(5) The name of all liability insurance carriers and the insurance policy numbers.

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~~(F)~~(6) An original amusement ride ~~certificate of inspection~~Certificate of Inspection for each amusement ride or device showing the name, serial number, manufacturer of the ride, the inspector's name, the owner/operator name and other information as required by 2-~~2(D)~~4 of these rules.

~~(G)~~(7) Any other information reasonably related to the standards set forth ~~above~~ in Article 2.

~~(H)~~(8) A certificate of liability insurance for the registration period in an amount of not less than $100,000 per occurrence with a $300,000 annual aggregate for Class A amusement rides and devices and an amount of not less than $1 million per occurrence for Class B amusement rides and devices insuring the owner or operator against liability for injury to persons arising out of the use of the amusement ride or device. For governmental entities, insurance or self-insurance in accordance with §~~Section~~ 24-10-115 of The Governmental Immunity Act, or participation in a public entity self-insurance pool pursuant to §~~Section~~ 24-10-115.5 of The Governmental Immunity Act shall be deemed to meet the financial standards of this section.

(B) Upon receipt of an application, the ~~Director~~Division shall review the application, and upon determining that the provisions of these rules have been met, shall approve the application, register the amusement rides or devices and issue a permit to operate.

(C) The submittal of a registration application does not guarantee the registration of any amusement ride or device. The owner/operator must obtain a permit from the Division prior to opening any ride or device to the public.

~~Section 3-12~~-3-2 Application Fees

Table ~~3-12~~-3-2	Annual Registration Fees		
Fee Category	Registration Fee Per Amusement Ride or Device Operator	**+ (and)**	Registration Fee Per Amusement Ride or Device
Fee Amount	$500	**+ (and)**	$130

~~Section 3-2 Registration Requirements~~

~~(I)~~(A) ~~The name and address of the operator.~~

~~(J)~~(B) ~~The trade name of the manufacturer, and the serial number of all rides and devices.~~

~~(K)~~(C) ~~A report of any injury occurring in any state caused by an amusement ride which results in death or requires medical treatment. An injury is caused by the ride if the injury occurs on the ride or is in any way associated with the ride.~~

~~(L)~~(D) ~~A list of the dates and locations of operation of the amusement rides or devices within the state for the upcoming permit year, including the dates at each location. This list may be updated throughout the permit year, provided that notification is received by the division prior to operation.~~

~~(M)~~(E) ~~The name of all liability insurance carriers and the insurance policy numbers.~~

~~(N)~~(F) ~~An original amusement ride certificate of inspection for each amusement ride or device showing the name, serial number, manufacturer of the ride, the inspector's name, the owner/operator and other information as required by 2-2(D) of these rules.~~

~~(O)~~(G) ~~Any other information reasonably related to the standards set forth above in Article 2.~~

~~(P)~~(H) ~~A certificate of liability insurance for the registration period in an amount of not less than $100,000 per occurrence with a $300,000 annual aggregate for Class A amusement rides and~~

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~~devices and an amount of not less than $1 million per occurrence for Class B amusement rides and devices insuring the owner or operator against liability for injury to persons arising out of the use of the amusement ride or device. For governmental entities, insurance or self insurance in accordance with Section 24-10-115 of The Governmental Immunity Act, or participation in a public entity self insurance pool pursuant to Section 24-10-115.5 of The Governmental Immunity Act shall be deemed to meet the financial standards of this section.~~

~~Upon receipt of an application, the Director shall review the application, and upon determining that the provisions of these rules have been met, shall approve the application, register the amusement rides or devices and issue a permit to operate.~~

~~Section 3-4~~2-3-3 Incomplete Applications

(A) Upon receipt of an incomplete application or an application requiring additional information, the applicant will be notified of the deficiency or additional requirements.

(B) If the deficiency is not corrected or if the Division does not receive the additional information within 180 days following the date of notification, the application shall be considered abandoned and the Division shall not retain the application.

2-3-4 Aerial Adventure Courses

(A) Each aerial adventure course is generally considered to be one ride or device based on the information plate.

(B) If an information plate is not provided, and the owner/operator registers multiple aerial adventure courses as one device, the following will apply:

(1) All aerial adventure courses registered as one device shall be inspected and listed on the Certificate of Inspection as one device by the Third-Party inspector.

(2) When any one aerial adventure course registered in the device is shut down or inoperative, all other aerial adventure courses included in the device must also be shut down.

(C) It is the responsibility of the aerial adventure course owner/operator to correctly register each device being operated.

2-3-5 Trampoline Courts

(A) Each trampoline court is generally considered to be one ride or device based on the information plate.

2-3-6 Zip Lines

(A) Each zip line is generally considered to be one ride or device based on the information plate.

(B) If an information plate is not provided and the owner/operator registers multiple zip lines as one device, the following will apply:

(1) All zip lines registered as one device shall be inspected and listed on the Certificate of Inspection as one device by the Third-Party inspector.

(2) When any one zip line registered in the device is shut down or inoperative, all other zip lines included in the device must also be shut down.

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(C) It is the responsibility of the zip line owner/operator to correctly register each device being operated.

Section 2-4 Inspections

2-4-1 Annual Inspections

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(A) An annual inspection by a Third-Party inspector must be conducted on each amusement ride.

(1) The inspection shall be conducted with the amusement ride or device in an operable state prior to opening to the public and include an evaluation of the ride or device for a minimum of one complete operating cycle, where applicable.

~~(M)~~(2) The inspection shall also include a review of the operator's daily inspection records, inspection and maintenance program records and training records in accordance with the standards adopted by these regulations and the manufacturer's recommendations, as applicable.

(B) Any amusement ride or device open to the public in the state of Colorado must have a valid Certificate of Inspection on file with the Division. ~~A separate C~~ertificate of ~~I~~nspection ~~shall be completed and signed by the inspector for each amusement ride or device and shall be submitted with the operator's application for registration.~~

(1) Each item number on the Certificate of Inspection is considered to represent one ride or device.

(2) The ride owner/operator shall be responsible for submitting a completed and signed Certificate of Inspection to the Division for all rides or devices being opened to the public.

(3) A grace period of 30 days immediately following the expiration date of a Certificate of Inspection shall exist and that Certificate of Inspection shall continue to be valid during that time period.

~~(N)~~(4) An inspection report for each amusement ride or device shall be made available to the ~~Director~~Division ~~or his agent and auditors/inspectors,~~ at reasonable times, including during an inspection, upon the ~~auditor's/inspector~~Division's request.

(C) The inspection certificate shall not be submitted to the Division until all discrepancies have been resolved and all necessary repair(s) or replacement(s) required in accordance with the standards of Section 2-2 ~~(A)~~ have been made.

(1) Resolution of discrepancies, repairs and replacements may be documented in writing by the owner/operator and delivered to the inspector.

(2) The inspector may corroborate such letter by review thereof, subsequent re-inspection, receipt of additional documentation~~,~~ or by other means which the inspector deems appropriate.

~~(O)~~(3) Corroborated discrepancies, repairs and replacements shall not require further inspection and such resolution shall be deemed to be in accordance with the standards of Section 2-2~~(A)~~.

(D) ~~If the amusement ride or device does not meet the standards of~~No person shall open to the public an amusement ride or device that has been inspected by a qualified inspector or by the Division according to Section 2-2 ~~(A)~~ of these regulations and found to be unsafe unless:

(1) All necessary repairs and modifications to the ride have been completed and certified as completed by a qualified inspector and

~~(P)~~(2) ~~the amusement ride shall not be opened to the public until all necessary repair(s) and/or replacement(s) have been made and a~~A valid Certificate of Inspection ~~has been issued~~is on file with the Division.

2-4-2 Daily Inspections

~~(Q)~~(A) In addition to the annual inspection required under this section, the owner/operator who operates an amusement ride or device must perform and record daily inspections of each amusement ride or device.

(B) Records of the daily inspections must be available for inspection at the location where the amusement ride or device is operated, and the records must be maintained with the amusement ride or device for a period of three years.

~~(R)~~(C) The daily inspection records must include an inspection of equipment identified for daily inspection in accordance with the applicable codes and the manufacturer's recommendations.

~~(S) The daily inspection record must include an inspection of equipment identified for daily inspection in accordance with the applicable codes and the manufacturer's recommendations. Where applicable, the inspection shall include:~~

~~(15) Safety belts, bars, locks and other passenger restraints;~~

~~(16) All automatic and manual safety devices;~~

~~(17) Signal systems, brakes and control devices;~~

~~(18) Safety pins and keys;~~

~~(19) Fencing, guards, barricades, stairways and ramps;~~

~~(20) Ride structure and moving parts;~~

~~(21) Tightness of bolts and nuts;~~

~~(22) Blocking, support braces and jackstands;~~

~~(23) Electrical equipment;~~

~~(24) Lubrication as per manufacturer's instructions;~~

~~(25) Hydraulic and/or pneumatic equipment;~~

~~(26) Check communication equipment necessary for operation;~~

~~(27) Prior to opening, operate ride through one complete cycle of proper functioning; and~~

~~(28) Any other component that is included in the manufacturer's specific ride maintenance and safety checks or standards adopted by these regulations, or that the operator or person performing the daily inspection deems necessary for inspection.~~

~~(T) No person shall open to the public an amusement ride or device that has been inspected by a qualified inspector or by the Division and found to be unsafe, unless all necessary repairs and modifications to the ride have been completed and certified as completed by a qualified inspector.~~

Section 2-5 Ride Operations

2-5-1 General

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(A) Amusement ride and device owners/operators are required to operate each ride or device in accordance with these regulations, adopted codes and all manufacturers' recommendations as applicable.

(B) Consideration shall be given to environmental factors, including humidity, precipitation, temperature and wind effects on patron safety, where applicable.

(C) Operators shall have a reasonable written plan in place for the management of emergencies, including, but not limited to the following, where applicable:

(1) Prevention strategies;

(2) Emergency preparedness;

(3) Administrative response to emergencies;

(4) Field response to medical emergencies;

(5) Field response to incidents/accidents and fatalities;

(6) Technical rescues;

(7) Activating the emergency medical system;

(8) Evacuations; and

(9) Addressing severe weather.

2-5-2 Zip Lines

(A) For zip line operations, the operator shall:

(1) Have a full understanding of and proficiency in the setup, operation and ongoing monitoring requirements of the braking system in effect when operating zip lines.

(2) Ensure that the departure of patrons from dispatch zones is performed in a controlled manner and only when the zip line is clear of other persons.

(3) Ensure that the deceleration and arrest of patrons arriving at landing zones is performed in a controlled manner.

(4) Ensure that padding used as a protective element in the landing area is not used as a brake component.

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~~**Section 3-5 Bungee Jumping**~~

~~(E) A system review (structures, cords, harnesses, attachment components, etc.) that includes evaluation and inspection by a Colorado registered Professional Engineer, with his certification/stamp that the system design is adequate for the intended application, shall be provided to the Public Safety Section.~~

~~(F) All elements of the American Society for Testing and Materials – Standards on Amusement Rides and Devices (2010 Edition), excluding the subsequent addenda incorporated by the code forward, are to be conformed to as a minimum standard. Documentation of this conformity shall be provided to the Public Safety Section.~~

~~(G) Where the facility incorporates a crane structure for hoisting customers and/or staff members, the~~

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mechanism must conform to national standards. These standards include both the Occupational Safety and Health Administration Standards (OSHA) – 1926.550 – August 9, 2010, excluding the subsequent addenda incorporated by the code forward, and the American Society of Mechanical Engineers (ASME) B30.5 – 2007. Documentation of this conformity shall be provided to the Public Safety Section.

(H) Where the facility incorporates a hot air balloon for elevation purposes, copies of the current, valid Standard Airworthiness Certificate and Special Airworthiness Certificate issued by the Federal Aviation Administration (FAA), and records showing that all maintenance and alterations have been performed in accordance with Parts 21, 43, and 91 of the Federal Aviation Regulations excluding the subsequent addenda, shall be provided to the Public Safety Section.

ARTICLE 43 RECORDS

Section 3-1 Records Requirements

(A) Every amusement ride or device operator shall maintain detailed records relating to the construction, repair and maintenance of its operation, including safety, inspection, maintenance records~~,~~ and ride operator training activities.

(B) ~~Such r~~Records shall be made available to the ~~Director or his agent and auditors/inspectors,~~Division at reasonable times, including during an inspection upon the ~~auditor's/inspector's~~Division's request.

(C) Records of daily inspections must be available for inspection at the location where the ride or device is operated.

(D) All records must be maintained for a period of three years.

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ARTICLE 45 INJURY REPORTING

Section 45-1 Reportable Injury

(A) State of Colorado regulations require that amusement ride and device operators notify the Division of any reportable injury.

(B) A reportable injury is any injury (as defined) caused by a malfunction or failure of an amusement ride or device, or any injury (as defined) caused by an operator or patron error which impairs the function of an amusement ride or device.

(C) A reportable injury as defined must be reported to the Division by:

(1) Calling 303-514-3281 within 24 hours of the time that the ride operator or operator becomes aware of the injury; and

(2) Submitting an injury report to the Division within 72 hours of the time that the ride operator or operator becomes aware of the injury

(D) Complete injury reports should be emailed to cdle_amusements@state.co.us or faxed to 303-318-8488.

~~A reportable injury as defined in Section 1-6 shall be reported to the Division by leaving a message at 303-514-3281 within 24 hours of the time that the ride operator or operator becomes aware of the injury.~~

~~A written report on a form provided by the Division shall be submitted to the Division within 72 hours of the time that the ride operator or operator becomes aware of the injury.~~

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Section 45-2 Reportable Injury Scene Preservation

If a reportable injury occurs, the equipment or conditions that caused the accident shall be preserved for the purpose of an investigation by the Division unless an investigation is deemed unnecessary by the Division.

ARTICLE 5 PATRON RESPONSIBILITY

A patron is required to follow any written or verbal instructions that are given to him regarding the use of amusement rides and devices.

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ARTICLE 6 ENFORCEMENT

Section 6-1 Enforcement Program

The ~~Director~~ Division provides these regulations to assist operators with safe and proper operation of amusement rides and devices. ~~Division staff~~The Division may inspect the premises and operation of the amusement ride or device to insure that the financial and safety standards in this regulation have been met. When an amusement ride or device is found to be out of compliance with these regulations, the ~~Director~~ Division will pursue enforcement actions against the operator.

The enforcement process will include requiring the operator to make repairs and/or upgrades, perform system tests, provide records and complete other actions to bring the amusement ride or device back into compliance. During and following the enforcement process, the ~~Director~~ Division will continue to assist the operator to remain in compliance. The enforcement process may include monetary penalties of up to one thousand dollars ($1,000) per violation per day according to statute (CRS 8-20-104) if the enforcement obligations are not implemented according to the required schedule.

6-1-1 Notice of Violation

(A) A notice of violation (NOV) may be issued when an amusement ride or device is found to be out of compliance with these regulations and/or statutes (C.R.S. §8-20). The notice of violation may include an order to cease and desist operation of the specific amusement ride or device until all violations are satisfactorily corrected.

(B) Within ten working days after an NOV has been issued, the person issued the NOV may file a written request with the ~~Director~~ Division for an informal conference regarding the NOV. If the person issued the NOV does not request an informal conference within this time frame, all provisions of the NOV shall become final and not subject to further discussion. If the NOV is not resolved within the prescribed time frame, the ~~Director~~ Division may then seek judicial enforcement of the NOV, or an enforcement order may be issued.

6-1-2 Enforcement Order

(A) An enforcement order may be issued when the violations included within an NOV are not resolved within the prescribed time frame. The enforcement order may include increased fines of up to one thousand dollars ($1,000~~.00~~) per violation for each day of violation. In addition, the enforcement order may include shut-down of the amusement ride or device.

(B) Within ten working days after an enforcement order has been issued, the operator may file a written request with the Executive Director for an informal conference regarding the enforcement order. If the operator does not request an informal conference within this time frame, all provisions of the enforcement order shall become final and not subject to further discussion. If the enforcement order is not resolved within the prescribed time frame, the ~~Director~~ Division may then seek judicial enforcement of the enforcement order.

6-1-3 Informal Conference

(A) Upon receipt of the request, the ~~director~~ Division shall provide the operator with notice of the date, time and place of the informal conference. The ~~director~~ Division shall preside at the informal conference, during which the operator and Division personnel may present information and arguments regarding the allegations and requirements of the NOV or the enforcement order.

(B) Within twenty days after the informal conference, the ~~Director~~ Division shall issue a settlement agreement in which the violations from the NOV and/or enforcement order will be upheld, modified or stricken. The settlement agreement will include a schedule of required activity for resolution of the violations. If the terms and/or schedule in the settlement agreement are not satisfied, an enforcement order will be issued, re-issued or the ~~Director~~ Division may seek judicial enforcement.

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Notice of Proposed Rulemaking

Tracking number

2015-00225

Department

2505,1305 - Department of Health Care Policy and Financing

Agency

2505 - Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

MEDICAL ASSISTANCE - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY

Rulemaking Hearing

Date

06/12/2015

Time

09:00 AM

Location

303 East 17th Avenue, 7th Floor, Denver, CO 80203

Subjects and issues involved

see attached

Statutory authority

25.5-1-301 through 25.5-1-303, CRS (2014)

Contact information

Name

Judi Carey

Title

MSB Coordinator

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COLORADO
Department of Health Care Policy & Financing
Medical Services Board

April 30, 2015

The Honorable Wayne W. Williams

Secretary of State

1560 Broadway, 2nd Floor

Denver, Colorado 80203

Dear Mr. Williams:

Attached is the Notice of Proposed Rules concerning Medical Assistance rules to be considered for final adoption at the June 2015 meeting of the Medical Services Board of the Department of Health Care Policy and Financing. The meeting will be held on Friday, June 12, 2015, beginning at 9:00 A.M., in the seventh floor conference room at 303 East 17th Avenue, Denver, CO 80203.

This notice is submitted to you for publication, pursuant to § 24-4-103(3)(a) and (11)(a), C.R.S.

Respectfully,

Judi Carey,
Medical Services Board Coordinator
Department of Health Care Policy and Financing

NOTICE OF PROPOSED RULES

The Medical Services Board of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, June 12, 2015, beginning at 9:00 a.m., in the seventh floor conference room at 303 East 17th Avenue, Denver, CO 80203. Reasonable accommodations will be provided upon request prior to the meeting, by contacting the Medical Services Board Coordinator at 303-866-4416.

A copy of the full text of these proposed rule changes is available for review from the Medical Services Board Office, 1570 Grant Street, Denver, Colorado 80203, (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Medical Services Board Office on or before close of business the Wednesday prior to the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the Department's website.

MSB 15-04-03-A, Revision to the Medical Assistance Special Financing Division Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003 and 8.2004.

Medical Assistance. Hospital Provider Fee Collection and Disbursement. Subsequent to the adoption of emergency rules, significant errors were discovered that required revisions to the provider fee and supplemental payment calculations. At the March 17, 2015 meeting, the Hospital Provider Fee Oversight and Advisory Board approved necessary changes to the hospital fee and payment calculations for the period October 1, 2014 through September 30, 2015 previously approved in MSB 14-11-04-A. Therefore, revisions to the rules concerning the fee collection and payment disbursement, 10 C.C.R. 2505-10 Section 8.2000 are being made accordingly.

The authority for this rule is contained in 25.5-4-402.3, C.R.S. (2014) and sections 25.5-1-301 through 25.5-1-303, CRS (2014).

MSB 15-02-26-A, Revision to the Medical Assistance Health Programs Benefits and Operations Rule Concerning Creation of Maternity Services, Section 8.732

Medical Assistance. This rule will define the amount, scope and duration of the maternity services benefit. In order to define amount, scope and duration, the Department is creating the maternity rule to place all of the substantive content from the Benefit Coverage Standards into rule. The Department has gone through a detailed analysis to ensure that the rule does not change any of the substantive content of the original Benefit Coverage Standard.

The authority for this rule is contained in section 1905(a)(18) of the Social Security Act, codified at 42 U.S.C. 1396f(a)(2); 42 CFR Section 440.230 and in sections 25.5-1-301 through 25.5-1-303, C.R.S (2014).

Notice of Proposed Rulemaking

Tracking number

2015-00224

Department

500,1008,2500 - Department of Human Services

Agency

2509 - Social Services Rules (Staff Manual Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-4

Rule title

CHILD WELFARE SERVICES

Rulemaking Hearing

Date

06/05/2015

Time

10:00 AM

Location

Colorado Department of Human Services, 1575 Sherman Street, 8th Floor C-Stat Room, Denver, CO 80203

Subjects and issues involved

#15-2-12-1: Other Planned Permanent Living Arrangement (OPPLA)

Statutory authority

26-1-107; 26-1-109; 26-1-111, C.R.S. (2014); 42 USC 622(b)(8)(A)(iii)(II), Sec. 422(b)(8)(A)(iii)(II); 42 USC 670, Sec. 475A(a), Part E of Title IV; 42 USC 675(5)(C)(i), Sec. 475(5)(C)(i); Pub. L. 113

Contact information

Name

Gretchen Russo

Title

Division of Child Welfare

Telephone

303-866-3197

Email

gretchen.russo@state.co.us

Title of Proposed Rule: Other Planned Permanent Living Arrangement (OPPLA)

Rule-making#: 15-2-12-1

Office/Division or Program: Office of Children, Youth, and Families/Division of Child Welfare

Rule Author: Gretchen Russo

Phone: 303-866-3197

E-Mail: gretchen.russo@state.co.us

STATEMENT OF BASIS AND PURPOSE

Summary of the basis and purpose for the rule or rule change. *(State what the rule says or does, explain why the rule or rule change is necessary and what the program hopes to accomplish through this rule. How do these rule changes align with the outcomes that we are trying to achieve, such as those measured in C-Stat?)*

The use of the permanency goal, Other Permanent Planned Living Arrangement (OPPLA), is used across Colorado and it is the Division of Child Welfare's assertion that the use of this goal should be limited. Also, it is important for Colorado to align with new federal law that passed in September 2014 that adds additional elements, judicial requirements, and benchmarks in order for this goal to be given to a youth in the custody of the child welfare system.

This rule aligns with the work in C-STAT where on a monthly basis the Division of Child Welfare staff identify and track youth who are legally free and who have not achieved legal permanency. The change to the existing rule will help to narrow the use and scope of the OPPLA permanency goal assigned to youth, in hopes of providing more opportunities for youth to find legal permanency.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

☐ to comply with state/federal law and/or

☐ to preserve public health, safety and welfare

Explain:

Authority for Rule:

State Board Authority: 26-1-107, C.R.S. (2013) - State Board to promulgate rules; 26-1-109, C.R.S. (2013) - state department rules to coordinate with federal programs; 26-1-111, C.R.S. (2013) - state department to promulgate rules for public assistance and welfare activities.

(continued)

Initial Review	05/08/2015	Final Adoption	06/05/2015
Proposed Effective Date	08/01/2015	EMERGENCY Adoption	N/A

DOCUMENT 4

[Note: "Strikethrough" indicates deletion from existing rules and "all caps" indicates addition of new rules.]

Title of Proposed Rule: Other Planned Permanent Living Arrangement (OPPLA)

Rule-making#: 15-2-12-1

Office/Division or Program: Office of Children, Youth, and Families/Division of Child Welfare

Rule Author: Gretchen Russo

Phone: 303-866-3197

E-Mail: gretchen.russo@state.co.us

STATEMENT OF BASIS AND PURPOSE (continued)

Program Authority: *(give federal and/or state citations and a summary of the language authorizing the rule-making)*
42 U.S.C. 675(5)(C)(i), Section 475(5)(C)(i);
42 U.S.C. 622(b)(8)(A)(iii)(II)), Section 422(b)(8)(A)(iii)(II), Section 475(5)(C);
42 U.S.C. 670 et seq., Section 475A(a), Part E of Title IV;
Public Law 113-183: Preventing Sex Trafficking and Strengthening Families Act; Section 112 Improving Another Planned Living Arrangement as a Permanency Option

Does the rule incorporate material by reference?		Yes	X	No
Does this rule repeat language found in statute?		Yes	X	No
If yes, please explain.				

The program has sent this proposed rule-making package to which stakeholders?

The Permanency Task group, Division of Child Welfare Permanency, Youth and Child Protection Units, Office of Child's Representative, State Court Administrator's Office

Attachments:
Regulatory Analysis
Overview of Proposed Rule
Stakeholder Comment Summary

Title of Proposed Rule: Other Planned Permanent Living Arrangement (OPPLA)

Rule-making#: 15-2-12-1

Office/Division or Program: Office of Children, Youth, and Families/Division of Child Welfare

Rule Author: Gretchen Russo

Phone: 303-866-3197

E-Mail: gretchen.russo@state.co.us

REGULATORY ANALYSIS

(*complete each question; answers may take more than the space provided*)

1. List of groups impacted by this rule:
Which groups of persons will benefit, bear the burdens or be adversely impacted by this rule?

Youth in the child welfare system who are sixteen years of age and over and are in need of a permanent home will benefit from this rule change. The Colorado Department of Human Services and county child welfare staff believe it is best practice to continue to find legal permanency until the youth exits the system, even if the youth has co-occurring issues such as mental health or disabilities.

County Department caseworkers are already required to provide concurrent planning for all cases, so helping a youth find permanency while preparing a youth for adulthood should not cause an additional burden for county staff.

2. Describe the qualitative and quantitative impact:
How will this rule-making impact those groups listed above? How many people will be impacted? What are the short-term and long-term consequences of this rule?

In Colorado, OPPLA is currently assigned to ninety (90) of 965 legally free children/youth. In 2012, the rule changed that no child/youth under the age of sixteen could be given the goal of OPPLA unless they were Unaccompanied Refugee Minors. The use of OPPLA should only be utilized as a last resort and after careful consideration by the team assigned to the case which, in most cases, will include the youth.

In the short-term, county departments bear the burden to continue to work towards permanency and to provide additional information and documentation to the courts for the judicial officers to make additional findings. The county departments will need to hold staffings on a six month basis until permanency is found or until the case is closed.

In the long-term, helping youth find permanency is in their best interest and can make a difference as they transition into adulthood. Youth can suffer serious consequences if they do not find permanency, such as homelessness, lack of educational success, unemployment, etc.

3. Fiscal Impact:
For each of the categories listed below explain the distribution of dollars; please identify the costs, revenues, matches or any changes in the distribution of funds even if such change has a total zero effect for any entity that falls within the category. If this rule-making requires one of the categories listed below to devote resources without receiving additional funding, please explain why the rule-making is required and what consultation has occurred with those who will need to devote resources.

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

There should not be costs for the state associated with this rule. There are potentially long term savings to many systems as youth who achieve permanency are more likely to become self-sufficient adults.

Office/Division or Program: Office of Children, Youth, and Families/Division of Child Welfare

Rule Author: Gretchen Russo

Phone: 303-866-3197

E-Mail: gretchen.russo@state.co.us

REGULATORY ANALYSIS (continued**)**

County Fiscal Impact

There may be a fiscal impact to counties to do more recruitment for placements, additional staffings and time to provide more details to the court; however, the fiscal impact of keeping a youth in the system can be higher than finding permanency for the youth.

Federal Fiscal Impact

None identified

Other Fiscal Impact *(such as providers, local governments, etc.)*

There may be a fiscal impact to Guardians ad Litem (GALs) if there is additional time spent by being more engaged in the case. In addition, judicial officers may also see an impact because of the additional findings required; however, this is part of federal legislation and the courts will need to determine if any additional resources are needed for their work.

4. Data Description:
List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

Public Law 113-183, the Preventing Sex Trafficking and Strengthening Families Act require states to add additional components to utilizing OPPLA as a permanency goal

Monthly Office of Children, Youth and Families, Division of Child Welfare C-Stat Data

IV-E Waiver Data

Survey results from County practices in August 2014

5. Alternatives to this Rule-making:
Describe any alternatives that were seriously considered. Are there any less costly or less intrusive ways to accomplish the purpose(s) of this rule? Explain why the program chose this rule-making rather than taking no action or using another alternative.

To align with Federal Public Law 113-183, the Department is proposing updates to the current rule.

The Division of Child Welfare strives to provide guidance and additional support to counties, as well as focus on the safety, permanency and well-being of all children and youth involved in child welfare, but especially those older youth who are legally freed and deserve attention to finding legal permanency. It is important to put into rule the narrowing of the use of assigning Other Permanent Planned Living Arrangement (OPPLA) permanency goal to legally freed youth.

Title of Proposed Rule: Other Planned Permanent Living Arrangement (OPPLA)

Rule-making#: 15-2-12-1

Office/Division or Program: Office of Children, Youth, and Families/Division of Child Welfare

Rule Author: Gretchen Russo

Phone: 303-866-3197

OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Section Numbers	Current Regulation	Proposed Change	Stakeholder Comment
7.301.24	Requirements for Use of Other Permanent Planned Living Arrangements	Revises and updates language to narrow the scope of OPPLA	_X_ Yes _ No

Title of Proposed Rule: Other Planned Permanent Living Arrangement (OPPLA)

Rule-making#: 15-2-12-1

Office/Division or Program: Office of Children, Youth, and Families/Division of Child Welfare

Rule Author: Gretchen Russo

Phone: 303-866-3197

STAKEHOLDER COMMENT SUMMARY

DEVELOPMENT

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

The Permanency Task group, Division of Child Welfare Permanency, Youth and Child Protection Units, Office of Child's Representative, State Court Administrator's Office

THIS RULE-MAKING PACKAGE

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

The Permanency Task group, Division of Child Welfare Permanency, Youth and Child Protection Units, Office of Child's Representative, State Court Administrator's Office

Are other State Agencies (such as Colorado Department of Health Care Policy and Financing) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

[X] Yes [ ] No

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[x] Yes [ ] No

Date presented _ March 5 and April 3, 2015 _.
Were there any issues raised? __X__ Yes ____ No

If not, why.

Comments were received from stakeholders on the proposed rules:

[X] Yes [ ] No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

El Paso County is concerned with a specific section of this rule regarding unaccompanied refugee minors and believes that statement should stay in the rule.

(12 CCR 2509-4)

7.301.24 Family Service Plan Out-of-Home Placement Documentation [Rev. eff. 12/1/12]

For child(ren) in out-of-home placement, the Family Service Plan documents:

===

Q. Requirements for use of Other Planned Permanent Living Arrangement (OPPLA) goals as follows:

1. The county department shall consider another planned permanent living arrangement as a permanency goal:

~~a.~~ For ~~children/~~youth WHO ARE SIXTEEN (16) YEARS OF AGE OR OVER AND ARE DEMONSTRATING EXCEPTIONAL CIRCUMSTANCES THAT PREVENT THE YOUTH FROM ~~in exceptional circumstances and who have co-occurring complex conditions that make them incapable of living in a family-like environment and therefore preclude their~~ returning home, adoption, legal guardianship or permanent custody.

~~b. For children and youth who are in the unaccompanied refugee minor program regardless of their age.~~

2. ~~Use of this~~ THE goal shall be REVIEWED THROUGH THE USE OF A FAMILY ENGAGEMENT MEETING OR EQUIVALENT TEAM THAT REVIEWS PERMANENCY NEEDS. ALL OF THE FOLLOWING SHALL BE SUBMITTED TO AND CONSIDERED BY THE REVIEW TEAM AND THE RECOMMENDATION SHALL BE SUBMITTED TO THE COURT. ~~by the county permanency review team. The following shall be submitted to the review team~~:

~~A.~~ a. DOCUMENTATION PERTAINING TO THE COMPLETION OF A RIGOROUS EXAMINATION OF KIN AND PERMANENT CONNECTIONS. THIS PROCESS SHALL ALSO ADDRESS:

1) A comprehensive assessment of the ~~child/~~ youth's strengths and needs. ~~If the assessment time period exceeds more than one year, a new comprehensive assessment must be conducted or a multi-disciplinary staffing (including participants with expertise in the child's needs) may substitute for the updated comprehensive assessment.~~ In addition to updating the ASSESSMENT OF THE ~~child/~~ youth's strengths and needs, the updated assessment or staffing shall address the YOUTH'S capacity to live within a family setting.

2) THIS REVIEW TEAM SHALL ALSO CONSIDER THE YOUTH'S DESIRED PERMANENCY OUTCOME.

~~B.~~ b. A detailed description of efforts made to achieve permanency through the other goals and identification of the barriers to achieve them.

~~C.~~ c. A DETAILED DESCRIPTION OF HOW OPPLA IS IN THE BEST INTEREST OF THE YOUTH.

3. ~~If approved by the review team, a compelling reason why the other permanency goals are unattainable~~ THE FOLLOWING is to be documented and made available to the court at EACH ~~the next~~ court review: ~~Documentation which includes the permanency review team's reasons for approving other planned permanent living arrangement shall also be~~

~~entered in the special review section of the Family Service Plan. The use of this goal must be reviewed by the county permanency review team every 12 months. The county shall request that the court, every 12 months, review the case to determine if the child remains incapable of living in a family-like environment~~.

a. DOCUMENTATION OF THE BARRIERS TO PERMANENCY TO DATE AND COMPELLING REASONS WHY THE OTHER PERMANENCY GOALS ARE NOT ATTAINABLE.

b. DOCUMENTATION OF THE YOUTH'S DESIRED PERMANENCY OUTCOME INCLUDING GIVING THE YOUTH AN OPPORTUNITY TO ATTEND EACH HEARING TO VOICE HIS/HER DESIRED GOAL.

c. DOCUMENTATION OF INTENSIVE, ONGOING, AND AS OF THE DATE OF THE HEARING, UNSUCCESSFUL EFFORTS TO RETURN THE YOUTH HOME OR SECURE A PLACEMENT FOR THE YOUTH WITH A FIT AND WILLING RELATIVE (INCLUDING ADULT SIBLINGS), A LEGAL GUARDIAN, OR AN ADOPTIVE PARENT, INCLUDING THOROUGH EFFORTS THAT UTILIZE TECHNOLOGY (INCLUDING SOCIAL MEDIA) TO FIND BIOLOGICAL FAMILY MEMBERS FOR THE YOUTH.

d. DOCUMENTATION OF THE STEPS TAKEN TO ENSURE THAT YOUTH ARE BEING SUPPORTED IN ENGAGING IN AGE OR DEVELOPMENTALLY APPROPRIATE ACTIVITIES AND SOCIAL EVENTS INCLUDING:

1) THE YOUTH'S FOSTER FAMILY HOME OR OTHER PLACEMENT IS FOLLOWING THE REASONABLE AND PRUDENT PARENT STANDARD; AND

2) THE YOUTH HAS REGULAR, ONGOING OPPORTUNITIES TO ENGAGE IN AGE OR DEVELOPMENTALLY APPROPRIATE ACTIVITIES (INCLUDING CONSULTING WITH THE YOUTH IN AN AGE-APPROPRIATE MANNER ABOUT THE OPPORTUNITIES OF THE YOUTH TO PARTICIPATE IN THE ACTIVITIES).

e. DOCUMENTATION WHICH INCLUDES THE REVIEW TEAM'S REASONS FOR APPROVING OTHER PLANNED PERMANENT LIVING ARRANGEMENT (OPPLA) SHALL ALSO BE ENTERED IN THE 5A OF THE FAMILY SERVICE PLAN.

4. THE USE OF THIS GOAL SHALL BE REVIEWED BY A FAMILY ENGAGMENT OR EQUIVALENT REVIEW TEAM AT A MINIMUM OF EVERY SIX (6) MONTHS. THE COUNTY SHALL REQUEST THAT THE COURTREVIEW THE CASE EVERY TWELVE (12) MONTHS TO DETERMINE IF THE YOUTH IS DEMONSTRATING EXCEPTIONAL CIRCUMSTANCES THAT PREVENT THE YOUTH FROM RETURNING HOME, ADOPTION, LEGAL GUARDIANSHIP OR PERMANENT CUSTODY.

5. If this goal is not achieved through relative care, a family-like network of significant people shall be developed to provide the ~~child~~/youth with a sense of belonging and with support expected to endure over a lifetime.

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Notice of Proposed Rulemaking

Tracking number

2015-00222

Department

500,1008,2500 - Department of Human Services

Agency

2509 - Social Services Rules (Staff Manual Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-4

Rule title

CHILD WELFARE SERVICES

Rulemaking Hearing

Date

06/05/2015

Time

10:00 AM

Location

Colorado Department of Human Services, 1575 Sherman Street, 8th Floor C-Stat Room, Denver, CO 80203

Subjects and issues involved

#15-3-30-1: Collaborative Management Program

Statutory authority

26-1-107; 26-1-109; 26-1-111; 24-1.9-102(2)(i); 24-1.9-103(1)(c), (2)(b)(II)-(VI), 24-1.9-104(3) and (3)(b), C.R.S. (2014)

Contact information

Name

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Title of Proposed Rule: Collaborative Management Program

Rule-making#: 15-3-30-1

Office/Division or Program: Office of Children, Youth and Families/Division of Child Welfare

Rule Author: Tiffany Sewell

Phone: 303-866-3930

E-Mail: tiffany.sewell@state.co.us

STATEMENT OF BASIS AND PURPOSE

Summary of the basis and purpose for the rule or rule change. *(State what the rule says or does, explain why the rule or rule change is necessary and what the program hopes to accomplish through this rule. How do these rule changes align with the outcomes that we are trying to achieve, such as those measured in C-Stat?)*

The Collaborative Management Program (CMP) develops a uniform system for agencies at the state and county levels to effectively and efficiently share resources or to manage and integrate the treatment and services provided to children and families who benefit from multi-agency services.

The CMP was created in 2004 and the rules associated with the program have not been updated since the inception of the program. In the first year, six (6) counties participated in the program. Last year, forty (40) counties/regions chose to be part of the CMP. Due to the changes and increased number of counties, the rule changes are necessary to continue to meet program needs. Also, in October 2014 a performance audit of the Department of Human Services' Child Welfare services reviewed the CMP. As a result of the legislative audit, rule changes are needed to address:

- Memorandum of Understanding (MOU) procedures and time frames;
- Elements of collaborative management;
- Collaborative management monitoring process that includes data collection; and,
- The distribution of incentive funds and general fund savings.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

☐ to comply with state/federal law and/or

☐ to preserve public health, safety and welfare

Explain:

Authority for Rule:

State Board Authority: 26-1-107, C.R.S. (2014) - State Board to promulgate rules; 26-1-109, C.R.S. (2014) - state department rules to coordinate with federal programs; 26-1-111, C.R.S. (2014) - state department to promulgate rules for public assistance and welfare activities.

(continued)

Initial Review	05/08/2015	Final Adoption	06/05/2015
Proposed Effective Date	08/01/2015	EMERGENCY Adoption	N/A

[Note: "Strikethrough" indicates deletion from existing rules and "all caps" indicates addition of new rules.]

Title of Proposed Rule: Collaborative Management Program

Rule-making#: 15-3-30-1

Office/Division or Program: Office of Children, Youth and Families/Division of Child Welfare

Rule Author: Tiffany Sewell

Phone: 303-866-3930

E-Mail: tiffany.sewell@state.co.us

STATEMENT OF BASIS AND PURPOSE (continued)

Program Authority: *(give federal and/or state citations and a summary of the language authorizing the rule-making)*
24-1.9-102(2)(i), C.R.S. (2014) - The memorandum of understanding shall include a provision stating whether the parties to the memorandum of understanding will attempt to meet performance measures specified by the department of human services and elements of collaborative management, as defined by rule of the state board of human services.

24-1.9-103(1)(c), C.R.S. (2014) - An accounting of moneys that were reinvested in additional services provided to children or families who would benefit from integrated multi-agency services due to cost-savings that may have resulted or due to meeting or exceeding performance measures specified by the department of human services and elements of collaborative management established by rule of the state board.

24-1.9-103(2)(b)(II)–(VI), C.R.S. (2014) - Defines members of executive director review team that have met or exceeded performance expectations established by the department of human services and the elements of collaborative management established by rule of the state board,.

24-1.9-104(3), C.R.S. (2014) - On and after July 1, 2005, the executive director of the department of human services shall allocate the moneys in the fund to provide incentives to parties to the memorandum of understanding who have agreed to performance-based collaborative management pursuant to section 24-1.9-102(2)(i) and who have successfully implemented the elements of collaborative management specified by rule of the state board and also met or exceeded the performance measures specified by the department of human services.

24-1.9-104(3)(b), C.R.S. (2014) - For the purposes of allocating incentive money in the fund pursuant to this subsection (3), the executive director of the department of human services shall submit an accounting of money in the fund available for incentives and a proposal for the allocation of incentive moneys to the state board of human services for review and approval prior to the allocation of the moneys. The state board of human services shall approve the proposal not later than thirty days after receipt of the proposal from the executive director of the department of human services.

Does the rule incorporate material by reference?

	Yes	X	No

Does this rule repeat language found in statute?

X	Yes		No

If yes, please explain. The rules mirror the following statutes:
24-1.9-101, C.R.S.
24-1.9-102, C.R.S.
24-1.9-102(2)(d), C.R.S.
24-1.9-102(2)(e), C.R.S.

Title of Proposed Rule: Collaborative Management Program

Rule-making#: 15-3-30-1

Office/Division or Program: Office of Children, Youth and Families/Division of Child Welfare

Rule Author: Tiffany Sewell

Phone: 303-866-3930

E-Mail: tiffany.sewell@state.co.us

STATEMENT OF BASIS AND PURPOSE (continued)

The program has sent this proposed rule-making package to which stakeholders?

The proposed rule-making package was reviewed at Child Welfare Sub-PAC on April 2, 2015.

The statewide CMP steering committee, which includes representatives from: state and local judicial districts; state health department; state and local school districts; local mental health centers; local behavioral health organizations; the Division of Youth Corrections; and, state and local child welfare agencies reviewed the proposed rule-making package.

Attachments:
Regulatory Analysis
Overview of Proposed Rule
Stakeholder Comment Summary

Title of Proposed Rule: Collaborative Management Program

Rule-making#: 15-3-30-1

Office/Division or Program: Office of Children, Youth and Families/Division of Child Welfare

Rule Author: Tiffany Sewell

Phone: 303-866-3930

REGULATORY ANALYSIS

(*complete each question; answers may take more than the space provided*)

1. List of groups impacted by this rule:
Which groups of persons will benefit, bear the burdens or be adversely impacted by this rule?

In Colorado there are currently 40 counties/regions that have implemented collaborative management. Each of the system partners and their community's will be impacted by the rules.

The system partners include the following collaborative management mandatory partners to the Memorandum of Understanding (MOU): local county Departments of Human Social Services; local Judicial Districts; local Health Departments; local School Districts; local Mental Health Centers; local Behavioral Health Organizations; Division of Youth Corrections; local designated Managed Services Organizations for the provision of treatment services for alcohol and drug abuse; and, local community domestic abuse programs.

Any collaborative management program that has non-mandatory participants in the MOU will also be affected. These non-mandatory members vary based on the county. Examples include: a family advocacy organization, youth advocates, District Attorney Offices and Diversion Programs, Respondent Parent Council, Guardian Ad Litem, Public Defender's Office, Board of Commissioners, and CASA organizations. Children, youth and/or families that live in communities in which there is a collaborative management program will also be affected by the rules.

The Collaborative Management Program (CMP) coordinators and each IOG will bear the burdens of: 1) preparing for the monitoring process created by the rule; 2) entering data into data system; and, 3) creation of IOG by-laws to address risk sharing, resource pooling, performance expectations, outcome monitoring and staff training.

2. Describe the qualitative and quantitative impact:
How will this rule-making impact those groups listed above? How many people will be impacted? What are the short-term and long-term consequences of this rule?

The rule will impact the above listed groups in a positive manner as the rules are meant to provide clarification regarding: MOU elements and timelines; elements of successful implementation of collaborative management; development of a monitoring process for the program; clarification on data systems use, reporting and collection; and, determination of general fund savings and its distribution. As part of the legislative audit of the Collaborative Management Program conducted in October 2014 it was recommended that the state provide clarification on the above listed items.

The short-term consequences of this rule will allow the Colorado Department of Human Services and the counties of Colorado to come into compliance with the recommendation made in the legislative audit. As well as, provide clarification on general fund savings and collaborative management processes and monitoring. The long-term consequences include a collaborative management program with greater oversight, accountability and improvement of general fund savings.

Title of Proposed Rule: Collaborative Management Program

Rule-making#: 15-3-30-1

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REGULATORY ANALYSIS (continued**)**

3. Fiscal Impact:

For each of the categories listed below explain the distribution of dollars; please identify the costs, revenues, matches or any changes in the distribution of funds even if such change has a total zero effect for any entity that falls within the category. If this rule-making requires one of the categories listed below to devote resources without receiving additional funding, please explain why the rule-making is required and what consultation has occurred with those who will need to devote resources.

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

The costs to the state include the costs for monitoring the program. The joint budget committee recently approved a 1.5 FTE which will provide the staff necessary to monitor the program throughout Colorado counties.

County Fiscal Impact

There should not be a cost associated with this rule.

Federal Fiscal Impact

There should not be a cost associated with these rules.

Other Fiscal Impact *(such as providers, local governments, etc.)*

There should not be a cost associated with these rules for other stakeholders.

4. Data Description:

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

None

5. Alternatives to this Rule-making:

Describe any alternatives that were seriously considered. Are there any less costly or less intrusive ways to accomplish the purpose(s) of this rule? Explain why the program chose this rule-making rather than taking no action or using another alternative.

No alternatives were considered as the legislative audit clearly states: “Working with the State Board of Human Services to promulgate rule” to address: MOU elements and timelines; elements of successful implementation of collaborative management; development of a monitoring process for the program; clarification on data systems use, reporting and collection; and, determination of general fund savings and its distribution.

Title of Proposed Rule: Collaborative Management Program

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OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Section Numbers	Current Regulation	Proposed Change	Stakeholder Comment			
7.303.3	Collaborative Management Program	Revised to provide clarification to mirror statute	_X_	Yes	_	No
7.303.31	Program Goals	Revised to provide clarification to mirror statute	_X_	Yes	_	No
7.303.32	Availability	Revised to add mandatory partners listed in statute; clarifies timelines for submitting MOUs and MOU review process	_X_	Yes	_	No
7.303.33	Program Components	Updates elements of collaborative management to mirror MOU; provides clarification on Interagency Oversight Group (IOG), target population and program monitoring	_X_	Yes	_	No
7.303.34	Section changed from Oversight to Reporting	Revised to clarify reporting requirements to mirror statute	_X_	Yes	_	No
7.303.35	Incentive funding for performance measures	Revised to clarify incentive funding formula to include performance measures, process measures and meaningful minimum	_X_	Yes	_	No
7.303.36	Section changed from program eligibility (already spelled out in 7.303.3) to General Fund savings and distribution	Clarifies general fund savings and distribution	_X_	Yes	_	No

Title of Proposed Rule: Collaborative Management Program

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STAKEHOLDER COMMENT SUMMARY

DEVELOPMENT

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

Collaborative Management Steering Committee which consists of members of state and local judicial departments, state and local educational departments, state and local mental health agencies, state and local child welfare agencies, Legislative Liaison and Sub-PAC

THIS RULE-MAKING PACKAGE

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

The Collaborative Management Program (CMP) Steering Committee, which includes representatives from the following counties and partner agencies: Adams; Alamosa; Boulder, Cheyenne; Chaffee; Conejos; Crowley; Otero; Bent; Denver; Douglas; Eagle; El Paso; Elbert; Fremont; Garfield; Grand; Gunnison/Hinsdale; Huerfano; Jefferson; Kiowa; Lake; Larimer; Lincoln; Logan; Mesa; Moffat; Dolores/Montezuma; Montrose; Morgan; Park; Prowers; Pueblo; Rio Grande; Routt; Teller; Weld

Are other State Agencies (such as Colorado Department of Health Care Policy and Financing) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?
Susan Collins from State Judicial; Ann-Marie Braga from the Colorado Department of Public Health and Environment (CDPHE); Janelle Kruger from the Colorado Department of Education (CDE); and, Meg Williams from the Colorado Department of Public Safety received copies for review. All agencies agreed with the proposed rules.

[X] Yes [ ] No

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[X] Yes [ ] No

Date presented _April 2, 2015_____. Were there any issues raised? _X_ Yes __ No

If not, why.

Comments were received from stakeholders on the proposed rules:

[X] Yes [ ] No

STAKEHOLDER COMMENT SUMMARY (continued)

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

Concerns raised during CW Sub-PAC included:

1) The ability to select savings or surplus in the MOU in the time frames presented in the rules.
2) The ability to select performance measures for the next fiscal year when they do not have a full report from the prior year.

The Department agreed to add section 7.303.32, E, to the rules that provides the counties with a report of their progress on the performance measures for the first three quarters of the performance year.

Concerns raised from stakeholders included:

1) Would like wording added to 7.303.32, G, that included a peer review process.

   The Department suggested the peer review process to the stakeholders and agreed to add the wording. However, because the peer review process consists of volunteers, if there are no such volunteers in future years the Department did not want to be out of compliance with rule.

2) "The rules presented are beyond the scope of the current statutory authority granted by the Department of Human Services or the State Board of Human Services. Legislation authorizes rules to define general fund savings and rules to define the elements of collaborative management. The rules presented also reflect ownership of the program by the Department/Child Welfare which is further not supported in Statute."

   The Department sought an informal opinion by the Attorney General's Office regarding its authority. The Attorney General believes that the Department does have authority.

3) Under 7.303.32, they would like wording to mirror statute.

   The Department added wording to mirror statute.

4) 7.303.32, D, "While it is certainly helpful information, this is beyond the scope of the statute."

   The Department agreed to recommendation 12B in the Child Welfare Performance Audit that requires the Department to "promulgating and communicating guidance; and establishing MOU review criteria and checklists."

STAKEHOLDER COMMENT SUMMARY (continued)

5) 7.303.33, B, "This section is not supported by children's code statute, counties are only required to serve to age 21 if they have custody of the youth. This is beyond statutory authority, and unclear as to how it could be collected."

   The Department agreed to recommendation 12B in the Child Welfare Performance Audit that requires the Department to "establish process to determine whether county-level programs have successfully implements the elements of collaborative management, and work with the State Board to promulgate rules as needed. This will include working with the Judicial Department to revise the MOU template to adequately capture statutory and regulatory requirements, including defining the target population and detailing expectations and requirements for the collaborative management processes."

6) 7.303.34, E, "This appears to be beyond the statutory authority to require of CMPs in the Department's rules."

   This section mirrors Section 24-1.9-103(d), of the Colorado Revised Statutes, which states, "A description of any identified barriers to the ability of the state and county to provide effective services to persons who received multi-agency services."

7.303.3 COLLABORATIVE MANAGEMENT PROGRAM

The Collaborative Management Program (CMP) is an optional county ~~plan~~ PROGRAM approved by the ~~State~~ DEPARTMENT OF HUMAN SERVICES, for A UNIFORM SYSTEM FOR AGENCIES TO SHARE RESOURCES OR TO MANAGE AND INTEGRATE THE TREATMENT AND SERVICES PROVIDED TO CHILDREN, YOUTH, AND FAMILIES WHO WOULD BENEFIT FROM A MULTI-SYSTEM APPROACH TO SERVICES AND SERVICE DELIVERY. ~~provision of child and family services for those who could benefit from the treatment and services that involve multiple agencies, divisions, and units at the county level~~.

7.303.31 Program Goals

The goals of the Collaborative Management Program include:

A. Reducing duplication and fragmentation of services TO CHILDREN, YOUTH, AND/OR FAMILIES WHO WOULD BENEFIT FROM INTEGRATED MULTI-AGENCY SERVICES OR APPROACH;

B. Increasing the quality, appropriateness, and effectiveness of services provided TO CHILDREN, YOUTH OR FAMILIES WHO WOULD BENEFIT FROM INTEGRATED MULTI-AGENCY SERVICES OR APPROACH; AND,

C. ENCOURAGING cost sharing among service providers.

~~D. Ultimately, better outcomes and, when possible, cost reduction for the services provided to children and families who would benefit from integrated multi-agency services.~~

7.303.32 Availability

A. Collaborative Management is an optional program for an individual county or groups of counties. Counties may elect to participate by ~~operating a State-approved Collaborative Care Program~~ ENTERING INTO A ~~and signing a~~ Memorandum of Understanding (MOU) THAT IS DESIGNED TO PROMOTE A COLLABORATIVE SYSTEM TO COORDINATE AND MANAGE THE PROVISION OF SERVICES TO CHILDREN, YOUTH, AND FAMILIES WHO WOULD BENEFIT FROM AN INTEGRATED MULTI-SYSTEM APPROACH TO SERVICES AND SERVICE DELIVERY. COUNTIES MUST USE the model MOU TEMPLATE provided by the State AND DEVELOPED IN CONJUNCTION WITH JUDICIAL DISTRICTS.

B. ~~Counties electing to participate shall have an MOU to coordinate multi-agency services.~~ The MOU shall be between interested county departments of human/social services and local representatives of each of the following agencies:

1. The local judicial district(s), including probation services;

2. The health department, whether a county, district, or regional health department;

3. The local school district(s);

4. Each community mental health center; ~~and,~~

5. Each Behavioral Health Organization (BHO);

6. THE DIVISION OF YOUTH CORRECTIONS;

7. A MANAGED SERVICE ORGANIZATION FOR THE PROVISION OF TREATMENT OF SERVICES FOR ALCOHOL AND DRUG ABUSE; AND,

8 A COMMUNITY DOMESTIC ABUSE PROGRAM, IF REPRESENTATION IS AVAILABLE.

C. Counties electing to participate in the MOU may involve other interested parties or organizations AND ARE ENCOURAGED TO INCLUDE A FAMILY MEMBER OR FAMILY ADVOCACY ORGANIZATION AS DEFINED IN SECTION 26-18-102C.R.S., AND A YOUTH MEMBER OR YOUTH ADVOCACY ORGANIZATION.

D. COUNTIES WILL BE PROVIDED WITH GUIDANCE/INSTRUCTIONS FOR THE COMPLETION OF THE MOU ESTABLISHED BY THE STATE DEPARTMENT TO HELP IN THE COMPLETION OF THE MOU PROCESS.

E. COUNTIES WILL BE PROVIDED WITH A THIRD QUARTER PROGRESS REPORT BY THE STATE DEPARTMENT TO HELP IN THE ELECTION OF THE PERFORMANCE MEASURES FOR THE MOU.

F. MOUS MUST BE SUBMITTED TO THE COLORADO DEPARTMENT OF HUMAN SERVICES ON OR BEFORE MAY 1ST OF THE CURRENT FISCAL YEAR PRIOR TO THE MOU AGREEMENT YEAR FOR REVIEW AND FEEDBACK. COMPLETED MOUS, INCLUDING ALL SIGNATURES, ARE DUE ON JUNE 30TH OF THE CURRENT FISCAL YEAR PRIOR TO THE MOU AGREEMENT YEAR. ANY MOU RECIEVED AFTER THAT DATE WILL NOT BE ACCEPTED AND WILL RESULT IN A LOSS OF FUNDING FOR THE NEXT FISCAL YEAR.

G. REVIEWS OF EACH COUNTY'S MOU WILL BE COMPLETED BY THE STATE DEPARTMENT AND WILL CONSIST OF A REVIEW AND COMPLETION OF THE MOU REVIEW CHECKLIST. THE REVIEW CHECKLIST CONSISTS OF THE FOLLOWING AREAS:

1. A LIST OF MANDATED PARTNERS;

2. MOU DEADLINES;

3. OVERSIGHT GROUP DOCUMENTATION;

4. TARGET POPULATION REVIEW;

5. SERVICES PROVIDED REVIEW;

6. FUNDING SOURCES REVIEW;

7. REINVENSTMENT OF FUNDS REVIEW;

8. COLLABORATIVE MANAGEMENT PROCESS REVIEW;

9. PERFORMANCE–BASED MEASURES REVIEW;

10. CONFIDENTIALITY COMPLIANCE REVIEW; AND,

11. REVIEW OF REQUIRED SIGNATURES.

H. EACH COLLABORATIVE MANAGEMENT PROGRAM THAT MEETS THE CRITERIA WILL RECEIVE A SIGNED LETTER OF ACCEPTANCE FROM THE STATE DEPARTMENT APPROVING THE MOU FOR THE NEXT FISCAL YEAR.

7.303.33 Program Components

Each ~~plan~~ MEMORANDUM OF UNDERSTANDING (MOU) shall contain the following program components. ~~These program components may be operationalized in another manner if approved by the State department.~~

A. ~~Utilization Management (UM)~~ INTERAGENCY OVERSIGHT GROUP (IOG)

A system of inter-agency OVERSIGHT WILL BE DEVELOPED IN THE MOU THROUGH THE CREATION OF AN INTERAGENCY OVERSIGHT GROUP (IOG). ~~services review which may include family and team decision-making with approval procedures designed to ensure that the services provided to a specific child or family at a given time are cost-effective, clinically appropriate, and least restrictive. The goal of utilization management is to provide the most appropriate, least restrictive service that meets the needs of the child and family.~~ Each ~~group~~ **IOG** MUST ~~shall~~ include a local representative of each party to the MOU ~~Memorandum of Understanding~~, each of whom shall be a voting member of the **IOG** ~~interagency oversight group~~. In addition, the ~~group~~ **IOG** may include~~, but is not limited to, the following~~ advisory non-voting members.

1. THE MOU SHALL DEFINE THE FOLLOWING COMPONENTS OF THE IOG:

   a. MEMBERSHIP REQUIREMENTS;

   b. THE STATUS OF EACH PARTY AS A VOTING MEMBER OR ADVISORY MEMBER;

   c. PROCEDURES FOR ELECTION OF OFFICERS;

   d. PROCEDURES FOR RESOLVING DISPUTES BY A MAJORITY VOTE OF VOTING MEMBERS; AND,

   e. PROCEDURES FOR THE DEVELOPMENT OF SUBCOMMITTEE GROUPS.

2. THESE COMPONENTS SHALL BE MAINTAINED IN EACH IOG'S BY-LAWS OR PROCEDURE GUIDE.

~~Utilization management may include:~~

~~1. Identification and tracking of selected cases implemented with any or all of the services used by the county departments;~~

~~2. Concurrent review activities which focus on reducing or increasing any level of service and may be conducted by dedicated staff and/or a multi-agency review team;~~

~~3. Written guidelines including standardized UM processes and criteria for UM that may include definitions for key levels of care;~~

~~4. Provider profiling where data is supplementally tracked, differentiating provider performance and competencies.~~

B. TARGET POPULATION

THE CMP TARGET POPULATION CONSISTS OF AT-RISK CHILDREN AND YOUTH AGES BIRTH THROUGH TWENTY ONE (21) YEARS OF AGE AND THEIR FAMILIES WHO WOULD BENEFIT FROM A MULTI-SYSTEM APPROACH OR INTEGRATED SERVICE PLAN AS DEFINED IN THE MOU. EACH MOU MUST INCLUDE THE POPULATION THAT WILL BE SERVED THROUGH THE DESIGNATED INDIVIDULAIZED SERVICE AND SUPPORT TEAM

(ISST) OR MULTI-SYSTEM INVOLVED TEAM AND CMP PREVENTION PROGRAMS. AT-RISK CHILDREN WILL BE DETERMINED IN ACCORANCE WITH PARTIES TO THE MOU.

1. THE ISST OR MULTI-SYSTEM INVOLVED TEAM MUST INCLUDE MULTIPLE DISCIPLINES IN THE DELIVERY OF SERVICES FOR THE TARGET POPULATION.

2. CMP PREVENTION PROGRAMS MUST DEMONSTRATE A MULTI-SYSTEMIC APPROACH. PROGRAMS MUST DEMONSTRATE IN THE MOU THAT MULTIPLE DISCIPLINES WERE INVOLVED IN THE DEVELOPMENT OR ENHANCEMENT OF THE PROGRAM OR THAT MULTIPLE AGENCIES ARE INVOLVED IN THE DELIVERY OF THE SERVICE.

3. PROGRAMS MUST DEMONSTRATE THAT THE PROGRAM WAS DEVELOPED TO REDUCE BIFURCATED SERVICES AIMED AT THE SAME OUTCOME AND DEMONSTRATE, IF NOT PROVIDED THROUGH CMP, THE BIFURCATED APPROACH WOULD BESTOW A BURDEN TO EACH OF THE SYSTEMS. EACH MOU MUST ARTICULATE HOW THE JOINT APPROACH WILL BENEFIT CHILDREN, YOUTH, AND/OR FAMILIES IN THEIR COMMUNITIES.

C. ELEMENTS OF COLLABORATIVE MANAGEMENT

EACH COUNTY/REGION MOU MUST ESTABLISH A COLLABORATIVE MANAGEMENT PROCESS THAT ADDRESSES:

1. RISK SHARING;

2. RESOURCE POOLING;

3. PERFORMANCE EXPECTATIONS;

4. OUTCOME MONITORING; AND,

5. STAFF TRAINING.

THE DEFINITIONS OF EACH FOR THE ELEMENTS OF COLLABORATIVE MANAGEMENT SHALL BE MAINTAINED BY EACH IOG'S BY-LAWS OR PROCEDURE GUIDE AND PROVIDED AS AN APPENDIX TO THE MOU ON AN ANNUAL BASIS.

D. MONITORING

THE DEPARTMENT WILL MONITOR AT LEAST ONE CMP PER QUARTER TO ENSURE IMPLEMENTATION OF THE COLLABORATIVE MANAGEMENT PROGRAM IN ACCORDANCE WITH STATUTES, RULES, AND THE MOU. THE MONITORING WILL INCLUDE:

1. CMP MONITORING OF:

   a. A REVIEW OF THE IOG PROCESS;

   b. A REVIEW OF THE BY-LAWS OR PROCEDURE GUIDE ENSURING IT INCLUDES THE ELEMENTS REQUIRED IN STATUTE AND RULE; AND,

   c. THE ACCURACY AND RELIABILITY OF COUNTY-LEVEL PROGRAM PERFORMANCE DATA.

2. A REVIEW OF PREVENTION PROGRAMS TO ENSURE THAT EACH IS IN COMPLIANCE WITH THE DEFINITIONS OUTLINED UNDER TARGET POPULATION IN THE MOU.

3. A REVIEW OF THE DATA REPORTING FOR ALL PROGRAM COMPONENTS AND EXPENDITURE DATA.

4. EACH COUNTY/REGION MUST ENTER ALL PARTICIPANTS SERVED THROUGH THE CMP PROGRAM'S TARGET POPULATIONS: DEMOGRAPHICS, SERVICES, OUTCOMES, AND EXPENDITURES IN THE DESIGNATED DATA COLLECTION SYSTEM AS DETERMINED BY THE DEPARTMENT, SO THAT IT CAN BE TRACKED AND MONITORED.

~~Case Management (CM)~~

~~Case management refers to a process by which the services provided to a specific child or family are tracked and managed to achieve optimum, cost-effective outcomes.~~

~~Case management activities may include:~~

~~1. Systematic management approach that integrates tracking and targeting of cases for identified, targeted interventions and outcomes;~~

~~2. Procedures which minimize time between referral and delivery of care, and provide dedicated resources and support for any or all of service referrals;~~

~~3. Prevention and early intervention which the county offers for support before more intensive intervention is needed.~~

~~C. Resource Strategies~~

~~Resource strategies involve efforts to organize and manage resources to achieve the goals of the collaborative management partnership paying for care.~~

~~Resource strategies may include:~~

~~1. Contract incentives employing shared risks or performance incentives to influence provider behavior and service delivery;~~

~~2. Efficiencies and standardized care approaches that promote efficient and appropriate care delivery;~~

~~3. Resource blending using collaborative efforts with other child and family servicing agencies.~~

~~D. Information Management Strategies (IM)~~

~~Information management strategies mean the identification, collection, analysis, and use of various types of data to further the collaborative management's mission and goals.~~

~~IM may include:~~

~~1. Tracking information related to service use, including identifying service utilization costs, aggregating and reporting;~~

~~2. Creating routine reports and IM activities, including trend analyses by case type, provider, services category and other variables; or using complex multi-level analyses to identify cost drivers and adjust risks.~~

~~E. Collaborative Integration (CI)~~

~~Collaborative integration means inclusion of consumers and agencies in the community in the development of the collaborative's vision, mission and goals, and in the implementation of the~~

~~program. Formal efforts may be directed at coordinating services, integrating care, and cooperation between agencies and consumers; and, must include:~~

~~1. Plans for integration, contractual agreements or blending of community resources;~~

~~2. Strategies to utilize formal and informal community based organizations and family support networks to ensure child and community safety and to promote child and family well-being; and,~~

~~3. Plans shall include formal inter-agency agreements and contracts with community-based organizations and a process to engage community partners.~~

~~F. Quality Improvement (QI)~~

~~Quality improvement means the formal organizational processes that emphasize the ongoing improvement of both the process of service delivery and client outcomes through the incorporation of data driven approaches and the institution of systems of monitoring, feedback and organizational learning.~~

~~QI activities may include implementing:~~

~~1. A formal QI process, which may be narrowly implemented, expanding over time agency-wide to include a written plan and formal process;~~

~~2. A training schedule for staff on aspects of the collaborative management principles or information obtained as a result of use of the principles, such as the outcome of the quality improvement process; or,~~

~~3. Quality improvement activities for at least one high cost driver and have dedicated staff for QI activities.~~

7.303.34 ~~Oversight~~ REPORTING

EACH IOG MUST PROVIDE AN ANNUAL REPORT TO THE STATE DEPARTMENT THAT INCLUDES:

A. THE ACTUAL NUMBER OF CHILDREN, YOUTH AND/OR FAMILIES SERVED THROUGH THE INDIVIDULAIZED SERVICE AND SUPPORT TEAM (ISST) OR MULTI-SYSTEM INVOLVED STAFFING AND THE OUTCOMES OF THE SERVICES PROVIDED, INCLUDING A DESCRIPTION OF ANY REDUCTION IN DUPLICATION OR FRAGMENTATION OF SERVICES PROVIDED AND A DESCRIPTION OF ANY SIGNIFICANT IMPROVEMENT IN OUTCOMES FOR CHILDREN, YOUTH AND/OR FAMILIES;

B. THE ACTUAL NUMBER OF CHILDREN, YOUTH, AND/OR FAMILIES SERVED THROUGH THE MULTI-SYSTEMIC PREVENTION PROGRAM AND THE OUTCOMES OF THE SERVICES PROVIDED INCLUDING A DESCRIPTION OF ANY REDUCTION IN DUPLICATION OR FRAGMENTATION OF SERVICES PROVIDED AND A DESCRIPTION OF ANY SIGNIFICANT IMPROVEMENT IN OUTCOMES FOR CHILDREN, YOUTH, AND OR FAMILIES;

C. A DESCRIPTION OF ESTIMATED COSTS OF IMPLEMENTING THE COLLABORATIVE MANAGEMENT PROGRAM AND ANY ESTIMATED COST-SHIFTING OR COST-SAVINGS THAT MAY HAVE OCCURRED;

D. AN ACCOUNTING OF FUNDS THAT WERE REINVESTED IN ADDITIONAL SERVICES PROVIDED TO CHILDREN, YOUTH, AND/OR FAMILIES DUE TO COST-SAVINGS THAT MAY HAVE RESULTED FROM EXCEEDING PERFORMANCE MEASURES; AND,

E. A DESCRIPTION OF ANY IDENTIFIED BARRIERS TO PROVIDE EFFECTIVE SERVICES.

~~A local-level interagency oversight group shall be created~~.

~~A. Representatives of interested local private sector entities; and,~~

~~B. Family members or caregivers of children who would benefit from integrated multi-agency services or current or previous consumers of integrated multi-agency services.~~

7.303.35 Incentive Funding for Performance MEASURES

In order to receive incentive ~~monies~~ FUNDS, the county must implement collaborative management ~~principles~~ COMPONENTS, ~~perform on specific indicators~~ ACHIEVE PERFORMANCE MEASURES INDICATED IN ITS MOU, and have a signed collaborative management MOU accepted by the Colorado Department of Human Services, Division of Child Welfare, ON OR BEFORE JUNE 30 OF THE CURRENT FISCAL YEAR. ~~By July 1 of each State Fiscal Year.~~

A FUNDING FORMULA BASED ON A COLLABORATIVE MANAGEMENT PROGRAM (CMP) SITE MEETING THREE PROCESS MEASURES AND THREE PERFORMANCE MEASURES WILL DETERMINE THE CMP'S PORTION OF THE INCENTIVE FUNDING ALLOCATION.

A. COUNTIES WILL RECEIVE THE MEANINGFUL MINIMUM BASED ON COUNTY SIZE AND MEETING PROCESS MEASURES OF COLLABORATIVE MANAGEMENT. IOGS WILL BE REQUIRED TO MEET THREE OF THE FOLLOWING SIX PROCESS MEASURES IN ORDER TO RECEIVE THE MEANINGFUL MINIMUM FUNDS.

1. IOG MEETING ATTENDANCE

   MEASURE: MANDATORY MEMBERS OF THE IOG WILL BE PRESENT 75% OF THE TIME AT THE FOUR REQUIRED MEETINGS IN A FISCAL YEAR. SIGN-IN SHEETS AND MEETING MINUTES WILL CONFIRM ATTENDANCE.

2. FAMILY AGENCY OR MEMBER PARTICIPATION ON THE IOG

   MEASURE: A VOTING FAMILY MEMBER OR AGENCY WILL BE IN ATTENDANCE AT 50% OF ALL IOG MEETINGS HELD WITHIN THE FISCAL YEAR. SIGN-IN SHEETS AND MEETING MINUTES WILL CONFIRM ATTENDANCE.

3. 75% OF THE AGENCIES CONTRIBUTE RESOURCES AT SERVICE LEVEL, EITHER IN-KIND OR ACTUAL MONIES

   MEASURE: ALL INTEGRATED SERVICE PLANS IDENTIFY TWO OR MORE AGENCIES IN THE PLAN. A COPY OF THOSE SERVICE PLANS WILL BE RETAINED BY THE CMP COORDINATORS.

4. USE OF EVIDENCE BASED OR EVIDENCE INFORMED PRACTICES

   MEASURE: AT LEAST ONE EVIDENCE BASED OR EVIDENCE INFORMED PRACTICE WILL BE IMPLEMENTED UNDER THE IOG, AS REFLECTED IN THE EXPENDITURES SECTION OF THE ANNUAL REPORT.

5. PROCESS OF CONTINUOUS QUALITY IMPROVEMENT USED BY THE IOG

   MEASURE: IOG WILL MEET NO LESS THAN QUARTERLY AND MEETING MINUTES WILL REFLECT THE CONTINUOUS QUALITY IMPROVEMENT PRACTICES USED TO INFORM AND IMPROVE EFFORTS.

6. EVIDENCE OF COST-SHARING AMONG IOG MEMBERS

   MEASURE: COST-SHARING WILL BE REFLECTED IN THE EXPENDITURES SECTION OF THE ANNUAL REPORT.

B. PERFORMANCE MEASURES ISSUED BY THE DEPARTMENT EACH FISCAL YEAR AND POPULATION SERVED WILL DETERMINE THE REMAINDER OF THE INCENTIVE FUNDING ALLOCATION.

1. POPULATION SERVED WILL BE ACTUAL NUMBER OF CLIENTS SERVED THAT YEAR.

2. IOGS MUST CHOOSE THREE STANDARD PERFORMANCE MEASURES TO STRIVE TO ACHIEVE IN THEIR MOU. FOR EVERY PERFORMANCE MEASURE ACHIEVED, A COUNTY WILL RECEIVE FUNDING BASED ON A WEIGHTING SYSTEM. THE WEIGHTING WILL BE BASED ON POPULATION SERVED AND NUMBER OF OUTCOMES ACHIEVED THAT WERE SELECTED IN THEIR MOU.

7.303.36 ~~Program Eligibility~~ GENERAL FUND SAVINGS AND DISTRIBUTION

~~County Departments shall define program eligibility criteria in the proposed plan including a definition of "children and families who would benefit from integrated multi-agency services. This criteria must be approved by the State Department.~~

COUNTY DEPARTMENTS MUST ELECT TO EITHER RETAIN THE STATE GENERAL SHARE OF THE COUNTY UNDER-EXPENDITURE OF THE GENERAL FUND COUNTY CHILD WELFARE BLOCK ALLOCATION OR PARTICIPATE IN SURPLUS DISTRIBUTION FOR EACH FISCAL YEAR IN THEIR MOU. IF A COUNTY/REGION CHOOSES TO RETAIN THE SAVINGS REALIZED, THEY MUST SELECT IF THOSE FUNDS WILL BE REINVESTED BY THE PARTIES TO THE MOU IN ORDER TO PROVIDE APPROPRIATE SERVICES TO CHILDREN, YOUTH, AND/OR FAMILIES, OR TO NOT REINVEST THE SAVINGS REALIZED TO THE PARTIES OF THE MOU.

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Permanent Rules Adopted

Department

Department of Revenue

Agency

Marijuana Enforcement Division

CCR number

1 CCR 212-2

Rule title

1 CCR 212-2 RETAIL MARIJUANA CODE 1 - eff 05/30/3015

Effective date

05/30/3015

Basis and Purpose – R 1004.5

The statutory authority for this rule is found at subsections 12-43.4-202(2)(b), 12-43.4-202(3)(a)(IV), and 12-43.4-202(3)(a)(VII), 12-43.4-404(6), and 25-4-1614(3)(a), C.R.S. Authority also exists in the Colorado Constitution at Article XVIII, Subsection 16(5)(a)(VI). The purpose of this rule is to ensure that every Retail Marijuana Products Manufacturing Facility labels each Shipping Container and Container holding a Retail Marijuana Product with all of the necessary and relevant information for the receiving Retail Marijuana Establishment. In addition, this rule clarifies basic packaging requirements. The State Licensing Authority wants to ensure the regulated community employs proper packaging and labeling techniques for each Retail Marijuana Product as this is a public health and safety concern.

R 1004.5 – Packaging and Labeling Requirements of a Retail Marijuana Product by a Retail Marijuana Products Manufacturing Facility

A. Applicability. This rule shall apply to all Retail Marijuana Products manufactured on or after February 1, 2015.

B. Packaging of Retail Marijuana Product by a Retail Marijuana Products Manufacturing Facility

1. General Standard.

a. Every Retail Marijuana Products Manufacturing Facility must ensure that each Container holding a Retail Marijuana Product is placed in a Shipping Container prior to transport or transfer to another Retail Marijuana Establishment.

2. Single-Serving Edible Retail Marijuana Product.

a. Every Retail Marijuana Products Manufacturing Facility must ensure that each Single-Serving Edible Retail Marijuana Product is packaged within a Child-Resistant Container prior to transport or transfer to another Retail Marijuana Establishment.

b. A Retail Marijuana Products Manufacturing Facility may bundle Single-Serving Edible Retail Marijuana Products that are packaged in Child-Resistant packaging and labeled pursuant to Rule R 1004.5(C) into a larger package that does not need to be Child-Resistant so long as the total amount of active THC contained within the bundled package does not exceed 100 milligrams and the external packaging complies with the Serving Size and Total Active THC Statement requirement of subparagraph (C)(2)(c) of this rule.

3. Multiple-Serving Edible Retail Marijuana Product.

a. Every Retail Marijuana Products Manufacturing Facility must ensure that each Multiple-Serving Edible Marijuana Product is packaged within a Child-Resistant Container that maintains its Child-Resistant effectiveness for multiple openings prior to transport or transfer to another Retail Marijuana Establishment.

4. Liquid Edible Retail Marijuana Product.

a. Liquid Edible Retail Marijuana Product that contains no more than one Standardized Serving Of Marijuana. A Retail Marijuana Products Manufacturing Facility must ensure that each product complies with subparagraph (B)(2)(a) of this rule.

b. Liquid Edible Retail Marijuana Product that contains more than one Standardized Serving Of Marijuana.

i. A Retail Marijuana Products Manufacturing Facility must ensure that each product is packaged in a Child-Resistant Container that maintains its Child-Resistant effectiveness for multiple openings; and

ii. The Container shall clearly demark each Standardized Serving Of Marijuana in a way that enables a reasonable person to intuitively determine how much of the product constitutes a single serving of active THC. The portion of the Container that clearly demarks each Standardized Serving Of Marijuana need not be Opaque; OR

iii. The Container shall include a device that allows a reasonable person to intuitively measure and serve a single serving of active THC.

5. Retail Marijuana Product that is not Edible Retail Marijuana Product.

a. Every Retail Marijuana Products Manufacturing Facility must ensure that each Retail Marijuana Product that is not an Edible Retail Marijuana Product is individually packaged within a Container prior to transport or transfer to another Retail Marijuana Establishment.

C. Labeling of Retail Marijuana Product Containers by a Retail Marijuana Products Manufacturing Facility. A Retail Marijuana Products Manufacturing Facility must ensure that a label(s) is affixed to every Container holding a Retail Marijuana Product that includes all of the information required by this rule prior to transport or transfer to another Retail Marijuana Establishment.

1. Required Information (General). Every Retail Marijuana Products Manufacturing Facility must ensure the following information is affixed to every Container holding a Retail Marijuana Product:

a. The license number of the Retail Marijuana Cultivation Facility(-ies) where the Retail Marijuana used to produce the Retail Marijuana Product was grown;

b. The Production Batch Number(s) of Retail Marijuana concentrate(s) used in the production of the Retail Marijuana Product.

c. The license number of the Retail Marijuana Products Manufacturing Facility that produced the Retail Marijuana Product.

d. A net weight statement.

e. The Production Batch Number(s) assigned to the Retail Marijuana Product.

f. A statement about whether the Container is Child-Resistant.

g. A clear set of usage instructions for non-Edible Retail Marijuana Product.

h. The Identity Statement and Standardized Graphic Symbol of the Retail Marijuana Products Manufacturing Facility that manufactured the Retail Marijuana Product. A Licensee may elect to have its Identity Statement also serve as its Standardized Graphic Symbol for purposes of complying with this rule. The Licensee shall maintain a record of its Identity Statement and Standardized Graphic Symbol and make such information available to the State Licensing Authority upon request;

i. The Universal Symbol, indicating that the Container holds marijuana, which must be no smaller than ¼ of an inch by ¼ of an inch;

j. The following warning statements:

i. **"There may be health risks associated with the consumption of this product."**

ii. **"This product is infused with marijuana."**

iii. **"This product was produced without regulatory oversight for health, safety, or efficacy."**

iv. **"The intoxicating effects of this product may be delayed by two or more hours."**

v. **"There may be additional health risks associated with the consumption of this product for women who are pregnant, breastfeeding, or planning on becoming pregnant."**

vi. **"Do not drive a motor vehicle or operate heavy machinery while using marijuana."**

k. A complete list of all nonorganic pesticides, fungicides, and herbicides used during the cultivation of the Retail Marijuana used to produce the Retail Marijuana Product.

l. A complete list of solvents and chemicals used in the creation of any Retail Marijuana concentrate that was used to produce the Retail Marijuana Product.

2. Required Information (Edible Retail Marijuana Product). Every Retail Marijuana Products Manufacturing Facility must ensure that the following information or statement is affixed to every Container holding an Edible Retail Marijuana Product:

a. Ingredient List. A list of all ingredients used to manufacture the Edible Retail Marijuana Product; which shall include a list of any potential allergens contained within.

b. Statement Regarding Refrigeration. If the Retail Marijuana Product is perishable, a statement that the Retail Marijuana Product must be refrigerated.

c. Serving Size and Total Active THC Statement. Information regarding: the size of Standardized Serving Of Marijuana for the product by milligrams, the total number of Standardized Servings of Marijuana in the product, and the total amount of active THC in the product by milligrams. For example: **"The serving size of active THC in this product is X mg**, **this product contains X servings of marijuana, and the total amount of active THC in this product is X mg."**

d. Statement of Production Date. The date on which the Edible Retail Marijuana Product was produced.

e. Statement of Expiration Date. A product expiration date, for perishable Retail Marijuana Product, upon which the product will no longer be fit for consumption, or a use-by-date, upon which the product will no longer be optimally fresh. Once a label with a use-by or expiration date has been affixed to a Container holding a Retail Marijuana Product, a Licensee shall not alter that date or affix a new label with a later use-by or expiration date.

f. A nutritional fact panel that must be based on the number of THC servings within the Container.

3. Permissive Information (Edible Retail Marijuana Product). Every Retail Marijuana Products Manufacturing Facility may affix a label(s) with the following information to every Container holding an Edible Retail Marijuana Product:

a. The Retail Marijuana Product's compatibility with dietary restrictions.

4. Required Statement When Contaminant Tests are Performed. Every Retail Marijuana Products Manufacturing Facility must ensure that a label is affixed to each Container holding a Retail Marijuana Product with a statement asserting that the Retail Marijuana Product was tested for contaminants and the results of those tests, if:

a. A Retail Marijuana Testing Facility(ies) tested every Harvest Batch used to produce the Retail Marijuana Product for contaminants required to be tested per rule R 1501;

b. A Retail Marijuana Testing Facility tested every Production Batch of Retail Marijuana concentrate used to produce the Retail Marijuana Product for contaminants required to be tested per rule R 1501; and

c. A Retail Marijuana Testing Facility(ies) tested the Production Batch of the Retail Marijuana Product for contaminants required to be tested per rule R 1501.

5. Required Statement When Cannabinoid Potency is Tested. Every Retail Marijuana Products Manufacturing Facility must ensure that a label is affixed to the Container with a potency profile expressed in milligrams pursuant to rule R 1503 and the number of THC servings within the Container.

6. Required Statement When No Contaminant Testing is Completed. Every Retail Marijuana Products Manufacturing Facility must ensure that a label is affixed to each Container that holds a Retail Marijuana Product with the statement: **"The marijuana product contained within this package has not been tested for contaminants."** unless:

    a. A Retail Marijuana Testing Facility(ies) tested every Harvest Batch used to produce the Retail Marijuana Product for contaminants required to be tested per rule R 1501;

    b. A Retail Marijuana Testing Facility tested every Production Batch of Retail Marijuana concentrate used to produce the Retail Marijuana Product for contaminants required to be tested per rule R 1501; and

    c. A Retail Marijuana Testing Facility(ies) tested the Production Batch of the Retail Marijuana Product for contaminants required to be tested per rule R 1501.

D. Labeling of Retail Marijuana Product Shipping Containers by Retail Marijuana Products Manufacturing Facility. Prior to transporting or transferring any Retail Marijuana Product to another Retail Marijuana Establishment, a Retail Marijuana Manufacturing Products Facility must ensure that a label is affixed to a Shipping Container holding Retail Marijuana Product that includes all of the information required by this rule. A Retail Marijuana Products Manufacturing Facility must include the following information on every Shipping Container:

1. The number of Containers holding a Retail Marijuana Product within the Shipping Container; and

2. The license number of the Retail Marijuana Products Manufacturing Facility(-ies) that produced the Retail Marijuana Product within the Shipping Container.

Basis and Purpose – R 1006.5

The statutory authority for this rule is found at subsections 12-43.4-202(2)(b), 12-43.4-202(3)(a)(IV), 12-43.4-202(3)(a)(VII), 12-43.4-402(4), and 25-4-1614(3)(a), C.R.S. Authority also exists in the Colorado Constitution at Article XVIII, Subsection 16(5)(a)(VI). The purpose of this rule is to ensure that the labeling on each Container holding a Retail Marijuana Product includes necessary and relevant information for consumers, does not include health and physical benefit claims, is easily accessible to consumers, and is clear and noticeable. In addition, this rule clarifies basic packaging requirements. Further, the State Licensing Authority believes based on written and oral comments it has received through the rulemaking process that prohibiting labels that are intended to target individuals under the age of 21 and requiring child-resistant packaging is of a state wide concern and would assist in limiting exposure and diversion to minors. The State Licensing Authority wants to ensure the regulated community employs proper packaging and labeling techniques for each Retail Marijuana Product as this is a public health and safety concern.

R 1006.5 – Packaging and Labeling of Retail Marijuana Product by a Retail Marijuana Store

A. Applicability. This rule shall apply to all Retail Marijuana Stores beginning February 1, 2015.

B. Packaging Requirements for a Retail Marijuana Store.

1. Beginning February 1, 2015, a Retail Marijuana Store shall not purchase, take possession of, or sell Edible Retail Marijuana Product that does not comply with rule R 1004.5.

2. A Retail Marijuana Store must ensure that each Edible Retail Marijuana Product placed within a Container for sale to a consumer pursuant to this rule must also be placed in an Opaque Exit Package at the point of sale to the consumer.

3. A Retail Marijuana Store must ensure that each Retail Marijuana Product that is not an Edible Retail Marijuana Product is placed within a Container prior to sale to a consumer. If the Container is not Child-Resistant, the Retail Marijuana Store must place the Container within an Exit Package that is Child-Resistant.

C. Labeling of Retail Marijuana Product by a Retail Marijuana Store. Every Retail Marijuana Store must ensure that a label(s) is affixed to every Exit Package at the time of sale to a consumer that includes all of the information required by this rule. If an Exit Package is not required pursuant to paragraph (B)(3) of this rule, and the Retail Marijuana Store elects not to provide one, then the Retail Marijuana Store must ensure the labels required by this rule are affixed to each Container.

1. Required Information.

a. The license number of the Retail Marijuana Store that sold the Retail Marijuana Product to the consumer;

b. The Identity Statement and Standardized Graphic Symbol of the Retail Marijuana Store that sold the Retail Marijuana Product to the consumer. A Licensee may elect to have its Identity Statement also serve as its Standardized Graphic Symbol for purposes of complying with this rule. The Licensee shall maintain a record of its Identity Statement and

Standardized Graphic Symbol and make such information available to the State Licensing Authority upon request;

c. The date of sale to the consumer;

d. The following warning statements:

i. **“There may be health risks associated with the consumption of this product.”**

ii. **“This product is intended for use by adults 21 years and older. Keep out of the reach of children.”**

iii. **“This product is unlawful outside the State of Colorado.”**

iv. **“This product is infused with marijuana.”**

v. **“This product was produced without regulatory oversight for health, safety, or efficacy.”**

vi. **“The intoxicating effects of this product may be delayed by two or more hours.”**

vii. **“There may be additional health risks associated with the consumption of this product for women who are pregnant, breastfeeding, or planning on becoming pregnant.”**

viii. **“Do not drive a motor vehicle or operate heavy machinery while using marijuana.”**

e. The Universal Symbol, indicating that the Exit Package holds marijuana, which must be no smaller than ¼ of an inch by ¼ of an inch.

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Tracking number: 2015-00145

Opinion of the Attorney General rendered in connection with the rules adopted by the

Marijuana Enforcement Division

on 04/15/2015

1 CCR 212-2

RETAIL MARIJUANA CODE

The above-referenced rules were submitted to this office on 04/17/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 27, 2015 13:05:31

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Education

Agency

Colorado State Board of Education

CCR number

1 CCR 301-8

Rule title

1 CCR 301-8 RULES (FOR THE) ADMINISTRATION OF THE EXCEPTIONAL CHILDREN'S EDUCATIONAL ACT 1 - eff 06/01/2015

Effective date

06/01/2015

DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES (FOR THE) ADMINISTRATION OF THE EXCEPTIONAL CHILDREN'S EDUCATIONAL ACT

1 CCR 301-8

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

2220-R-1.00 STATEMENT OF BASIS AND PURPOSE

1.00(1) - (16) [NO CHANGE]

1.00(17) The statutory authority for the amendments to these Rules is found in Title 22, Article 20, Sections 103 and 106, which amended the definition of "administrative unit" to include a "multi-district administrative unit." The purpose of these amendments is to incorporate the new statutory provisions relating to multi-district administrative units into the Rules. Secondly, these amendments incorporate, by reference, the Temporary Educator Eligibility (TEE) Authorization / Special Education Temporary Authorization (SETA) requirements according to 1 CCR 301-37, 2260.5-R-4.13. Thirdly, amendments to these Rules includes specific procedures and criteria required by House Bill 14-1102 to implement gifted education concerning identification, data collection, advanced learning plan content and procedures, portability procedures, accountability for student achievement, program and budget, family engagement and communication, procedures used to resolve disagreements, and add to the Rules provisions for a grant program. These amendments are authorized by Title 22, Article 20, Section 203. Finally, some inaccurate section numbering has been corrected.

2220-R-2.00 DEFINITIONS USED IN THESE RULES

2.01 Act

Act, when used in 34 CFR Parts 300 and 303, means the federal Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. §1400 et seq. (IDEA) as amended.

2.02 Administrative Unit

Administrative Unit (AU) means a school district, board of cooperative services, multi-district administrative unit, or the State Charter School Institute, that is providing educational services to exceptional children and that is responsible for the local administration of these Rules. In order to qualify as an administrative unit, school districts, boards of cooperative services and multi-district administrative units shall meet all minimum standards established in Section 3.01 of these Rules. All administrative units shall be approved by the Department of Education.

2.02(1) Administrative unit of residence

Pursuant to sections 22-1-102 and 22-20-107.5, C.R.S., an administrative unit of residence (AUR) shall mean the unit in which the child resides on a day-to-day basis with the following exceptions to apply when a child has been determined to have a disability:

2.02(1)(a) If a child with a disability is living at one of the regional centers, an approved facility school, a mental health institute operated by the Department of Human Services,

or if the child attends the Colorado School for the Deaf and the Blind, such child shall be deemed to reside where the parent or guardian of such child resides.

2.02(1)(b) If a child has been placed by a Colorado public agency and lives in one of the regional centers, a mental health institute, a facility, or a group home, and the AUR cannot be determined because parental rights have been relinquished by the parents or terminated by a court, the parents are incarcerated, cannot be located, reside out of state, are deceased, or the child is legally emancipated, the child shall be considered a resident of the administrative unit in which the regional center, mental health institute, facility or group home is located.

2.02(1)(c) If the child resides in a foster care home, the child shall be deemed to be a resident of the AU in which the foster care home is located.

2.02(1)(d) When a child attends a school in another district under the provisions of the public schools of choice law, the child shall be considered a resident of the AU in which the parent or guardian resides.

2.02(1)(e) When a child attends a Charter School in another district, the child shall be considered a resident of the AU in which the parent or guardian resides.

2.02(1)(f) When a child attends a public school on-line program in another district, the child shall be considered a resident of the AU in which the parent or guardian resides.

2.02(1)(g) If a child with a disability is homeless, as defined by Section 22-1-102.5, C.R.S., the provisions of Section 22-1-102(2), C.R.S., apply.

2.02(1)(h) Disputes regarding residency

If there is a dispute as to which AU constitutes the AUR, the Commissioner of Education shall have the authority to determine questions of residency and thus responsibility after reviewing necessary details involved in the determination of residency.

2.02(2) Administrative unit of attendance

An administrative unit of attendance (AUA) shall mean the unit that delivers the special education program for a child. It may be different from the AUR when:

2.02(2)(a) The AUR does not have an adequate number of children with similar needs, and chooses to send the child to another AU for his or her special education program.

2.02(2)(b) The child resides at one of the regional centers, mental health institutes, residential child care facilities, hospitals, group care facilities or homes or in a facility formerly operated by or under contract to the Department of Institutions and now transferred to the Department of Human Services, or attends the Colorado School for the Deaf and the Blind and the special education program is provided by an AU other than the AUR.

2.02(2)(c) The child attends a Charter School, School of Choice or a public school on-line program and the Special Education program is provided by a special education AU other than the AUR.

2.02(3) Multi-district Administrative Unit

Multi-district Administrative Unit means a group of two or more school districts that did not form a Board of Cooperative Services but were (a) parties to an agreement existing on January 1, 2011, to provide educational services to exceptional children and to be responsible for the local administration of these Rules, and (b) recognized by the Department as of January 1, 2011, as an administrative unit.

2.03 – 2.53 [NO CHANGE]

2220-R-3.00 ADMINISTRATION

3.01 Standards For Administrative Units

3.01(1) A special education AU shall satisfy the following standards:

3.01(1)(a) The AU shall be deemed to be of sufficient size and geographic makeup if it fulfills the requirements of the IDEA, the ECEA and their implementing regulations. Administrative unit compliance with these requirements shall be measured by:

3.01(1)(a)(i) The AU's performance as determined by monitoring activities conducted by the Department including: desk audits; focused and comprehensive on-site monitoring; dispute resolution findings; and verification activities to ensure timely correction of noncompliance;

3.01(1)(a)(ii) The AU's performance as determined by its annual determination issued by the Department consistent with 34 CFR § 300.604 and related indicators under Colorado's IDEA Part B State Performance Plan;

3.01(1)(a)(iii) A federal application, approved by the Department, for IDEA Part B and Preschool grant funds;

3.01(1)(a)(iv) Compliance with all federal and state reporting requirements, including fiscal and data reporting requirements;

3.01(1)(a)(v) Compliance with IDEA Part B and IDEA Preschool grant fiscal requirements, including maintenance of effort, excess costs and "supplement not supplant" requirements;

3.01(1)(a)(vi) Maintaining auditable documentation to track expenditures of state and federal special education funds, to ensure that the funds are used solely for allowable uses, as defined by federal and state law;

3.01(1)(b) Provide for sufficient instructional and related services staff to identify and evaluate children who are suspected of having a disability, and plan for and provide appropriate services for all children with disabilities as defined by ECEA Rule 2.08.

3.01(1)(c) Employment of a properly licensed and endorsed professional who will function at least half time as director of special education and who has the authority and responsibility to assure that all the duties and responsibilities of the AU as specified in these Rules are carried out.

3.01(1)(d) Development and implementation of compliant special education comprehensive plan as required by IDEA and approved by the Department.

3.01(1)(e) Accurate completion and submission of all special education student, staff, cost and revenue data on or before dates established by the Department of Education.

3.01(1)(f) Governance by a board which may be a local board as follows:

3.01(1)(f)(i) In the case of a single district AU, the local board of education;

3.01(1)(f)(ii) In the case of an AU that is a board of cooperative services, the board of cooperative services;

3.01(1)(f)(iii) In the case of a multi-district AU, governance consistent with the AU's operating agreement; and

3.01(1)(f)(iv) In the case of the Charter School Institute, the Institute Board.

3.01(2) - 3.01(5) [NO CHANGE]

3.02 [NO CHANGE]

3.03 [NO CHANGE]

3.04 Personnel Qualifications

All personnel providing special education services to children with disabilities shall be qualified.

3.04(1) Personnel qualifications

3.04(1)(a) Teachers

3.04(1)(a)(i) Special education

All special education teachers shall hold Colorado teacher's certificates or licenses with appropriate endorsements in special education. Special education teachers shall also be highly qualified, consistent with Section 2.20 of these Rules.

Each special education teacher will serve, at a minimum, a majority of special education students with the same identified area of need as that teacher's special education license or certification endorsement. The endorsement level must be appropriate for the age being taught.

3.04(1)(a)(ii) Home-hospital

Home-hospital teachers for children with disabilities shall hold Colorado teacher's certificates or licenses.

3.04(1)(a)(iii) Specialty

Specialty teachers in music, art, adapted physical education, home economics, industrial arts and vocational education shall possess Colorado teacher's certificates or licenses with endorsements in the area of instruction.

3.04(1)(b) Related services personnel

All related services personnel providing services to children with disabilities shall hold Colorado special services licenses or certificates with appropriate endorsements. For those areas for which Colorado special services licenses or certificates are not available,

appropriate licenses from the state regulatory agency or professional organization registration are required.

3.04(1)(c) Special education coordinators

Special education coordinators shall have at least a Bachelor's degree and certification and/or licensure in a relevant field. Documentation of their expertise shall be submitted to the Department of Education.

3.04(1)(d) Administrators

Special education directors and assistant directors must possess a certificate or administrator's license with appropriate endorsement.

3.04(1)(e) Paraprofessionals

Each AU or approved facility school will determine the qualifications and competencies required for paraprofessionals. Administrative units and approved facility schools shall assure and document that they meet the requirements for supervision of non-certificated personnel as mandated under Section 22-32-110(1)(ee), C.R.S.

3.04(1)(f) Educational Interpreters

As of July 1, 2000, any person employed as an Educational Interpreter by an AU or approved facility school on a full-time or part-time basis shall meet the following minimum standards, and documentation for meeting these standards must be renewed every five years:

3.04(1)(f)(i) Demonstration of a rating of 3.5 (average) or better in the four areas of the Educational Interpreter Performance Assessment (EIPA).

3.04(1)(f)(ii) Documented content knowledge in these areas: child development, language development, curriculum, teaching and tutoring methods, deafness and the educational process for deaf children.

The Colorado Department of Education will provide guidelines for the implementation of these minimum standards.

3.04(2) [Expired 05/15/2014 per House Bill 14-1123]

3.04(3) Temporary Educator Eligibility (TEE) Authorization / Special Education Temporary Authorization (SETA)

Authorization for Temporary Educator Eligibility (TEE) for staff providing special education and related services to students with disabilities shall be formally referred to as Special Education Temporary Authorization (SETA) and conducted in accordance with Section 4.13 of the Rules for the Colorado Educator Licensing Act of 1991 at 1 CCR 301-37, 2260.5-R-4.13.

3.05 [NO CHANGE]

3.06 [NO CHANGE]

2220-R-4.00 CHILD FIND, EVALUATIONS, ELIGIBILITY DETERMINATIONS, INDIVIDUALIZED EDUCATION PROGRAMS, AND EDUCATIONAL PLACEMENTS

4.01 [NO CHANGE]

4.02 [NO CHANGE]

4.03 Individualized Education Programs

The term "Individualized Education Program" or "IEP" means a written statement for each child with a disability that is developed, reviewed and/or revised in accordance with these Rules. Except as is otherwise set forth in this Section 4.03, the requirements regarding IEPs shall be consistent with 34 CFR §300.320 through §300.325.

4.03(1) – (5) [NO CHANGE]

4.03(6) Content of IEP/Record of Meeting.

The IEP must meet the IEP content requirements established by 34 CFR §300.320(a) and §300.320(c). In addition, the following IEP content is required:

4.03(6)(a) [NO CHANGE]

4.03(6)(b) The written IEP for each child with a vision disability shall include a Learning Media Plan as developed by the IEP team based on comprehensive assessment of the student's learning and literacy modalities by a licensed teacher endorsed in the area of visual impairment. Braille shall be the literacy medium selected unless the IEP team determines, based on the comprehensive literacy learning media assessment that instruction in Braille is not appropriate.

4.03(6)(b)(i) The plan shall include the following:

4.03(6)(b)(i)(A) A statement of how the selected learning and literacy mode or modes will be implemented as the student's primary or secondary mode for achieving literacy and why such mode or modes have been selected,

4.03(6)(b)(i)(B) A statement of how the student's instruction in the selected learning and literacy mode or modes will be integrated into educational activities.

4.03(6)(b)(i)(C) The date on which the student's instruction in the selected mode or modes shall commence, the amount of instructional time to be dedicated to each learning and literacy mode, and the service provider responsible for each area of instruction, and

4.03(6)(b)(i)(D) A statement of the level of competency in each selected learning and literacy mode or modes which the student should achieve by the end of the period covered by the IEP.

4.03(6)(b)(ii) Colorado teachers licensed and endorsed in the area of Visual Impairment must have demonstrated competency in reading and writing literary Braille per the guidelines developed by the Colorado Department of Education.

4.03(6)(c) – (f) [NO CHANGE]

4.03(7) - (11) [NO CHANGE]

2220-R-5.00 [NO CHANGE]

2220-R-6.00 [NO CHANGE]

2220-R-7.00 [NO CHANGE]

2220-R-8.00 [NO CHANGE]

2220-R-9.00 [NO CHANGE]

2220-R-10.00 (reserved)

2220-R-11.00 (reserved)

2220-R-12.00 GIFTED STUDENT PROGRAMMING

Administrative units shall implement gifted education student programs providing programming options and services for gifted children for at least the number of days calendared for the school year by each school district.

12.01 Definitions

12.01(1) **"Administrative Unit"** or "AU" means a school district, a board of cooperative services, or the state Charter School Institute that: oversees and/or provides educational services to exceptional children; is responsible for the local administration of Article 20 of Title 22, C.R.S.; and meets the criteria established in Section 3.01 of these Rules (see Rule 2.02 of these Rules).

12.01(2) **"Advanced Learning Plan"** or "ALP" means a written record of a gifted student's strengths, academic and affective learning goals and the resulting programming utilized with each gifted child and considered in educational planning and decision making.

12.01(3) **"Affective Development"** means social and emotional programming intended to:

12.01(3)(a) assist gifted students in understanding themselves as gifted learners, and the implications of their abilities, talents, and potential for accomplishment (intrapersonal skills); and

12.01(3)(b) assist gifted students in developing and/or refining interpersonal skills.

12.01(4) **"Annual Plan"** means an AU's comprehensive educational plan and annual proposed budget form that the AU submits to the Department pursuant to State Board rules.

12.01(5) **"Aptitude"** means abilities or behaviors that can be monitored, evaluated, or observed to determine potential or a level of performance in problem solving, reasoning, and other cognitive functions (e.g., memory, synthesis, creativity, speed in problem solving). Aptitude or general ability assessments predict potential in an area of giftedness and/or academic school success.

12.01(6) **"Aptitude Test"** means an ability test to determine potential or level of performance in problem solving, reasoning and other cognitive functions. Aptitude or ability tests predict potential in an area of giftedness and/or future academic school success.

12.01(7) **"Articulation",** for purposes of this Rule 12.00, means the communication that occurs as students move or transition through the school system, grade by grade and school level to school level.

12.01(8) **"Assessment"** means methods, tools, and data collected as a body of evidence for use in the following gifted education processes:

12.01(8)(a) Identification and programming;

12.01(8)(b) Monitoring the gifted child's performance and outcomes; and

12.01(8)(c) Program evaluation.

12.01(9) " **Board of Cooperative Services"** means a regional educational services unit created pursuant to Article 5 of Title 22, C.R.S., and designed to provide supporting, instructional, administrative, facility, community, or any other services contracted by participating members.

12.01(10) **"Competence"** means documented performance, achievement, or test scores on standardized or locally normed test results. Screening procedures consider competence in the context of a defined range of student performance, as described herein, for purposes of recognizing gifted potential or identifying a talent pool for developing giftedness.

12.01(11) **"Commensurate Growth"** means the academic and affective progress that can be measured and should be expected of a gifted student given the student's level of achievement, learning needs, and abilities matched with the appropriate instructional level."

12.01(12) **"Early Access"** means early entrance to kindergarten at age 4 or early entrance to first grade at age 5 for highly advanced gifted children who are placed in a grade level above other same aged peers based upon the following conditions:

12.01(12)(a) the student is formally identified as gifted as specified in 12.01(16); and

12.01(12)(b) the student meets requirements for accelerated placement as determined in an auditable body of evidence (e.g., achievement, ability, social-emotional factors, school learning skills, developmental characteristics, and family and school support).

12.01(13) **"Early Childhood Special Educational Services"** means those instructional strategies, curriculum, affective and programming options that nurture and develop exceptional abilities or potential for gifted students, including but not limited to an early entrance strategy or advanced level pre-school interventions.

12.01(14) **"Engagement"** means the collaboration of families, schools, and communities as active partners in improving learner, classroom, school, district, and state outcomes.

12.01(15) **"Evaluation"** means evaluation procedures, methods, and tools used to initially identify a gifted child, assess and monitor the child's progress, and evaluate the child and the gifted program. Evaluation includes, but need not be limited to:

12.01(15)(a) Identifying the child's unique strengths, interests, and needs;

12.01(15)(b) Monitoring the child's academic achievement and growth and affective goals;

12.01(15)(c) Identifying the priorities and concerns of the child's family and resources to which the family and the child's school have access; and

12.01(15)(d) Determining program strengths and areas for program improvement.

12.01(16) **"Gifted Children"** means those persons between the ages of four and twenty-one whose aptitude or competence in abilities, talents, and potential for accomplishment in one or more domains are so exceptional or developmentally advanced that they require special provisions to meet their educational programming needs. Gifted children are hereafter referred to as gifted students. Children under five who are gifted may also be provided with early childhood special educational services. Gifted students include gifted students with disabilities (i.e. twice exceptional) and students with exceptional abilities or potential from all socio-economic, ethnic, and cultural populations. Gifted students are capable of high performance, exceptional production, or exceptional learning behavior by virtue of any or a combination of these areas of giftedness:

12.01(16)(a) General or Specific Intellectual Ability

12.01(16)(a)(i) Definition

Intellectual ability is exceptional capability or potential recognized through cognitive processes (e.g., memory, reasoning, rate of learning, spatial reasoning, ability to find and solve problems, ability to manipulate abstract ideas and make connections, etc.).

12.01(16)(a)(ii) Criteria

Intellectual ability is demonstrated by advanced level on performance assessments or ninety-fifth percentile and above on standardized cognitive tests.

12.01(16)(b) Specific Academic Aptitude

12.01(16)(b)(i) Definition

Specific academic aptitude is exceptional capability or potential in an academic content area(s) (e.g., a strong knowledge base or the ability to ask insightful, pertinent questions within the discipline, etc.).

12.01(16)(b)(ii) Criteria

Specific academic aptitude is demonstrated by advanced level on performance assessments or ninety-fifth percentile and above on standardized achievement tests.

12.01(16)(c) Creative or Productive Thinking

12.01(16)(c)(i) Definition

Creative or productive thinking is exceptional capability or potential in mental processes (e.g., critical thinking, creative problem solving, humor, independent/original thinking, and/or products, etc.).

12.01(16)(c)(ii) Criteria

Creative or productive thinking is demonstrated by advanced level on performance assessments or ninety-fifth percentile and above on standardized tests of creative/critical skills or creativity/critical thinking.

12.01(16)(d) Leadership Abilities

12.01(16)(d)(i) Definition

Leadership is the exceptional capability or potential to influence and empower people (e.g., social perceptiveness, visionary ability, communication skills, problem solving, inter and intra-personal skills and a sense of responsibility, etc.).

12.01(16)(d)(ii) Criteria

Leadership is demonstrated by advanced level on performance assessments or ninety-fifth percentile and above on standardized leadership tests.

12.01(16)(e) Visual Arts, Performing Arts, Musical, Dance, or Psychomotor Abilities

12.01(16)(e)(i) Definition

Visual arts, performing arts, musical, dance or psychomotor abilities are exceptional capabilities or potential in talent areas (e.g., art, drama, music, dance, body awareness, coordination and physical skills, etc.).

12.01(16)(e)(ii) Criteria

Visual arts, performing arts, musical, dance or psychomotor abilities are demonstrated by advanced level on performance talent-assessments or ninety-fifth percentile and above on standardized talent-tests.

12.01(17) "**Gifted Education Services**" or "**Gifted Education Programs**" means the services, delivery model and programs provided to gifted students pursuant to these Rules. "Gifted education services" and "gifted education programs" include, but need not be limited to, strategies, programming options, and interventions reflecting evidence-based practices, such as acceleration, concurrent enrollment, differentiated instruction, and affective guidance.

12.01(18) **"Highly Advanced Gifted Child"** means a gifted child whose body of evidence demonstrates a profile of exceptional ability or potential compared to same-age gifted children. To meet the needs of highly advanced development, early access to educational services may be considered as a special provision. For purposes of early access into kindergarten or first grade, the highly advanced gifted child exhibits exceptional ability and potential for accomplishment in cognitive process and academic areas.

12.01(19) **"Parent"** for purposes of this Rule 12 means the natural or adoptive parent, or legal guardian, unless the gifted student is also a child with a disability in which case parent shall be defined consistent with federal special education law.

12.01(20) **"Performance Assessment"** means systematic observation of a student's performance, examples of products, tasks, or behaviors based upon established criteria, scoring rubric or rating scale for juried performance.

12.01(21) "**Portability"** means that a student's state-approved identification in one or more categories of giftedness transfers to any district in the state. Gifted programming must continue according to the receiving district's programming options. Portability of identification is a part of the student's permanent record and advanced learning plan.

12.01(22) **"Pre-Collegiate"** means a variety of programs to help students plan for college, identify scholarship opportunities, and provide assistance with the application process for selected post-

secondary options. Programs may be offered through middle and high schools, colleges and universities or community organizations and businesses.

12.01(23) **"Pre-Advanced Placement"** means a variety of programs and strategies that prepare students to take advanced placement courses beginning in the early grades, through middle school and high school. "Advanced Placement" means college-level courses and/or exams offered and certified through the College Board.

12.01(24) **"Program Elements"** means components of a comprehensive program plan, which include, but need not be limited to, definition, communication, identification, programming, personnel, accountability, reporting, record keeping, and resolution of disagreements.

12.01(25) **"Program Plan"** means a comprehensive and complete narrative of program elements, including, but need not be limited to:

12.01(25)(a) Procedures and criteria the AU will use for identification;

12.01(25)(b) Programming options for each category of giftedness that the AU will implement in the gifted program; and

12.01(25)(c) Actions and tools for the academic achievement of gifted children, and for evaluating the gifted program, which actions and tools are aligned with state accountability and program evaluations.

12.01(26) **"Qualified Personnel"** or **"Qualified Person"** means a licensed, content endorsed educator who also has an endorsement or higher degree in gifted education; or who is working toward an endorsement or higher degree in gifted education.

12.01(27) **"Screening"** means an assessment method that uses a tool(s) to determine if the resulting data provides evidence of exceptional potential in an area of giftedness. Screening tools may be qualitative or quantitative in nature, standardized and/or normative. Screening data are one component in a body of evidence for making identification and instructional decisions.

12.01(28) **"Special Educational Services"** or **"Special Educational Programs"** means the services or programs provided to exceptional children including children with disabilities and gifted students.

12.01(29) **"Special Provisions"** means the programming options, strategies and services necessary to implement the gifted student's ALP.

12.01(30) **"Twice Exceptional"** means a student who is:

12.01(30)(a) Identified as a gifted student pursuant to Section 12.01(9) of these Rules; and

12.01(30)(b)(1) Identified as a child with a disability pursuant to Section 4.02 of these Rules; or

12.01(30)(b)(2) A qualified individual pursuant to Section 504 of the Rehabilitation Act of 1973, 29 U.S.C.A. §794.

12.01(31) **"Universal Screening"**, for purposes of Section 22-20-202, C.R.S., means the systematic assessment of all students within a grade level of an AU or district for identifying students with exceptional ability or potential, especially students from traditionally underrepresented populations; and/or screening in conjunction with creation of each student's individual career and academic plan (ICAP).

12.02 Administrative Unit Gifted Education Program Plan

12.02(1) Annual Plan

Administrative units shall submit to the Department an annual plan that is a gifted education UIP addendum. In multi-district AUs or BOCES, member districts submit the UIP addendum. Multi-district AUs and BOCES submit a summary for improving gifted student performance that includes annual assurances and a proposed budget for the forthcoming fiscal year. The annual plan shall be integrated with a district's accountability UIP timelines, or no later than April 15. The UIP gifted education addendum, as the annual plan, shall include an action plan to meet designated targets. An AU shall submit an annual plan before receiving AU gifted education funds. Exception to this annual plan is for small rural districts that function on a bi-annual unified improvement plan submission. (C.R.S. 22-11-303(4)(b))

12.02(2) Comprehensive Plan

Administrative units shall submit to the Department a comprehensive gifted education program plan on a multiple-year cycle as declared by the Department, such cycle to be no longer than 5 years. The program plan shall be implemented by all constituent schools and districts of the AU. The filing of the program plan shall include a proposed program plan budget. Plans shall be filed by April 15 of the fiscal year prior to the funding year. The Department will review all program plans for completeness. An AU's program plan shall be deemed complete if it addresses all elements specified in Section 12.02(2)(a) through 12.02(2)(l) of these Rules. A program plan for the education of gifted students submitted to the Department for funding purposes and program description shall contain the following elements:

12.02(2)(a) Procedures for Parent, Family, and Student Engagement and Communication

12.02(2)(a)(i) The program plan shall describe how the AU implements parent, family, and student engagement and communication with regard to gifted education programs that include, but are not limited to: how parents are informed about access to identification procedures; ways to educate parents and families about giftedness or parenting gifted students; information about involvement and progress reporting; what programming options are available to match student strengths and challenges; information about concurrent enrollment; how to be involved in college and career planning; primary languages in the AU, and ways parents and families may participate in the school community.

12.02(2)(a)(ii) In multi-district AUs and BOCES, methods of engagement and communication may vary based upon individual district procedures, but each district must have a plan for parent, family, and student communication and engagement.

12.02(2)(b) Definition of "Gifted Student"

The program plan shall include a written definition that is the same as or substantially similar to the definition of "gifted student" specified in section 12.01(16) of these Rules. This definition shall serve as the basis for the implementation of all other program plan elements described below.

12.02(2)(c) Identification Procedures

The program plan shall describe the assessment process used by the AU for identifying students who meet the definition specified in section 12.01(16) and for identifying the

educational needs of gifted students. The assessment process shall recognize a student's exceptional abilities or potential, interests, and needs in order to guide student instruction and individualized planning and programming. In traditionally under-represented student groups and visual/music/performing arts student groups or talent pools, identification may require the collection of student information over time, using additional data points from a response to intervention approach, or additional assessment. The AU identification procedures shall include, but need not be limited to:

12.02(2)(c)(i) A method(s) to ensure equal and equitable access for all students. The program plan shall describe the efforts that the AU will make to identify gifted students from all populations, including preschool (if applicable) through twelfth grade students, minority students, economically diverse students, culturally diverse students, students with limited English proficiency and children with disabilities;

12.02(2)(c)(ii) Referral procedures that seek referrals from a variety of sources, and screening procedures used for conducting identification assessment. Every AU is strongly encouraged to include optional universal screening in identification procedures;

12.02(2)(c)(iii) A time line of no more than 30 school days after a referral to determine whether a student will continue with formal identification assessment, or will receive talent pool designation;

12.02(2)(c)(iv) Implementation of assessments that align with the purpose of identifying exceptionality in the categories of giftedness, and in traditionally underrepresented populations. The AU may choose local assessment tools from the Department's chart of common and varied assessment tools used in identification;

12.02(2)(c)(v) Collection of data for a body of evidence that includes, but is not limited to: assessment results from multiple sources and multiple types of data (i.e. qualitative and quantitative data about achievement, cognitive ability, performance, parent and teacher input, motivation and observations of gifted characteristics/behaviors). The body of evidence contains data to identify the strength area defined in the definition of gifted children and determine appropriate programming services. These same categories are used in data collection and for developing the ALP;

12.02(2)(c)(vi) A review team procedure; and that includes at least one person trained or endorsed in gifted identification and programming;

12.02(2)(c)(vii) A review team procedure for determining identification or a talent pool designation from a body of evidence and for developing individualized ALPs for identified students. When only cognitive ability assessment data meets criteria in a body of evidence, the review team may determine that the student is identified with general or specific intellectual ability. This identification meets the condition of portability;

12.02(2)(c)(viii) A determination letter for parents and school files describing the decision of the review team, and area(s) of giftedness if the student is found to have exceptional abilities; and

12.02(2)(c)(ix) A communication procedure by which parents are made aware of the identification assessment process for their student, understand the results of the determination, and engage in the development and review of the student's ALP.

12.02(2)(d) **Criteria for Determining Exceptional Ability (Giftedness) or Talent Pool**

12.02(2)(d)(i) For each category of giftedness defined in 12.01(16), criteria for exceptional ability means: 95 percentile or above on a standardized nationally normed test or observation tool, or a rating on a performance assessment that indicates exceptionality/distinguished compared to age mates.

12.02(2)(d)(ii) Not meeting criteria on a single assessment tool shall not prevent further data collection or consideration for identification, if other indicators suggest exceptional potential as observed in a body of evidence.

12.02(2)(d)(iii) Criteria for screening assessments is a score range less than the 95 percentile ranking or results on observation/performance assessment tools as determined by the AU to determine referrals, further data collection and observation, and/or formation of student talent pools.

12.02(2)(e) **Identification Portability**

Identification portability shall be based upon AU implementation of statewide identification procedures required in Section 12.02(2)(c) and use of criteria set for exceptionality in Section 12.02(2)(d) and determination of a student's identification in one or more of the categories of giftedness as described in the state definition of gifted children in Section 12.01(16). Administrative units shall implement procedures for statewide portability of identification that include, but may not be limited to:

12.02(2)(e)(i) A requirement that the sending school/district transfer the body of evidence for identification and the ALP with student records when the student moves from one district to another;

12.02(2)(e)(ii) Review of the transferred student's ALP within 45 school days of start date to determine programming options and services that serve the identified area(s) according to the district and community resources of the receiving district;

12.02(2)(e)(iii) If the receiving district finds the body of evidence to be incomplete, the receiving district shall consult with, as practical, the former district, parents, and student and re-evaluate the identification determination; and

12.02(2)(e)(iv) Communication to parents within 60 school days of start date about how the new district will meet the needs outlined in the student's ALP.

12.02(2)(f) **Advanced Learning Plan Content**

The AU shall develop an ALP for every gifted student according to the student's determined area(s) of giftedness, interests, and instructional and affective needs. The ALP shall be considered in educational planning toward post-secondary readiness outcomes and decision-making concerning subsequent programming for that student and be used in the articulation/transition process, preschool (if applicable) through grade 12. At the high school level ALPs may blend with the student's individualized career and academic plan (ICAP) if all content of the ALP are inclusive in the ICAP which includes achievement and affective goals. The ALP content shall include, but not be limited to:

12.02(2)(f)(i) A student profile described in a body of evidence. This profile shall be subject to the AU's student records confidentiality guidelines. The local AU determines periodic updates of the student profile, especially in terms of interests, and/or demonstration of previously unidentified strengths;

12.02(2)(f)(ii) A working-document section of the ALP. This portion of the ALP records annual measurable, attainable achievement and affective goals and progress. Achievement goals are standards-based statements in strength area(s). Additional achievement goals may be needed to address documented achievement gaps or career interest. Affective goals reflect development of personal, social, communication, leadership, and/or cultural competency;

12.02(2)(f)(iii) Description or delineation of supplemental curriculum, activities, specific programs or coursework, specific strategies, and/or extended or expanded learning opportunities available in the AU that match a student's strength area(s) and support the goals;

12.02(2)(f)(iv) Progress reports that align with the AU's or member district's schedule for parent-reporting and/or conferences about student progress. Adjustments to goals and programming options may occur during any progress reporting period; and

12.02(2)(f)(v) Personnel involved in ALP development, and in progress report meetings or conferences, including, but not limited to classroom teacher(s), student, parents, gifted education staff or staff with training in gifted education identification and programming, and support staff as appropriate.

12.02(2)(g) **ALP Procedures and Responsibilities**

The AU shall have procedures for developing ALPs that include, but need not be limited to:

12.02(2)(g)(i) Notification of ALP development and times in the school year when parents, teachers and the student talk about student academic and affective goal progress;

12.02(2)(g)(ii) Personnel assigned with the responsibility for development and monitoring. At minimum the student's parents and classroom teachers should be familiar with and support ALP goals, and/or write ALP measurable goals according to local procedures. Gifted education resource personnel may assist in the writing of goals, but may not be the sole custodian of the ALP. Goals are written and aligned with classroom tiered instruction and expanded learning opportunities for supplemental or intensive programming;

12.02(2)(g)(iii) A method to develop student awareness and active participation in the ALP process;

12.02(2)(g)(iv) A process for management of ALPs within the cumulative file system including a procedure for transferring ALPs between grade levels, school levels, and districts. It is highly encouraged that ALPs are written by those working with the gifted student and that the ALP is an ongoing plan for coursework, tiered instruction, and increasing performance in the student's area of strength. ALP goals should be written or reviewed for current relevancy to teachers and students at the beginning of the school year;

12.02(2)(g)(v) An ALP progress reporting timeline. The review of progress integrates with ongoing conference or reporting periods of the district. It is highly encouraged that ALPs be student-led at the secondary level; and

12.02(2)(g)(vi) A system to show evidence of parent engagement and input in ALP development and in the review of progress. Evidence may include, but is not limited to: signature, electronic signature or checkbox of involvement, checklist, or other assurance supporting the student's growth. If after 3 documented attempts to contact the parents for signature, no parental signature is obtained, school personnel shall continue with ALP implementation and continue to engage parents in the process.

12.02(2)(h) **Programming**

12.02(2)(h)(i) The program plan shall describe the programming components, options, and strategies that will be implemented by the AU and schools to appropriately address the educational needs of gifted students. Programming shall match the academic strengths and interests of the gifted student. Other educational or affective needs shall be addressed according to the individual student's profile. Programming components, options, and strategies shall include, but need not be limited to:

12.02(2)(h)(i)(A) Alignment of the gifted student's assessment data and ALP goals to programming options in the areas of giftedness;

12.02(2)(h)(i)(B) Structures or type of delivery by which gifted students are served at the different school levels (e.g., the general classroom, resource location, small instructional group, and/or pullout for direct and extended instruction aligned to strength area);

12.02((2)(h)(i)(C) Support in differentiated instruction and methods (e.g., acceleration, cluster grouping and higher order thinking skills);

12.02(2)(h)(i)(D) Affective and guidance support systems (e.g., social skills training, early college and career planning);

12.02(2)(h)(i)(E) Diverse content options provided for gifted students in their areas of strength (e.g., mentorship, Socratic seminars, advanced math, honors courses);

12.02(2)(h)(i)(F) The means by which articulation for preschool (if applicable) through grade 12 is planned and implemented;

12.02(2)(h)(i)(G) Pre-collegiate and/or pre-advanced placement support;

12.02(2)(h)(i)(H) ALP development and reviews conducted through the collaborative efforts of the teacher(s), other school personnel (as needed), parents and the student (as appropriate); and

12.02(2)(h)(i)(I) Post-secondary options available to gifted students.

12.02(2)(h)(i)(J) Concurrent enrollment opportunities, if indicated by a gifted child's ALP or ICAP. To be considered in an ALP, the AU shall consider the student's need for appropriate concurrent enrollment, available options, funding, and requirement for administrative approval.

12.02(2)(h)(ii) Students identified with exceptional ability require provisions to develop the areas of strength over time. When underachievement and/or motivational issues are observed behaviors in a gifted student, the ALP team, child study team, or review team shall problem solve in collaboration with the family, the student, and appropriate staff.

12.02(2)(i) **Evaluation and Accountability Procedures**

The comprehensive program plan shall describe the AU's procedures for evaluation and accountability including, but not limited to:

12.02(2)(i)(i) Unified improvement plan addendum methods by which gifted student performance is monitored and measured for continual learning progress and how such methods align with the state accreditation process (e.g., annual UIP gifted education addendum, multi-district/BOCES summary, intervention progress monitoring data sources, ALP goals, and performance, district, and/or state assessment data). These methods include UIP elements such as annual gifted student performance target(s) and an action plan to meet the target(s) and a timeline to report on progress toward targets;

12.02(2)(i)(ii) Methods by which student affective growth is monitored and measured for continual development (e.g., rubrics for personal journals and anecdotal data, student surveys, demonstration of self-advocacy, and student career and/or college plans);

12.02(2)(i)(iii) Methods for ensuring that gifted student performance (achievement and growth) and reporting are consistent with state accreditation and accountability requirements (i.e., disaggregation of state assessment data for gifted students, identification of discrepancies in the data, goal setting and demonstration of achievement and growth); and

12.02(2)(i)(iv) Methods for self-evaluation of the gifted program including a schedule for periodic feedback and review (e.g., review of gifted policy, goals, identification process, programming components, personnel, budget and reporting practices, and the impact of gifted programming on student achievement and progress); and

12.02(2)(i)(v) Methods by which parents, educators, and other required persons are informed about the methods described in 12.02(2)(i)(i-iv) above.

12.02(2)(j) **Personnel**

12.02(2)(j)(i) The program plan shall describe the personnel who provide instruction, counseling, coordination and other programming for gifted students. Personnel shall be knowledgeable in the characteristics, differentiated instructional methods and competencies in the special education of gifted students. Qualified personnel with endorsement or an advanced degree in gifted education are preferred in specific programs and classrooms consisting of mainly gifted students. Beginning with the 2010-2011 school year, every AU shall employ or contract with a person who is responsible for:

12.02(2)(j)(i)(A) Management of the program plan; and

12.02(2)(j)(i)(B) Professional development activities, the purposes of which are:

12.02(2)(j)(i)(B)(I) To improve and enhance the skills, knowledge and expertise of teachers and other personnel who provide instruction and other supportive services to gifted students; and

12.02(2)(j)(i)(B)(II) To increase, to the extent practicable, the number of qualified personnel providing instruction to gifted students.

12.02(2)(j)(ii) The AU shall make good faith effort to hire and retain on at least a half-time basis one qualified person to administer and monitor the implementation of the AU's gifted program.

12.02(2)(j)(iii) Administrative units should consider employing sufficient personnel for ALP writing and monitoring, and differentiated instruction for gifted students.

12.02(2)(j)(iv) Administrative units should collaborate with universities and colleges for the development of qualified personnel.

12.02(2)(j)(v) Personnel responsible for the instruction and learning of gifted students in core academic areas must meet the requirements under federal law for highly qualified teachers.

12.02(2)(j)(vi) Paraprofessionals may serve in supportive roles, but may not be the sole instructional provider, nor may such paraprofessionals be funded using state gifted education funds.

12.02(2)(j)(vii) The program plan shall also indicate the content of and means by which the AU supports the acquisition and/or improvement of the knowledge and competencies of personnel through appropriate professional development relating to the instruction, programming and counseling for gifted students. (e.g., induction and in-service programs, job-embedded training and coaching, gifted education workshops or institutes and college coursework). Key topics should include, but need not be limited to, gifted characteristics and myths, differentiated instruction, affective needs, counseling, content instructional options and advanced curricular strategies (e.g., higher order thinking strategies).

12.02(2)(k) **Budget**

12.02(2)(k)(i) The AU shall include in the annual plan a budget for gifted education which reflects the collaborative efforts of the AU and cost of implementing the program elements and the student goals stated in the annual comprehensive program plan. The budget shall detail the funding committed by the AU and funding requested from the Department. Funding committed by the AU shall be an amount determined by the AU to contribute towards the AU's gifted student education program described in the AU's program plan. Funds requested from the Department may be used for:

12.02(2)(k)(i)(A) Salaries for appropriately licensed and endorsed personnel primarily serving gifted students (e.g., gifted education directors, coordinators, resource teachers, counselors and teachers of gifted classrooms);

12.02(2)(k)(i)(B) Professional development and training relating to gifted education;

12.02(2)(k)(i)(C) Programming options and school counseling or affective guidance specific to gifted students and their ALPs ;

12.02(2)(k)(i)(D) Materials used in instructional programming for gifted education; and

12.02(2)(k)(i)(E) Administrative costs (classified or grant fiscal staff), technology, and equipment necessary for the education of gifted students up to ten percent for any one of these limited expenditures, and, not to collectively exceed twenty percent of the total amount requested from the Department.

12.02(2)(k)(ii) Administrative units may contract with other AUs to establish and maintain gifted student programs (e.g., art, music, online coursework, and counseling) for the education of gifted children, sharing costs of student programing in accordance with terms of a contract. This action is optional based upon available AU resources, and subject to AU discretion. An AU with less than six children who need a particular program may purchase services from one or more AUs that provide the appropriate gifted education program for individual or groups of gifted students. Gifted education personnel in these AUs shall collaborate on the content and monitoring of such contracts.

12.02(2)(l) **Early Access**

If early access is permitted in the AU, an AU shall include in its program plan provisions to identify and serve highly advanced gifted children pursuant to Section 12.08 of these Rules. Constituent schools or districts within the AU shall abide by the requirements established in the program plan.

12.03 Reports

Administrative units shall submit to the Department an end-of-year report for the prior fiscal year, including:

12.03(1) A detailed report of financial income and expenditures;

12.03(2) The number of formally identified gifted students served through gifted student programming reported by:

12.03(2)(a) Each grade level, preschool (if applicable) through grade 12;

12.03(2)(b) Gender and ethnicity;

12.03(2)(c) Free and reduced lunch;

12.03(2)(d) Area(s) of giftedness;

12.03(2)(e) Twice exceptionality; and

12.03(2)(f) Gifted preschoolers served through early entrance per local policies and procedures, if applicable;

12.03(3) The percent of students in the AU who have been identified as gifted and talented through a formal identification procedure;

12.03(4) Qualified personnel by school level, district resource personnel and central administration;

12.03(5) The types of programming strategies utilized most commonly at each school level to address the needs of gifted students reported by:

12.03(5)(a) Programming options for each area of giftedness as specified in 12.01(16) of these Rules;

12.03(5)(b) Methods of articulation through the grades; and

12.03(5)(c) Methods and tools used in accountability to monitor gifted student achievement and commensurate growth related to the implementation of the programming components; and

12.03(6) Administrative units and their member districts, if any, shall comply with the requirements of accreditation, pursuant to Article 11 of Title 22, C.R.S., with regard to gifted student achievement, identification of disparities in the data, instructional goals, growth and reporting.

12.04 Audits

All programs receiving funding under the provisions of the Exceptional Children's Educational Act are subject to monitoring by the Department as is more fully described in Section 12.07 of these Rules.

12.05 Record Keeping

Administrative units shall have the following record keeping and reporting responsibilities:

12.05(1) **Financial Records**

Financial records shall be kept in accordance with generally accepted principles of governmental accounting. Recommended accounting principles are listed in the Financial Policies and Procedures Handbook.

12.05(2) **Inventory**

An inventory shall be maintained of all equipment for which funding was received. These records shall be maintained throughout the useful life of the equipment.

12.05(3) **Student Education Records**

The ALP documents shall be part of the student's cumulative education record.

12.05(4) **Confidentiality of Student Education Records**

Individually identifiable records of students referred, assessed, evaluated, and/or served through programming for gifted and talented students in any AU shall be held to be confidential and protected in accordance with applicable federal and state laws and regulations. Student records that are collected and/or stored electronically shall be held to current state law and FERPA regulations governing the protection of personally identifiable information and the privacy interests of students.

12.05(5) **Maintenance and Destruction of Student Education Records**

Gifted student education records and ALPs shall be maintained, retained and destroyed consistent with the ongoing system of student record keeping established in the AU, including its member districts or the Charter School Institute for student records, preschool (if applicable) through grade 12.

12.06 Procedures for Disagreements

The program plan shall describe procedures for resolving disagreements with parents/guardians, or students in regard to identification, programming, and ALPs. The procedures for resolving disagreements shall include, but need not be limited to: a method for the aggrieved individual to express issues and concerns; a means to discuss disagreements in a timely manner with personnel designated by the district with authority to resolve the disagreement. The procedures shall afford the aggrieved individual notice of the decision giving rise to the dispute and an opportunity to be heard before the decision is implemented. The procedures must be posted for ease of access by stakeholders.

12.07 Monitoring

12.07(1) Each AU shall comply with all applicable state and federal laws and regulations regarding the program plan, identification and special educational services for gifted students.

12.07(2) Each AU shall be subject to ongoing monitoring by the Department concerning implementation of the program plan.

12.07(3) Monitoring procedures shall include:

12.07(3)(a) A determination of compliance with all applicable state and federal laws and regulations, and

12.07(3)(b) An assessment of program quality based on the standards established by the Department of Education.

12.07(4) Monitoring activities shall include:

12.07(4)(a) A review of the annual and comprehensive program plans;

12.07(4)(b) A review of the annual enrollment and student performance reports;

12.07(4)(c) A planned comprehensive on-site procedure integrated with the continuous improvement and gifted education review process in the Department of Education; and

12.07(4)(d) Follow-up activities including the provision of technical assistance in areas of non-compliance and verification that areas of non-compliance have been corrected.

12.08 Early Access

12.08(1) **[NO CHANGE]**

12.08(2) **[NO CHANGE]**

12.08(2)(a)-(d) [NO CHANGE]

12.08(2)(e) **Process for Early Access**

The AU shall establish a collaborative process among parents, preschool, general and gifted educators and school administration for evaluating early access referrals. The process implemented shall include the following components:

12.08(2)(e)(i) Timelines

12.08(2)(e)(i)(A) Applications for early access are due by April 1 for the next school year. Each AU shall declare when it will begin accepting applications.

12.08(2)(e)(i)(B) Determinations shall be made within 60 calendar days of the AU receiving the child's portfolio submitted by the child's parent in accordance with Section 12.08(2)(e)(iii)(A) of these Rules.

12.08(2)(e)(i)(C) For referrals received after April 1, the AU may, at its discretion, consider the child's information, provided the determination is made by September 1 or by the start of the upcoming school year, whichever is earlier.

12.08(2)(e)(i)(D) A student shall be age 4 by October 1 for kindergarten; and, age 5 by October 1 for first grade.

12.08(2)(e)(ii)-(iv) [NO CHANGE]

12.08(2)(e)(v) Procedures for Disagreements

Procedures for disagreements for early access shall be in accordance with Section 12.06 of these Rules.

12.09 Gifted Education Grants

12.09(1) **Screening Grants**

An AU may apply to the Department for a grant for the universal screenings it conducts. An AU may conduct a universal screening of enrolled students no later than end of second grade; and/or a second universal screening in conjunction with the creation of each child's ICAP by end of eighth grade year.

12.09(1)(a) The amount of each grant request must be based on the number of students who participate in the screening and the per pupil cost of the screening.

12.09(2) **Grants to offset the costs incurred in employing qualified personnel**

An AU that hires a qualified person to administer the AU's gifted programs and implement the AU's program plan may apply to the Department for a grant to offset the costs incurred in employing the qualified person up to .5 FTE.

12.09(2)(a) The amount of each grant request must be equal to the costs incurred by the applying AU in employing the qualified person up to .5 FTE.

12.09(3) **Grant Distribution**

Grants are dependent upon the annual appropriation provided to the Department in any given year and shall be distributed to applicants in accordance with 22-20-205, C. R. S.

12.09(3)(a) If funds are sufficient to fully fund all requests received by the Department, the Department shall distribute awards to each AU applicant.

12.09(3)(b) If funds are insufficient to fully fund all the requests received by the Department, the Department shall distribute funds in the order in which the Department received the applications by date of receipt over the course of three days. If funds are sufficient to fully fund each request received on the first date of receipt, the Department shall distribute awards to each AU application received on that date. If funds are insufficient to fund each request received on day-one of receipt, then funds will be proportionally distributed to each day-one applicant on a pro-rata basis. If grant funds remain after day-one distributions, then funds for day-two applicants and day-three applicants would be distributed in the same manner, until all funds are expended.

12.09(3)(c) If grant funds are not fully expended in a given fiscal year, the Department shall distribute the monies appropriated in the same manner that it distributes AU annual allocations.

12.09(4) **Application Window**

During the first year of implementation, 2014-15 school year, applications will be due to the Department during a three-day application window no later than December 15 as specified in the grant application. Beginning on April 15-17, 2015, and each year thereafter, subject to available appropriations, Gifted Education Grant applications will be due during an April 15-17 application window for funding available July 1 of the subsequent fiscal year.

12.09(5) **Application Procedures**

The Department will develop an application, pursuant to the Department's grant process and pursuant to the requirements and timelines found in 22-20-205, C.R.S. Each grant application may include a request for one, or more, of the allowable uses: one qualified personnel (up to .5 FTE), as the term is defined by 22-20-202(7), C. R. S. and universal screenings in K-2 and/or middle school years.

12.09(5)(a) Each universal screening grant request shall at a minimum specify the name of the screening tool, the number of students who will participate in the universal screening, and the per pupil cost of the screening;

12.09(5)(b) Each qualified personnel grant request shall at a minimum specify the cost to employ a qualified person and a letter or certified document that verifies the qualified person has an endorsement or higher degree in gifted education, or is working toward attaining an endorsement or higher degree in gifted education.

12.09(6) **Duration of Grant Awards**

Each grant shall have a term of one year. Funds must be utilized within the fiscal year (July-June) of the distribution of grant funds.

12.09(7) **Reporting**

In any fiscal year in which the General Assembly makes an appropriation to the Department for the purposes of the grant program, each AU that receives a grant shall report the following information to the Department each year during the term of the grant:

12.09(7)(a) The number of and grade of students who participated in the universal screening, the per pupil cost of the screening, evidence of payment for the screening tool, and the name of tool(s) used; and/or

12.09(7)(b) The number of qualified personnel hired using grant moneys, and the type of endorsement/degree held by the qualified person or documentation that the qualified person is working toward attaining an endorsement or higher degree in gifted education.

12.10 Advisory Committee

Administrative units are highly encouraged to establish and maintain a local advisory committee for gifted education.

Editor's Notes

History

Entire rule eff. 12/30/2007.

Regulations 2220-R-1.00, 2220-R-12.00 emer. rule eff. 08/14/2008.

Regulations 2220-R-1.00, 2220-R-12.00 eff. 10/31/2008.

Regulations 2220-R-1.00 (11); 2220-R-2.08 (7), 2.08 (7)(b) - (b)(i-iii), 2.10 - 2.11; 2220-R-5.01, 5.01 (24) eff. 09/30/2009.

Regulations 2220-R-1.00 (12); 2220-R-2.02; 2220-R-3.01(1)(a), 3.01(2)(a), 3.01(3), 3.01(4)(a-c); 7.06 emer. rule eff. 10/06/2010; expired eff. 02/03/2011.

Regulations 2220-R-1.00(12); 2220-R-12.01(1), 12.02(1)(g) eff. 03/02/2011.

Regulations 2220-R-1.00(13), 2220-R-2.02, 2.08(6), 2220-R-6.02 - 6.02(7.5) emer. rule eff. 06/08/2011.

Regulations 2220-R-1.00(13), 2220-R-2.02, 2.08(6), 2220-R-6.02 - 6.02(7.5) eff. 09/30/2011.

Regulations 2220-R-1.00(13) – (14), 2220-R-2.02, 2220-R-3.01, 2220-R-7.07 eff. 7/30/2012.

Regulations 2220-R-1.00(15), 2220-R-2.02, 2220-R-2.08, 2220-R-2.14, 2220-R-2.44, 2220-R-3.02, 2220-R-9.01(3) eff. 10/30/2012.

Regulations 2220-R-1.00(16), 2.02, 2.02(1)(b), 2.08(13), 2.14 – 2.18, 2.20, 3.02(1), 3.04(1)(e) – (f), 3.04(2), 3.05, 3.06, 4.03(4), 4.03(5)(c), 4.03(6)(c)(ii), 4.03(8)(b)(ii)(A), 5.01(8), 6.02(7.5), 6.02(7.5)(d)(ii)(D), 6.02(8)(k), 7.01(1)(b), 7.01(3)(c), 7.05, 7.07, 8.00, 8.01(2), 8.01(2)(a), 8.02(1)(c), 8.03(2), 8.04(1), 8.04(1)(c), 8.05(1)(c), 8.06(1)(c), 9.01(1)(a)(i) – (ii), 9.01(3), 9.01(5) – (6), 9.01(8), 9.02(1), 9.02(1)(a), 9.02(2), 9.03(1)(a), 9.03(2)(a), 9.06(1) eff. 03/02/2013. Regulation 2220-R-6.02(7) repealed eff. 03/02/2013.

Annotations

Rule 3.04(2) (adopted 01/09/2013) was not extended by House Bill 14-1123 and therefore expired 05/15/2014.

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Office of the Attorney General

Tracking number: 2015-00027

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado State Board of Education

on 04/08/2015

1 CCR 301-8

RULES (FOR THE) ADMINISTRATION OF THE EXCEPTIONAL CHILDREN'S EDUCATIONAL ACT

The above-referenced rules were submitted to this office on 04/15/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 27, 2015 12:04:24

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

CCR number

3 CCR 702-1

Rule title

3 CCR 702-1 ADMINISTRATIVE PROCEDURES 1 - eff 06/01/2015

Effective date

06/01/2015

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-1

ADMINISTATIVE PROCEDURES

Amended Regulation 1-2-14

CONCERNING RECORD KEEPING AND REPORTING REQUIREMENTS FOR INSURANCE PRODUCERS AUTHORIZED TO WRITE BAIL BONDS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109, 10-2-104, and 10-2-705, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements to file the annual report required by § 10-2-415.6, C.R.S., and describe additional documents that must be retained by insurance producers pursuant to § 10-2-705(5), C.R.S.

Section 3 Applicability

This regulation shall apply to insurance producers who are authorized to write bail bonds in the state of Colorado.

Section 4 Definitions

As used in this regulation, and unless the context requires otherwise:

A. “Bail insurance company” shall have the same meaning as defined in § 10-1-102(3.5), C.R.S.

B. “Division” means the Colorado Division of Insurance.

C. "Reporting Year" means the period of time from July 1 through June 30 of the following year. For example, July 1, 2012 through June 30, 2013.

D. "Transaction" means a bail transaction that occurs at the earliest of the issuance or execution of any of the documents listed in § 10-2-705, C.R.S., the payment of premium or the taking of collateral.

Section 5 Rules

A. Annual Report

1. The annual report required by § 10-2-415.6, C.R.S., must be filed in the format and manner set forth in Bulletin B-1.28. The Division will not accept filings in any other format or manner.

2. The annual report must be filed by October 1st of the calendar year following the conclusion of the Reporting Year. For example, if the Reporting Year is July 1, 2012 through June 30, 2013 then the annual report is due by October 1, 2013.

3. A report must be filed by every insurance producer who was at any time during the Reporting Year appointed by a bail insurance company. The report must be filed regardless of the producer's license status on the due date, or appointment status on the due date or whether the producer wrote any bail bond business during the Reporting Year.

B. Records Required to be Maintained

1. Section 10-2-705(5), C.R.S., requires that certain records be maintained by the insurance producer who posts the bail bond with the court. The following records must also be maintained by the insurance producer who posts the bail bond with the court:

   a. Copies of all documents related to the bail transaction.

   b. Copies of all voided documents related to the bail transaction regardless of the reason for the document being voided.

   c. Copies of all documents related to a bail bond that is voided or cancelled by the court.

2. Documents must be maintained for three years after the later of:

   a. The date of discharge of the bail bond and return of any collateral;

   b. Proof of notice to the defendant or indemnitor that any promissory note has been satisfied; or

   c. The date the bail bond was voided or cancelled by the court.

3. If a bond was never posted with the court then all documents related to the transaction must be maintained for three years from the date the documents were prepared and must be maintained by the insurance producer that signed the document.

Section 6 Incorporation by Reference

"Bulletin B-1.28" shall mean Division of Insurance Bulletin number B-1.28 as published on the effective date of this regulation and does not include later amendments to or editions of Bulletin B-1.28. A copy of Bulletin B-1.28 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202 or by visiting the Division of Insurance's website at: http://cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22B-1.28+Annual+Reporting+Requirements+and+Format+for+Insurance+Producers+Authorized+to+Write+Bail+Bonds.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251876035476&ssbinary=true

A Certified copy of Bulletin B-1.28 may be requested from the Colorado Division of Insurance for a fee.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation is effective June 1, 2015.

Section 10 History

Originally issued as Emergency Regulation 04-E-6, effective July 1, 2004.
Emergency Regulation 04-E-8, effective July 23, 2004.
Emergency Regulation 04-E-11, effective October 21, 2004.
Regulation 1-2-14, effective December 1, 2004.
Regulation 1-2-14, effective November 1, 2009.
Emergency Regulation 12-E-05, effective July 1, 2012.
Repealed and Repromulgated Regulation 1-2-14, effective October 15, 2012.
Amended Regulation 1-2-14, effective February 1, 2014.
Amended Regulation 1-2-14, effective June 1, 2015.

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Tracking number: 2015-00142

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 04/09/2015

3 CCR 702-1

ADMINISTRATIVE PROCEDURES

The above-referenced rules were submitted to this office on 04/16/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 27, 2015 13:04:10

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

CCR number

3 CCR 702-1

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3 CCR 702-1 ADMINISTRATIVE PROCEDURES 1 - eff 06/01/2015

Effective date

06/01/2015

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance
3 CCR 702-1

ADMINISTRATIVE PROCEDURES

Regulation 1-2-20

CONCERNING THE FORMAT OF STANDARD BAIL BOND FORMS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109 and 10-2-104, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish five (5) standardized bail bond forms that may be used by bail insurance companies and their insurance producers licensed by the state of Colorado. The use of these forms, apart from the disclosure statement, is not mandatory. The disclosure statement contained in this regulation must be used by bail insurance companies and their insurance producers licensed by the state of Colorado. For purposes of market conduct examination exceptions, proper use of these forms will ensure compliance with the relevant requirements of § 10-2-705, C.R.S., for each form.

Section 3 Applicability

This regulation shall apply to all bail insurance companies and their insurance producers licensed and appointed to act as an agent of a bail insurance company pursuant to § 10-2-415.5, C.R.S.

Section 4 Definitions

A. “Bail insurance company”, for the purposes of this regulation, shall have the same meaning as found at § 10-1-102(3.5), C.R.S.

B. “Disclosure Statement”, for the purposes of this regulation, shall mean the form contained in Appendix A of this regulation.

C. “Insurance Producer”, for the purposes of this regulation, shall mean a licensed insurance producer that is appointed pursuant to § 10-2-415.5, C.R.S., and is authorized to write bail bonds.

Section 5 Forms

A. All bail insurance companies and their insurance producers licensed by the state of Colorado may elect to utilize the forms found in the appendices, with the exception of disclosure statement found in Appendix A, which must be utilized. For purposes of market conduct examination exceptions, proper use of these forms will ensure compliance with the relevant requirements of § 10-2-705, C.R.S., for each form.

B. The forms found in the appendices of this regulation consist of the following standardized forms:

1. The required disclosure statement found at § 10-2-705(2)(b), C.R.S.;

2. The collateral receipt form found at § 10-2-705(1)(c), C.R.S.;

3. The bail bond revocation form found at § 10-2-705(1)(d), C.R.S.;

4. The premium payment plan form found at § 10-2-705(2)(a), C.R.S.; and

5. The premium receipt form found at § 10-2-705(3)(a), C.R.S.

C. Insurance producers are also reminded that they must comply with the remaining document requirements found at § 10-2-705, C.R.S., which are:

1. The indemnity agreement found at § 10-2-705(1)(a), C.R.S.;

2. The promissory note found at § 10-2-705(1)(b), C.R.S.; and

3. If a bond is to be secured by real estate, the disclosure of lien against real property required by § 10-2-705(3.5), C.R.S.

Section 6 Required Disclosure Statement

A. The disclosure statement shall not be altered and must be issued in the format contained in Appendix A.

B. The disclosure statement shall be signed and dated by the producer and the defendant or indemnitor.

C. A disclosure statement shall be provided to each defendant who provides consideration, pays premium or pledges collateral and to each indemnitor who provides consideration, pays premium or pledges collateral.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective June 1, 2015.

Section 10 History

New regulation effective June 1, 2015.

Appendix A: Disclosure Statement

Name of Licensed Insurance Producer Posting Bail Bond:	Bail Insurance Company Name: Insurance Company Contact Information:

(Insurance Producer name, license number, physical address and phone number must be printed or stamped above for delivery of the bond discharge)

Disclosure Statement

Combining multiple Bail Bonds on this form is prohibited

Power of Attorney Number (if available):	Court Case Number or Arrest Number (if assigned):
Bail Bond Amount ($):	Premium Charged:
Name of Indemnitor:	
Collateral Amount:	Collateral Type: ☐ Cash ☐ Real Property ☐ Other
Full Description of Collateral:	
Court Name and Location (if assigned):	

Pursuant to § 18-13-130, C.R.S., your insurance producer or bail insurance company must return any nonforfeited collateral to you within fourteen (14) days of receiving a copy of the court order that results in the release of the bond by the court. In order to begin this process, you may deliver a copy of the court order resulting in a release of the bond by the court to the insurance producer who posted the bond with the court or the bail insurance company. Pursuant to § 10-2-705(3.5)(d), C.R.S., applicable to the use of real property, your reconveyance of title, certificate of discharge, or a full release of any lien shall be provided within 35 days after receiving notice that the time for appealing an order that exonerated the bail bond has expired.

Insurance producers are regulated by the Colorado Division of Insurance. TO ENSURE THE PROMPT RETURN OF YOUR COLLATERAL, THE DIVISION RECOMMENDS YOU HAND DELIVER THE COURT'S BOND DISCHARGE/BOND RELEASE TO THE INSURANCE PRODUCER WHO POSTED THE BOND AND OBTAIN A RECEIPT FROM THE INSURANCE PRODUCER WHO POSTED THE BOND SHOWING THE DATE YOU DELIVERED THE DISCHARGE/RELEASE. If you deliver the bond discharge/release to the insurance producer who posted the bond by mail, it is suggested to use certified mail, return receipt requested, with another certified mail copy to the bail insurance company.

YOU SHOULD RETAIN A COPY OF ALL DOCUMENTS RELATED TO THIS BAIL BOND.

Pursuant to § 10-2-707, C.R.S., the insurance producer who posted the bond with the court, with your consent, may use your collateral to secure the following obligations:

- compliance with the bond issued on behalf of the defendant (which may include costs associated with recovering the defendant should the defendant fail to appear for any court appearance associated with this bond if the court revokes the defendant's bond);
- any balance due on the premium, commission, or fee for the bond; and
- any related costs incurred by the agent as a result of issuing the bond.

READ ALL AGREEMENTS WITH THE INSURANCE PRODUCER CAREFULLY. BE SURE YOU UNDERSTAND ALL OF THE TERMS YOU ARE AGREEING TO.

I have read and understood this Disclosure Statement and consent that the insurance producer in this matter may use my collateral to secure the above obligations.

_____ _____

Signature of defendant or indemnitor **Date Signed**

Printed Name of Licensed Insurance Producer Issuing Disclosure Statement :	Signature of Licensed Insurance Producer Issuing Disclosure Statement:	Date Signed:

Form shall be Deemed Incomplete and Non-Compliant if not filled out correctly and completely.

A completed copy of this document must be kept in the Insurance Producer's records.

Appendix B: Collateral Receipt Form

Name of Licensed Insurance Producer Posting Bail Bond:	Bail Insurance Company Name: Insurance Company Contact Information:

(Insurance Producer name, license number, physical address and phone number must be printed or stamped above)

COLLATERAL RECEIPT

Combining multiple Bail Bonds on this form is prohibited

Power of Attorney Number:		Prenumbered Receipt Number:
Defendant Last Name:	Middle Name:	First Name:
Bond Amount ($):	Premium Charged:	
Court Name and Location (if assigned):		Court Case Number (if assigned):
Collateral Type: ☐ Cash ☐ Real Property ☐ Other		
Collateral Amount:		
Full Description of Collateral (If NOT filled out, form shall be deemed incomplete and non-compliant):		
Name of Person Tendering Collateral:	Address of Person Tendering Collateral:	Phone Number of Person Tendering Collateral:

Printed Name of Licensed Insurance Producer Receiving Collateral:	Signature of Licensed Insurance Producer Receiving Collateral:	Date Signed:
ACKNOWLEDGEMENT: ***I HAVE BEEN PROVIDED A COPY OF THIS COLLATERAL RECEIPT***		
Printed Name of Person Pledging Collateral:	Signature of Person Pledging Collateral:	Date:

Collateral will be returned after receipt of a copy of the Court Order that results in a release of the bond by the Court. Collateral will be returned within fourteen (14) calendar days. Pursuant to § 10-2-705(3.5)(d), C.R.S., applicable to the use of real property, your reconveyance of title, certificate of discharge, or a full release of any lien shall be provided within 35 days after receiving notice that the time for appealing an order that exonerated the bail bond has expired. Trust Deeds will be returned within thirty-five (35) calendar days. If the bail bond is not posted within twenty-four hours of receipt of full payment or a signed contract for payment, collateral must be returned and the lien released within seven days (7) after receipt of good funds.

Form shall be Deemed Incomplete and Non-Compliant if not filled out correctly and completely

A completed copy of this document must be kept in the Insurance Producer's records.

Appendix C: Bail Bond Revocation Request Form

Name of Licensed Insurance Producer Posting Bail Bond:	Bail Insurance Company Name: Insurance Company Contact Information:

(Insurance Producer name, license number, physical address and phone number must be printed or stamped above)

BAIL BOND REVOCATION REQUEST

Combining multiple Bail Bonds on this form is prohibited

Defendant Name	**Bail Bond Amount**
Court Name (if assigned)	**Court Case No. (if assigned)**

I, _____ request that the bail bond specified above be
(defendant or indemnitor name)

revoked.

_____
Defendant or Indemnitor printed name

_____ _____
Defendant or Indemnitor Signature Date

_____
Printed Name of Licensed Insurance Producer

_____ _____
Signature of Licensed Insurance Producer Date

Form shall be Deemed Incomplete and Non-Compliant if not filled out correctly and completely

A completed copy of this document must be kept in the Insurance Producer's records.

A completed copy of this document must be kept in the Producer's records.

Appendix D: Premium Payment Plan Form

Name of Licensed Insurance Producer Posting Bail Bond:	Bail Insurance Company Name: Insurance Company Contact Information:

(Insurance Producer name, license number, physical address and phone number must be printed or stamped above)

PREMIUM PAYMENT PLAN

Combining multiple Bail Bonds on this form is prohibited

Defendant Name	**Bail Bond Amount**
Court Name (if assigned)	**Court Case No. (if assigned)**

Bail Bond Premium Charged:	
Bail Bond Filing Fee:	
Total Due:	
Amount Paid To Date:	
Balance Owed:	

This is a Premium Payment Plan for the payment of the remaining balance owed for the issuance and posting of the bail bond described below.

1. Payment Schedule:

Payment #1:	Amount of Payment $:		Date payment due:	
Payment #2:	Amount of Payment $:		Date payment due:	
Payment #3:	Amount of Payment $:		Date payment due:	
Payment #4:	Amount of Payment $:		Date payment due:	

(NOTE: There is no requirement in Colorado Revised Statutes limiting the payment schedule to four (4) payments.)

2. If a refund of premium is ordered by the Court after the bond is posted, premium will be returned in the amount and within the time specified by the court order. Otherwise, the person(s) signing this Premium Payment Plan must make all payments regardless of whether the bail bond has been revoked, the conditions of the bond have changed or the status of the defendant has changed.

3. The person signing below acknowledges receiving a copy of this Premium Payment Plan.

_____ _____ _____

Printed Name of Licensed Insurance Producer Issuing Premium Payment Plan | Signature of Licensed Insurance Producer | Date

_____ _____ _____

Defendant/Indemnitor Printed Name | Defendant/Indemnitor Signature | Date

This document shall not constitute a Premium Receipt. To issue a Premium Receipt, please use a "Premium Receipt Form" (BBD-PR). Every payment made requires a separate premium receipt.

Form shall be Deemed Incomplete and Non-Compliant if not filled out correctly and completely

A completed copy of this document must be kept in the Insurance Producer's records.

A completed copy of this document must be kept in the Producer's records.

Appendix E: Premium Receipt Form

Name of Licensed Insurance Producer Posting Bail Bond:	Bail Insurance Company Name: Insurance Company Contact Information:

(Insurance Producer name, license number, physical address and phone number must be printed or stamped above)

PREMIUM RECEIPT

Combining multiple Bail Bonds on this form is prohibited

Power of Attorney Number:		Prenumbered Receipt Number:
Description of Bail Bond Issued		
Defendant Last Name:	Middle Name:	First Name:
Bond Amount ($):		
Court Name and Location (if assigned):		Court Case Number (if assigned):

Premium Receipt Information

Bond Premium Charged:	Filing Fee/Jail Posting Fee:	Total Due for Premium/Posting/Filing Fees:
Amount of Premium Received:	☐ Cash ☐ Check ☐ Money Order ☐ Credit Card ☐ Other (Describe below)	Balance of Premium Due *(payment terms must be in writing and set forth in the Premium Payment Plan)*:
Received from Printed Name:		
Date Received:	Purpose:	

Printed Name of Licensed Insurance Producer Receiving Payment:	Signature of Licensed Insurance Producer Receiving Payment:	Date:

ACKNOWLEDGEMENT:

I HAVE BEEN PROVIDED A COPY OF THIS PREMIUM RECEIPT

Payer Printed Name:	Date:

If a refund of premium is ordered by the Court after the bond is posted, premium will be returned in the amount and within the time specified by the court order. If the bail bond is not posted within twenty four hours, as required by law, all monies paid must be returned within seven days (7) after receipt of good funds. A separate Premium Receipt shall be prepared each time an insurance producer posts a Bail Bond with the court.

Form shall be Deemed Incomplete and Non-Compliant if not filled out correctly and completely

A completed copy of this document must be kept in the Insurance Producer's records.

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

MELANIE J. SNYDER
Chief of Staff

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Office of the Attorney General

Tracking number: 2015-00143

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 04/09/2015

3 CCR 702-1

ADMINISTRATIVE PROCEDURES

The above-referenced rules were submitted to this office on 04/16/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 27, 2015 13:04:34

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

CCR number

3 CCR 702-4 Series 4-3

Rule title

3 CCR 702-4 Series 4-3 LIFE, ACCIDENT AND HEALTH, Series 4-3 1 - eff 06/01/2015

Effective date

06/01/2015

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-3-1

MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES

Appendix C Replacement Forms
Appendix D Form for Reporting Duplicate Policies
Appendix E Disclosure Statement

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109 and Article 18 of Title 10, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosure in the sale of accident and sickness insurance coverage to persons eligible for Medicare.

Section 3 Applicability

A. Except as otherwise specifically provided in Sections 7, 11, 12, 13, 16 and 21, this regulation shall apply to:

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

2. All certificates issued under group Medicare supplement policies or subscriber contracts, 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 organization, 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 organization.

C. Except as specifically provided by statute, Medicare supplement polices are regulated under §§ 10-18-101 to 109, C.R.S., and any regulations promulgated there under. Nothing in this regulation shall be construed as conflicting with statutes that are not specifically applicable to Medicare supplement insurance.

Section 4 Definitions

A. "Applicant" means, for the purposes of this regulation:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy, the proposed certificate holder.

B. “Bankruptcy” means, for the purposes of this regulation, when a Medicare Advantage organization that is not an issuer has filed, or has filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means, for the purposes of this regulation, any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means, for the purposes of this regulation, the form on which the certificate is delivered or issued for delivery by the issuer.

E. “Continuous period of creditable coverage” means, for the purposes of this regulation, 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 for voluntary terminations and six (6) months for involuntary terminations (other than non payment of premium or fraud).

F. Creditable Coverage

1. “Creditable coverage” means, for the purposes of this regulation, with respect to an individual, coverage of the individual provided under any of the following:

    a. A group health plan;

    b. Health insurance coverage;

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

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

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

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

    g. A state health benefits risk pool;

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

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

    j. A health plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

2. “Creditable coverage” shall not include, for the purposes of this regulation, one or more, or any combination of, the following:

    a. Coverage only for accident or disability income insurance, or any combination thereof;

    b. Coverage issued as a supplement to liability insurance;

    c. Liability insurance, including general liability insurance and automobile liability insurance;

    d. Workers’ compensation or similar insurance;

    e. Automobile medical payment insurance;

    f. Credit-only insurance;

    g. Coverage for on-site medical sites; and

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

3. “Creditable coverage” shall not include, for the purposes of this regulation, the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

a. Limited scope dental or vision benefits;

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

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

4. “Creditable coverage” shall not include, for the purposes of this regulation, the following benefits if offered as independent, non-coordinated benefits:

a. Coverage only for a specified disease or illness; and

b. Hospital indemnity or other fixed indemnity insurance.

5. “Creditable coverage” shall not include, for the purposes of this regulation, the following if it is offered as a separate policy, certificate or contract of insurance:

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

b. Coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code; and

c. Similar supplemental coverage provided to coverage under a group health plan.

G. “Employee welfare plan” means, for the purposes of this regulation, a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. "Health care expenses" mean, for the purposes of Section 13 of this regulation, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of issuers.

I. “Insolvency” means, for the purposes of this regulation, when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by court of competent jurisdiction in the issuer’s state of domicile.

J. "Issuer" includes, for the purposes of this regulation, insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

K. "Medicare" means, for the purposes of this regulation, "The Health Insurance for the Aged Act," Title XVIII of the federal "Social Security Act" as amended. This regulation does not cover amendments to this statute that were promulgated later than the effective date of this regulation.

L. “Medicare Advantage plan” means, for the purposes of this regulation, a plan of coverage for health benefits under Medicare Part C as defined in the definition of Medicare Advantage plan in 42 U.S.C. 1395w-28(b)(1). Included are:

1. Coordinated care plans, which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

3. Medicare Advantage private fee-for-service plans.

M. "Medicare supplement policy" means, for the purposes of this regulation, a group or individual policy of sickness and accident insurance or a subscriber contract of a hospital and medical service association or a health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et. seq.), or an issued policy under a demonstration project, specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. “Medicare supplement policy” does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under § 1833(a)(1)(A) of the Social Security Act.

N. “Nurse” means, for the purposes of this regulation, a “graduate nurse”, “practical nurse”, “trained practical nurse”, “licensed vocational nurse”, “licensed practical nurse”, “registered nurse” or “registered professional nurse” as defined under § 12-38-103, C.R.S.

O. "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan," or "Pre-Standardized plan" mean, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued prior to May 1, 1992.

P. “1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan," or "1990 plan" mean, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued on or after May 1, 1992 and prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after April 30, 1992 which are not replaced by the issuer at the request of the insured.

Q. “2010 Standardized Medicare supplement benefit plan,” “2010 Standardized benefit plan,” or “2010 plan” means, for the purposes of this regulation, a group or individual policy of Medicare supplement insurance issued with an Effective Date for Coverage issued on or after June 1, 2010.

R. "Policy form" means, for the purposes of this regulation, the form on which the policy is delivered or issued for delivery by the issuer.

S. “Secretary” means, for the purposes of this regulation, the Secretary of the U.S. Department of Health and Human Services.

Section 5 Policy Definitions and Terms

No policy or certificate may be identified in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms that conform to the requirements of this section.

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

1. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

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

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined by Medicare.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined by Medicare.

D. "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 by Medicare.

E. "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 federal "Social Security Act," as amended by the Social Security amendments of 1965, and as 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.

F. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

G. "Physician" shall not be defined more restrictively than as defined by Medicare.

H. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6 Policy Provisions

A. Except for permitted preexisting conditions clauses as described in Section 7.A.1., Section 8.A.1., and Section 8.1.A.1. of this regulation, no policy or certificate may be identified as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

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

D. Rules for Prescription Drugs

1. Subject to Sections 7.A.4., 5 and 7 and 8.A.4. and 5., a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll In Medicare Part D at the option of the policyholder.

2. A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

3. After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

   a. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under Medicare Part D; and

   b. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

E. All Medicare supplement insurance policies shall provide for a refund of unearned premium, when the policy is replaced by another Medicare supplement carrier or given a request for cancellation by the insured.

Section 7 Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates issued for Delivery Prior to May 1, 1992

No policy or certificate may be identified as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits, which are not inconsistent with these standards.

A. General Standards

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

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

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

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts Premiums may be modified to correspond with such changes.

4. A "non-cancelable," "guaranteed renewable," or "non-cancelable and guaranteed renewable" Medicare supplement policy shall not:

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

b. Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

5. Replacement, Termination, and Nonrenewal

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

b. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph 5.d. of this section, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

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

(2) An individual Medicare supplement policy, that provides only such benefits as are required to meet the minimum standards as defined in Section 8.1.B. of this regulation.

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

(1) Offer the certificate holder such conversion opportunities as are described in Subparagraph b.; or

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

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

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefits period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

7. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. Minimum Benefit Standards

1. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

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

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

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

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

6. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system (PPS), the copayment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

7. 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 Medicare Part A, subject to the Medicare deductible amount.

Section 8 Minimum Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after May 1, 1992 and with an Effective Date for Coverage Prior to June 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after May 1, 1992 and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be identified as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

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

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

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any

changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable and:

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

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

   c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.A.5.e., the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

      (1) Provides for continuation of the benefits contained in the group policy; or

      (2) Provides for such benefits as otherwise meets the requirements of this subsection.

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

      (1) Offer the certificate holder the conversion opportunity described in Section 8 A.5.c.; or

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

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

   f. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this Paragraph.

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining continuous loss.

7. Suspension and reinstitution of Medicare supplement policies shall be in accordance with the following:

a. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) 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 (Medicaid), but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

b. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in § 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of the loss of coverage within ninety (90) days after the date of the loss.

d. Reinstitution of such coverages as described in Subparagraphs b. and c.:

(1) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(2) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(3) 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.

8. If an issuer makes a written offer to the Medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1992 Standardized plan as described in Section 9 of this regulation to a 2010 Standardized plan as described in Section 9.1. of this regulation, the offer and subsequent exchange shall comply with the following requirements:

a. An issuer need not provide justification to the Commissioner if the insured replaces a 1992 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new

exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the Commissioner.

b. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

c. An issuer:

(1) Shall not apply new preexisting condition limitations or a new contestability period to the new policy for those benefits contained in the exchanged 1992 Standardized policy or certificate of the insured; but

(2) May apply pre-existing condition limitations of no more than six(6) months to any added benefits only if this fact is clearly disclosed in the offer to the consumer.

d. The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan; except where the offer or issue would be in violation of state or federal law.

B. Standards for Basic ("Core") Benefits Common to All Benefit Plans A-J

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof:

1. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage of Medicare Part A eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3. Upon exhaustion of the Medicare inpatient hospital coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance.

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

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a PPS, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit plans "B" through "J" only as provided by Section 9 of this regulation:

1. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amounts per benefit period.

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

3. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the differences between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. One hundred percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

6. Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may have been included for sale or issuance in a Medicare supplement policy until January 1, 2006.

7. Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may have been included for sale or issuance in a Medicare supplement policy until January 1, 2006.

8. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States subject to calendar year deductible of two hundred fifty dollars ($250) and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

    a. An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph b. and patient education to address preventive health care measures.

    b. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

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

10. At-Home Recovery Benefit: Coverage for services to provide short term, At-Home assistance with activities of daily living for those recovering from an illness, injury or surgery.

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

        (1) "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.

        (2) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurse’s registry.

        (3) "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.

        (4) "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 24-hour period of services provided by a care provider is one (1) visit.

    b. Coverage Requirements and Limitations:

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

        (2) 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.

        (3) Coverage is limited to:

            (a) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

            (b) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

            (c) One thousand six hundred dollars ($1,600) per calendar year.

(d) Seven (7) visits in any one week.

(e) Care furnished on a visiting basis in the insured's home.

(f) Services provided by a care provider as defined in Section 8.C.10.a.(2).

(g) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(h) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

c. Coverage is excluded for:

(1) Home care visits paid for by Medicare or other government programs; and

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

D. Standards for Plans K and L:

1. Standardized Medicare Supplement Benefit Plan “K” shall consist of the following:

a. Coverage of one hundred percent (100%) of the Medicare Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

b. Coverage of one hundred percent (100%) of the Medicare Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

c. Upon exhaustion of the Medicare hospital inpatient coverage, including reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

d. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph j.;

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

f. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph j.;

g. Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph j.;

h. Except for coverage provided in Subparagraph i.;below, coverage for the fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Medicare Part B deductible until the out-of-pocket limitation is met as described in Subparagraph j. ;

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

j. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B. This amount may be indexed each year by the appropriate inflation adjustment by the Secretary of the U.S. Department of Health and Human Services.

2. Standardized Medicare Supplement Plan “L” shall consist of the following:

a. The benefits described in Subparagraphs 1.a., b., c. and i.;

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

c. The benefit described in Subparagraph 1.j. but substituting the amount specified by the Secretary of the U.S. Department of Health and Human Services.

Section 8.1 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be identified as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1992 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010 remain subject to the requirements of Section 8 of this regulation.

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

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

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

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable and:

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

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

    c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1.A.5.e., the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

        (1) Provides for continuation of the benefits contained in the group policy; or

        (2) Provides for such benefits as otherwise meets the requirements of this subsection.

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

        (1) Offer the certificate holder the conversion opportunity described in Section 8.1.A.5.c.; or

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

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

6. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining continuous loss.

7. Suspension and reinstatement of Medicare supplement policies shall be in accordance with the following:

    a. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the

policyholder or certificate holder for the period (not to exceed twenty-four (24) months) 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 (Medicaid), but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

b. If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in § 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of the loss of coverage within ninety (90) days after the date of the loss.

d. Reinstatement of such coverages as described in Subparagraphs b. and c.:

(1) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(2) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(3) 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.

B. Standards for Basic ("Core") Benefits Common to All Medicare supplement insurance benefit plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu of it:

1. Coverage of Medicare Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2. Coverage of Medicare Part A eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3. Upon exhaustion of the Medicare inpatient hospital coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate

Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a PPS, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans B, C, D, F, F with High Deductible, G, M and N as provided by Section 9.1 of this regulation:

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

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

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

4. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

5. One hundred percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

6. 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 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.

Section 9 Minimum Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery After April 30, 1992 and with an Effective Date for Coverage Prior to June 1, 2010

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 Section 8.B. of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Sections 9.G. and 24 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this section and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Section 8.B, 8.C. or 8.D. and list the benefits in the order shown in this section. For the 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. of this section, other designations to the extent permitted by law.

E. Make-up of benefit plans:

1. Standardized Medicare Supplement Benefit Plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in Section 8.B. of this regulation.

2. Standardized Medicare Supplement Benefit Plan "B" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible as defined in Section 8.C.1.

3. Standardized Medicare Supplement Benefit Plan "C" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.C., Paragraphs 1., 2., 3., and 8., respectively.

4. Standardized Medicare Supplement Benefit Plan "D" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Section 8.C., Paragraphs 1., 2., 8., and 10., respectively.

5. Standardized Medicare Supplement Benefit Plan "E" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care Benefit defined in Section 8.C., Paragraphs 1., 2., 8., and 9., respectively.

6. Standardized Medicare Supplement Benefit Plan "F" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, the Skilled Nursing Facility Care, the Part B deductible, one hundred percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.C., Paragraphs 1., 2., 3., 5., and 8., respectively.

7. Standardized Medicare Supplement Benefit High Deductible Plan “F” shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan “F” deductible. The covered expenses include the “core” benefit as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, Skilled Nursing Facility Care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.C., Paragraphs 1., 2., 3., 5., and 8.,

respectively. The annual high deductible Plan “F” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “F” policy, and shall be in addition to any other specific benefit deductibles, 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 ten dollars ($10).

8. Standardized Medicare Supplement Benefit Plan "G" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, Skilled Nursing Facility Care, eighty percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Section 8.C., Paragraphs 1., 2., 4., 8., and 10., respectively.

9. Standardized Medicare Supplement Benefit Plan "H" shall consist of only the following: The Basic ("Core") Benefits as defined in Section 8.B. 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 Section 8.C., Paragraphs 1., 2., 6., and 8., respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

10. Standardized Medicare Supplement Benefit Plan "I" shall consist of only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, Skilled Nursing 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 the At-Home Recovery Benefit as defined in Section 8.C., Paragraphs 1., 2., 5., 6., 8., and 10., respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

11. Standardized Medicare Supplement Benefit Plan "J" shall consist of only the following: The Basic ("Core") Benefits as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B Excess Charges, Extended Prescription drug benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and the At-Home Recovery Benefit as defined in Section 8.C., Paragraphs 1., 2., 3., 5., 7., 8., 9., and 10., respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

12. Standardized Medicare Supplement Benefit High Deductible Plan “J” shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible Plan “J” deductible. The covered expenses include “Basic (Core) Benefits” as defined in Section 8.B. of this regulation, plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and the At-Home Recovery Benefit as defined in Section 8.C., Paragraphs 1., 2., 3., 5., 7., 8., 9., and 10., respectively. The annual high deductible Plan “J” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “J” policy, and shall be in addition to any other specific benefit deductibles, 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 ten dollars ($10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

F. Make-up of benefit plans “K” and “L”:

1. Standardized Medicare supplement Benefit Plan “K” shall consist of only those benefits described in Section 8.D.1.

2. Standardized Medicare supplement Benefit Plan “L” shall consist of only those benefits described in Section 8.D.2.

G. New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. The innovative benefit shall not include an outpatient prescription drug benefit.

Section 9.1 Standard Medicare Supplement Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be identified as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of Section 9.

A. Standard Plans issued on or after June 1, 2010 shall comply with the following standards:

1. An issuer shall make available to each prospective policyholder and certificate holder a policy or certificate form containing only the Basic "Core" Benefits, as defined in Section 8.1.B. of this regulation.

2. If an issuer makes available any of the additional benefits described in Section 8.1.C. or offers Standardized Benefit Plans K or L (as described in Sections 9.1.E.8. and 9. of this regulation) then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the “Basic (Core) Benefits” as described in Paragraph 1. above, a policy form or certificate form containing either Standardized Benefit Plan C (as described in Section 9.1.E.3. of this regulation or Standardized Benefit Plan F (as described in Section 9.1.E.5. of this regulation).

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Sections 9.1.F. and 24 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this section and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1.B. and 8.1.C. of this regulation, or, in the case of plans K or L, in Sections 9.1.E.8. or 9. of this regulation and list the benefits in the order shown. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C. of this section, an issuer may use other designations to the extent permitted by law.

E. Make-up of 2010 Standardized Benefit Plans:

1. Standardized Medicare Supplement Benefit Plan "A" shall include only the following: The Basic (“Core”) Benefits as described in Section 8.1.B. of this regulation.

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

3. Standardized Medicare Supplement Benefit Plan "C" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.1.B. of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, Skilled Nursing Facility Care, one hundred percent (100%) of the Medicare Part B deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8.1.C., Paragraphs 1., 3., 4., and 6., of this regulation respectively.

4. Standardized Medicare Supplement Benefit Plan "D" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.1.B. of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, Skilled Nursing Facility Care, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.1.C. , Paragraphs 1., 3., and 6., of this regulation respectively.

5. Standardized Medicare Supplement Benefit Plan "F" shall include only the following: The Basic ("Core") Benefits as defined in Section 8.1.B. of this regulation, plus the Medicare Part A deductible, the Skilled Nursing Facility Care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.1.C., Paragraphs 1., 3., 4., 5., and 6., of this regulation, respectively.

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

   a. The Basic ("Core") Benefits as defined in Section 8.1.B. of this regulation, plus the Medicare Part A deductible, the Skilled Nursing Facility Care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.1.C., Paragraphs 1., 3., 4., 5., and 6., respectively.

   b. The annual deductible in Plan F with High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the regular plan “F” policy, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be annual and shall be adjusted annually by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

7. Standardized Medicare Supplement Benefit Plan "G" shall include only the following: The Basic (“Core”) Benefits as defined in Section 8.1.B. of this regulation, plus one hundred

percent (100%) of the Medicare Part A deductible, the Skilled Nursing Facility Care, one hundred percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.1.C., Paragraphs 1., 3., 5., and 6., respectively.

8. Standardized Medicare Supplement Benefit Plan K is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and shall include only the following:

   a. Part A Hospital Coinsurance 61st to 90th days: Coverage of one hundred percent (100%) of the Part A inpatient hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

   b. Part A Hospital Coinsurance, 91st to 150th days: Coverage for one hundred percent (100%) of the Part A inpatient hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through 150th day in any Medicare benefit period;

   c. Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare inpatient hospital coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

   d. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph j. of this Paragraph 8.;

   e. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph j. of this Paragraph 8.;

   f. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph j. of this Paragraph 8.;

   g. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph j. of this Paragraph 8.;

   h. Part B Cost Sharing: Except for coverage provided in Subparagraph i. of this Paragraph 8., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph j. of this Paragraph 8.;

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

j. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B. This amount may be indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

9. Standardized Medicare Supplement Benefit Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

a. The benefits described in Subparagraphs 9.1.E.8. a., b., c., and i. of this regulation;

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

c. The benefit described in Subparagraph 9.1.E. 8. j. of this regulation, but substituting the amount specified by the Secretary of the U.S. Department of Health and Human Services.

10. Standardized Medicare Supplement Benefit Plan M shall include only the following: The Basic ("Core") Benefits as defined in Section 8.1.B. of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, Skilled Nursing Facility Care, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.1.C., Paragraphs 2., 3., and 6. of this regulation, respectively.

11. Standardized Medicare Supplement Benefit Plan N shall include only the following: The Basic ("Core") Benefits as defined in Section 8.1.B. of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, Skilled Nursing Facility Care, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 8.1.C., Paragraphs 1., 3., and 6. of this regulation, respectively, with copayments in the following amounts:

a. The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

b The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

F. New or Innovative Benefits: An issuer may, with the prior approval of the Commissioner offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any Standardized plan.

Section 10 Open Enrollment

A. No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection regardless of age.

B. No issuer shall 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 that policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant under age sixty-five (65), if the application for the policy or certificate is submitted prior to or during the six (6)-month period beginning with the first day of the first month during which the applicant becomes enrolled for benefits under Medicare Part B, without regard to age.

C. Conditions under which benefits may be reduced or excluded:

1. If the applicant qualifies under either Subsection 10.A. or 10.B., submits an application during the applicable time period referenced in those subsections, 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 either Subsection 10.A. or 10.B., submits an application during the applicable time period referenced in those subsections, 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.

D. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants to whom an issuer is required to issue a policy or certificate of Medicare supplement insurance

E. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under Subsection 14.C. by either:

1. Charging a premium rate for persons under age sixty-five (65) that does not exceed the highest available premium rate for each plan, type, and form level; or

2. Making a premium adjustment for persons under age sixty-five (65) that is equal to the premium adjustment for persons over age sixty-five (65); or

3. Special Case. If the filing is to introduce a new product to Colorado, the carrier must charge a premium rate for persons under age sixty-five (65) that is equal to 1.5 times the age sixty-five (65) premium rate.

F. Each Medicare supplement carrier shall actively market Medicare supplement insurance during the open enrollment periods described in Subsection 10.B.

G. No Medicare supplement carrier shall directly or indirectly engage in the following activities respecting persons enrolled in Medicare Part B by reason of disability during the open enrollment periods described in Subsection 10.B.:

1. Encouraging or directing such persons to refrain from filing an application for Medicare supplement insurance because of the health status, claims experience, receipt of health care or medical condition of the person; or

2. Encouraging or directing such persons to seek coverage from another carrier because of the health status, claims experience, receipt of health care or medical condition of the person.

H. Carriers may not vary the commission paid on the sale or renewal of a Medicare supplement insurance policy due to any factor, except first year or renewal status, including, but not limited to, the plan marketed, the insured's age, health status, claims experience, location of residence, receipt of health care, or medical condition. However, carriers may pay a different commission on a policy transferred to a different agent for servicing purposes, following the initial sale, or on a policy sold over the internet, providing there is no variation for any other reason.

I. A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale, during the open enrolment periods described in Subsection 10.B., of a Medicare supplement insurance policy or certificate.

J. No Medicare supplement insurance carrier shall terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to the age, health status, claims experience, receipt of health care, or medical condition of an applicant, eligible by reason of Subsection 10.B. for Medicare supplement insurance, placed by a producer with the Medicare supplement insurance carrier.

K. Except as provided in Subsection 10.C. and Section 22, Subsection 10.A. and 10.B.~~,~~ 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.

L. Except as provided in Subsection 10.B. and Section 22, Subsection10.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.

Section 11 Guaranteed Issue for Eligible Persons

A. Guaranteed Issue

1. Eligible persons are those individuals described in Subsection 11.B. who seek to enroll under the policy during the period specified in Subsection 11.C., and who submit evidence of the date of termination, or disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 11.E. that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons

An eligible person is an individual described in any of the following examples:

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

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under § 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

    a. The certification of the organization or plan under this part has been terminated;

    b. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

    c. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in § 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 § 1856), or the plan is terminated for all individuals within a residence;

    d. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

        (1) 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

        (2) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

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

3. The individual is enrolled with any of the following and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 11.B.2.:

    a. An eligible organization under a contract under § 1876 of the Social Security Act (Medicare or cost);

b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

c. An organization under an agreement under § 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

d. An organization under a Medicare Select Policy.

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

a. The insolvency of the issuer or bankruptcy of the non-issuer organization; or

b. Other involuntary termination of coverage or enrollment under the policy;

c. The issuer of the policy substantially violating a material provision of the policy; or

d. 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. Terminations and Reenrollments

a. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Medicare Part C, any eligible organization under a contract under § 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under § 1894 of the Social Security Act, or a Medicare Select policy; and

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

6. The individual, upon first becoming eligible for benefits under Medicare Part A, enrolls in a Medicare Advantage plan under Medicare Part C, or with a PACE provider under § 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment; or

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 11.E.

C. Guaranteed Issue Time Periods

1. In the case of an individual described in Subsection 11.B.1., whose cancellation was not due to nonpayment of premium or fraud, the guaranteed issue period begins on the later of:

a. The date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or

b. The date that the applicable coverage terminates or ceases; and ends six (6) months thereafter if they leave the plan involuntarily or sixty three (63) days if voluntary; and

2. In the case of an individual described in Subsections 11.B.2., 3., 5. or 6. whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date the individual receives notice of termination and six (6) months after the date the applicable coverage terminated;

3. In the case of an individual described in Subsection 11.B.4.a., the guaranteed issue period begins on the earlier of:

a. The date that the individual receives notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any, and

b. The date that the applicable coverage is terminated, and ends on the date that is six (6) months after the date the coverage is terminated;

4. In the case of an individual described in Subsections 11.B.2., 4.b., 4.c., 5. or 6. who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the disenrollment effective date and ends on that date that is sixty-three (63) days after the disenrollment date;

5. In the case of an individual described in Subsection 11.B.7., the guaranteed issue period begins on the date the individual receives notice pursuant to § 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Medicare Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in Subsection 11.B. but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of the voluntary disenrollment and ends on the date that is sixty-three (63) days after the effective date. If the termination is involuntary (also, not due to nonpayment of premium or fraud), the guaranteed issue period begins on the date of involuntary termination and ends on the date that is six (6) months after the involuntary termination date.

D. Extended Medigap Access for Interrupted Trial Periods

1. In the case of an individual described in Subsection 11.B.5. (or deemed to be so described, pursuant to this Paragraph) whose enrollment with an organization or provider described in Subsection 11.B.5.a. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Subsection 11.B.6.;

2. In the case of an individual described in Subsection 11.B.6. (or deemed to be so described, pursuant to this Paragraph) whose enrollment with a plan or in a program described in Subsection 11.B.6. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Subsection 11.B.6.; and

3. For the purposes of Subsections 11.B.5. and 6., no enrollment of an individual with an organization or provider described in Subsection 11.B.5.a., or with a plan or in a program described in Subsection 11.B.6., may be deemed to be an initial enrollment under this Paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

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

1. Subsections 11.B.1., 2., 3. and 4., is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, offered by any issuer.

a. Subject to Subparagraph b., Subsection 11.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 Paragraph 1.

b. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this Subparagraph is:

(1) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(2) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by the any issuer;

2. Subsection 11.B.6. shall include any Medicare supplement policy offered by any issuer.

3. Subsection 11.B.7. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient drug coverage.

F. Notification Provisions

1. At the time of an event described in Subsection 11.B. causing an individual to lose 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 11.A. Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in Subsection 11.B. causing an individual to cease 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 Subsection 11.A. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

Section 12 Standards for Claims Payment

A. An issuer shall comply with §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 notice from a Medicare carrier on dually assigned claims submitted by participating providers 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 the notice;

2. Notifying the participating provider or supplier and the beneficiary of the payment determination;

3. Paying the participating provider 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 issuer 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 issuers.

B. Compliance with the requirement set forth in Subsection 12.A. above shall be certified on the Medicare supplement insurance experience reporting form.

Section 13 Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards

1. Lifetime Requirements

a. Indemnity Forms: 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 forms:

(1) Group Policies: At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(2) Individual Policies: At least sixty-five (65%) percent of the aggregate amount of premiums earned in the case of individual policies.

b. HMOs: 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 such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(1) Home office and overhead costs;

(2) Advertising costs;

(3) Commissions and other acquisition costs;

(4) Taxes;

(5) Capital costs;

(6) Administrative costs; and

(7) Claims processing costs.

2. Historical Requirement (Standardized Forms): All filings of rates and rating schedules shall demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the experience period (historical loss ratio) comply with the requirements of Paragraph 1. of this section or provide acceptable justification as to why this historical requirement has not yet been met. If this requirement has not been demonstrated, the rate filing will be disapproved.

3. Future Period Requirement (Standardized Forms): All filings of proposed rate revisions shall also demonstrate that the anticipated loss ratio for each year of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the loss ratio requirements from Paragraph 1. of this section, or provide acceptable justification as to why this future period requirement has not been met. All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc. If this requirement has not been demonstrated, the rate filing will be disapproved.

4. For purposes of applying Subsections 13.A.1. and 14.C.3. only, group certificates issued as a result of solicitations of individuals through the mail or by mass media advertising (including both print and broadcast advertising) shall be required to comply with the group Medicare supplement requirements.

5. Pre-Standardized Plans: For policies issued prior to May 1, 1992, the ratio of incurred claims to earned premiums (loss ratio) shall comply with all of the following requirements. If compliance with these requirements is not demonstrated, the rate filing will be disapproved.

   a. Historical Requirement: All filings of rates and rating schedules shall demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the experience period (historical loss ratio) is greater than or equal to the originally filed loss ratio for the form(s), or provide acceptable justification as to why this historical requirement has not yet been met;

   b. Historical Requirement Since April 1, 1996: All filings of rates and rating schedules shall demonstrate that the historical loss ratio since April 1, 1996 meets the appropriate loss ratio requirement from Paragraph 1. of this section as applied to the actual experience beginning with April 1, 1996 to the last date of the experience period;

   c. Future Period Requirement: All filings of proposed rate revisions shall also demonstrate that the anticipated loss ratio for each year of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the loss ratio requirements from Paragraph 1. of this section. All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc.; and

d. Lifetime Requirement: All filings of rates and rating schedules shall also demonstrate that the ratio of incurred claims to earned premiums from inception of the form(s) to the last date of the entire future period for which the revised rates are computed to provide coverage can be expected to meet or exceed the originally filed loss ratio for the form(s). All assumptions underlying the projected future experience should be clearly supported. These include lapse, mortality, morbidity, etc.

6. Experience Data

a. Each Medicare supplement issuer shall file the 2010 standardized plans concurrently with the 1990 standardized plans. The rates for the 1990 plans and the 2010 plans shall be submitted in separate SERFF filings.

b. Each Medicare supplement issuer shall provide pooled experience of all 1990 standard plans with the experience of all the 2010 standard plans of the same letter and type as well as the experience for just the 1990 standardized plans or 2010 standardized plans separately in each filing.

c. Issuers are allowed to vary rate increases between the 1990 plans and the 2010 plans of the same letter, as long as they follow the guidelines listed above; that is, as long as the adjustments within the pool are on a revenue neutral basis and as long as it results in the 1990 plan rates to move closer to the 2010 plan rates.

7. Rate filings for each plan, type, and form level permitted under Subsection 10.C. for standardized plans marketed after February 1, 2005, must demonstrate compliance with the requirements of Subsection 10.E.

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 of 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 subsection, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all other group policies combined for experience after April 1, 1996. Reports are due by May 31 of each calendar year.

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 credit exceeds a *de minimis* level. Such refund shall include interest from the end 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 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued in this state shall file, on an annual basis, its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Commissioner in accordance with the filing requirements and procedures prescribed 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. Such demonstration shall exclude active life reserves. An expected third-year, and each subsequent year, loss ratio, which is greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three (3) years.

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

1. Appropriate premium adjustments necessary to produce loss ratios as anticipated for current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filings.

2. An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with 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 such 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.

3. 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.

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

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 in this state 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 such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the Commissioner.

Section 14 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 file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and

Modernization Act of 2003 only with the Commissioner in the state in which the policy of certificate was issued.

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

D. Issuers have the option of offering Medicare Supplement plans on an attained age basis, issue age basis, or a dual rating basis. Issuers are required to provide adequate information to consumers so an informed choice can be made on their Medicare Supplement purchases. Issuers may offer dual rating but are not required to do so.

If an issuer elects to offer dual rating methodologies, the issuer must comply with the following requirements:

1. Under individual insurance policies, the individual policyholder should have a choice as to whether to elect an issue age or attained age rating methodology. For a group policy, it is the group policyholder, not the certificate holder, who has this choice. However, both methodology options shall be presented to each consumer prior to purchase.

2. Issuers shall develop materials that disclose both rating methodologies and also include an explanation of how they differ both in the near term and the long term. Producers shall carefully explain to the prospective consumers the difference between the two (2) rating methodologies and explain their rights to switch from one rating methodology to another. All marketing material and/or advertisements shall be submitted to the Division of Insurance for review and must demonstrate the differences between the two (2) rating methodologies.

3. The producer commissions shall be the same for both methodologies. The dollar level of first-year commissions should be no more than twice the dollar level of second-year commissions and shall not vary based on the rating methodology elected by the consumer. Renewal commissions for years two (2) through six (6) may be a constant dollar amount that does not vary based on the rating methodology or must be defined as a constant percentage of the issue age premium.

4. Consumers should be allowed to switch from an attained age rating methodology to an issue age rating methodology. However, consumers shall not be allowed to switch from an issue age rating methodology to an attained age rating methodology.

E. Limitations on the number of forms that may be approved for standardized Medicare supplement benefit plans.

1. Except as provided in Paragraph 2. of this subsection, an issuer shall not file for approval more than one (1) 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 producer marketing methods;

c. The addition of either guaranteed issue or underwritten coverage; and

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 or a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

F. Rules for Medicare supplement benefit plans considered available for purchase versus discontinued plans.

1. Except as provided in Subparagraph 1.a. below, 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 1.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 Paragraph 1. unless the issuer complies with the following requirements:

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

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.

G. Each filing of premium rates will include applicable experience as outlined below.

1. Except as provided in Paragraph 2., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 13 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.

H. Each filing of premium rates is expected to include the following items for each policy form included in the filing. Filings not containing these items may be returned to the filing company as incomplete.

1. The expected loss ratio by duration for the life of the policy form. These durational expected loss ratios will be evaluated for reasonableness.

2. Each rate filing shall compare the actual to the expected loss ratio by duration since inception of the policy form. This comparison should:

a. Be prepared on a calendar year basis including a row for each duration and a total row including the expected overall loss ratio for that calendar year; and

b. Include a summary comparison over all durations, including the overall expected loss ratio over all durations.

This analysis is considered to be most important in the final decision to approve or disapprove a rate increase request.

3. Each rate filing shall demonstrate that the third year, and each subsequent year, loss ratio, for policies in force for three years or longer, is greater than or equal to the applicable percentage in Section 13.A.1.a. or 2., or provide acceptable justification as to why this requirement has not yet been met.

4. Each rate filing is expected to include all required items from Section 6.A. of Colorado Insurance Regulation 4-2-11.

I. Each Medicare supplement rate filing submitted in Colorado, including annual rate filings, shall include the following Actuarial Certification on a separate page of the rate filing:

1. To the best of my knowledge and judgment, the following are true with respect to this Medicare supplement rate filing;

2. The assumptions present my best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

3. The anticipated lifetime loss ratio, future loss ratios, and third year loss ratios all equal or exceed the applicable required loss ratio in Colorado;

4. The filed rates maintain the proper relationship between policies which were originally filed with differing rating methodologies;

5. The filing was prepared based on current standards of practice as promulgated by the Actuarial Standards Board, including the data quality standard of practice;

6. The filing is in compliance with applicable Colorado laws and regulations;

7. The rates are reasonable in relationship to benefits; and

8. A qualified actuary shall sign and date the certification. The actuary's professional credentials and company affiliation should be included below the signature.

J. The full credibility standard for Medicare supplement policies is 2000 life-years, and 2000 claims, for rating purposes. These standards must be met in a maximum of three (3) years. Any filing which bases its conclusions on data not meeting these standards is considered not fully credible unless the issuer can justify a lesser standard of full credibility. If the underlying data is not fully credible, for purposes of rate filings only, the filing should aggregate the underlying data according to the following requirements. Once the data has been aggregated, for purposes of rate filings, the data is expected to be aggregated in the same manner for all future rate filings unless further aggregation is necessary to achieve full credibility. Each rate filing must discuss how the data relied upon for the rate revision meets the Colorado data credibility requirement.

1. Pre-standardized Forms: If experience for the pre-standardized forms is not fully credible by form, the experience should be combined over all pre-standardized forms. If the combined experience is still not fully credible, the experience must be:

   a. Combined with the experience for similar pre-standardized forms marketed by an affiliated company; or

   b. Combined with experience for the standardized forms.

2. Standardized Forms: If experience for a standardized form is not fully credible, experience should be either aggregated with the experience of the most similar standardized form(s) to achieve full credibility; or aggregated over all standardized forms. If the experience has been aggregated over all standardized forms to achieve the credibility standard, the indicated increase, following the aggregate analysis, may be allocated over the standardized forms in a manner to be determined by the issuer, providing that the sum of the proposed increases over all forms, is numerically equal to the indicated amount from the aggregate analysis.

   a. This allows the rate relationships over forms to remain reasonable.

   b. Rate changes for all affected standardized forms should be made concurrently.

3. Alternative Means: If full credibility cannot be achieved used the above methodology, a weighted average approach should be incorporated in determining a reasonable rate increase. The issuer should assign the maximum weight possible to the Colorado data and use an acceptable alternative data source to compliment this data.

K. The following items will be evaluated in determining the acceptability of a rate change request:

1. All of the required items from Colorado Insurance Regulation 4-2-11, in particular support for each of the underlying rating assumptions, such as the persistency and trend assumptions, used to calculate the earned premiums and incurred claims.

2. A discussion as to how the underlying data meets the Colorado credibility requirement. Please see Section 14.~~I~~J. of this regulation. Any rate change request, which bases its conclusions on data that is not fully credible, must discuss how the rate change request was modified for less than fully credible data. If the data is aggregated to meet the credibility requirement, the aggregated data should be used to demonstrate that the requirements of Paragraphs 3., 4., and 5. of this subsection have been met.

3. The presentation as to how the rates for each year of the projection period were determined. These rates must be calculated using expected loss ratios greater than or equal to the composite expected loss ratios by duration that were derived from the expected loss ratios included in the original rate filing for the block of business, unless the issuer provides acceptable justification and support as to why these ratios are

inappropriate. A composite weighted average of loss ratios that are greater than or equal to the originally filed expected loss ratios may be used for aggregated blocks of business, with an explanation as to how the expected loss ratios were determined.

4. A demonstration that the historical loss ratio, the loss ratios for each year of the projection period and the lifetime loss ratio are greater than or equal to the minimum loss ratio requirements from Section 13.A. of this regulation must be included as part of the rate change request.

5. The actual-to-expected loss ratio analysis for each calendar year by issue year, required by Section 14.H. of this regulation, must be included as part of the rate change request. In order for the rate change request to be considered, the overall actual-to-expected loss ratio for the most recent full calendar year, and for the current partial calendar year if historical data is provided, must be greater than or equal to 1.0 or, in cases where this ratio is less than 1.0, an acceptable reason(s) as to why the rate change request should be considered must accompany the rate change request.

6. Rates for the category “under age 65” must be calculated using Section 10.E. of this regulation and the expected loss ratio as described in Paragraph 5. of this subsection must be used to calculate the “indicated premiums” for each plan.

L. Rates and policy forms shall be submitted electronically in a form specified by the Division.

Section 15 Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to a producer 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 at least five (5) renewal years.

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

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

Section 16 Required Disclosure Provisions

A. General Rules

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

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

3. A Medicare supplement policy or certificate 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. Such notice shall include in bold face type the address and telephone number of the Colorado Division of Insurance and a statement that in the event the issuer does not refund the premium within thirty (30) days from the date such refund is requested, the Division should be informed accordingly.

6. Guide to Health Insurance for People with Medicare

   a. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this 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 acknowledgment 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 the time the policy is delivered.

   b. For the purposes of this section, “form” means the language, format, size, 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 policies or certificates in a format acceptable to the Commissioner. Such notice shall:

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

b. Inform each policyholder or 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. Such notices shall not contain or be accompanied by any solicitation.

C. Medicare Modernization Act (MMA) Notice Requirements

Issuers shall comply with any and all notice requirements of the Medicare Prescription Drug Improvement, and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies

1. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such 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 such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name.

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

3. The outline of coverage provided to applicants pursuant to this subsection consists of four (4) parts: cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

4. The outline of coverage shall include items contained in Appendix B.

E. Notice Regarding Policies or Certificates which are not Medicare Supplement Policies

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy or a policy issued pursuant to a contract under § 1876 of the Federal Social Security Act (42 U.S.C. 1395 et seq.); disability income policy; or other policy identified in Section 3.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 insured 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 [issuer]."

2. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection 16.E.1. shall disclose, using the applicable statement in Appendix E, 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.

Section 17 Requirements for Application Forms and Replacement Coverage

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

[Statements]

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

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

3. You may be eligible for benefits under Medicaid or may not need a Medicare supplement policy.

4. If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for twenty four (24) months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage

for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior issuer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior issuer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark "Yes" or "No" below with an "X"]

(1) To the best of your knowledge,

(a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(1) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(2) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

(3) If you had coverage from any Medicare plan other than original Medicare within the past 6 months (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(b) Was this your first time in this type of Medicare plan?

Yes____ No____

(c) Did you drop a Medicare supplement policy to enroll in this Medicare plan?

Yes____ No____

(d) Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or for fraud?

Yes____ No ___

(4.) Do you have another Medicare supplement policy in force?

Yes____ No____

(a) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

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

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 6 months? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

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

(c) Has your coverage under a previous policy been involuntarily terminated for reasons other than nonpayment of premiums or for fraud?

Yes____ No ___

B. Producers shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

2. List policies sold in the past five (5) years which are no longer in force.

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

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its producer, 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 (1) copy of such notice signed by the applicant and producer, except where the coverage is sold without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage, in Appendix C, required by Subsection 17.D. for an issuer, shall be provided in the format prescribed and separately adopted by the Commissioner of Insurance, in no less than twelve (12) point type.

F. Paragraphs 1. and 2., contained in such Notice to the Applicant Regarding Replacement of Medicare Supplement Insurance, (applicable to preexisting conditions), in Appendix C, may be deleted by an issuer if the replacement does not involve the application of a new preexisting condition limitation.

Section 18 Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, television, websites, other media or sales presentations, to the Commissioner for review. Such advertisement shall comply with all applicable requirements of Colorado Division of Insurance Regulation 4-2-3, 3 C.C.R. 702-4 and related guidelines as amended.

Such advertisements shall also include a disclosure that all Medicare supplement standardized plans are offered to qualified individuals under the age of 65, or a disclosure that all Medicare supplement standardized plans are offered to Medicare qualified individuals due to disability and must be clearly visible in the advertisement or web page.

This disclosure shall be presented in a clear, conspicuous and reasonably understandable manner, and designed to call attention to the nature and significance of the information it contains. The disclosure is considered designed to call attention to the nature and significance of the information in it if the carrier:

A. Uses a typeface and type size that are easy to read;

B. Provides wide margins and ample line spacing;

C. Uses boldface, italics, underscoring, or capitals for key words and phrases; and

D. In a form that combines the disclosure with other information, uses a plain-language heading to call attention to the disclosure portion of the document, and uses a type size that is greater than the type size predominantly used in the rest of the document.

Advertising shall be submitted electronically in a format specified by the Division.

Section 19 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 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; and

5. Establish auditable procedures for verifying compliance with this Subsection 19.A.

B. In additional to the practices prohibited in § 10-3-1104, C.R.S., the following acts and practices are prohibited.

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or issuers 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 issuer.

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 conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer 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 being marketed and issued in compliance with this regulation.

Section 20 Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate, a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Medicare Part C coverage.

Section 21 Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report to the Division, using the Reporting Medicare Supplement Policies Form prescribed and separately adopted by the Commissioner of Insurance (Appendix D), which provides 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.

Section 22 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 for similar benefits to the extent such period had elapsed under the original policy or certificate.

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 for benefits similar to those contained in the original policy or certificate.

Section 23 Readability Standards

A Medicare supplement policy shall meet the following readability standards:

A. The text must achieve a minimum score of 40 on the Flesch reading ease test;

B. The policy shall be printed, except for specification pages, schedules and tables, in not less than ten (10) point type, one point leaded;

C. The style, arrangement and overall appearance of the policy shall not give undue prominence to any portion of the text of the policy or to any endorsement or riders; and

D. The policy shall contain a table of contents or an index of the principal sections of the policy if the policy has more than 3,000 words printed on three (3) or fewer pages of text or if the policy has more than three (3) pages regardless of the number of words.

Section 24 Medicare Select Policies and Certificates

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

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

C. For the purposes of this section:

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

2. "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

3. "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

4. "Medicare Select policy" or "Medicare Select certificate" mean, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

5. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

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

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

D. 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.

E. 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.

F. 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:

(1) To deliver adequately all services that are subject to a restricted network provision; or

(2) 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 Subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2. A statement or map providing a clear description of the service area.

3. A description of the grievance procedure to be utilized.

4. A description of the quality assurance program, including:

a. The formal organizational structure;

b. The written criteria for selection, retention and removal of network providers; and

c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

5. A list and description, by specialty, of the network providers.

6. Copies of the written information proposed to be used by the issuer to comply with Subsection 24.I.

7. Any other information requested by the Commissioner.

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

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

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

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

I. 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.

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

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

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

   b. Other Medicare Select policies or certificates.

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

3. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

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

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

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

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

K. 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.

L. 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 to the Commissioner, no later than March 31 of each year, 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 calendar year and a summary of the subject, nature and resolution of such grievances.

M. 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.

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

O. For the purposes of this section, 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 subsection, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.

P. 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 subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Medicare Part B excess charges.

Q. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies for the purpose of evaluating the Medicare Select Program.

Section 25 Incorporation by Reference

The relevant portions of § 1882 (42 U.S.C. 1395ss) and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Simplification Act published by the NAIC shall mean the relevant portions of §1882 (42 U.S.C. 1395ss) and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Simplification Act published on the effective date of this regulation and does not include later amendments or editions of relevant portions of § 1882 (42 U.S.C. 1395ss) and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Simplification Act. A copy of the relevant portions of the §1882 (42 U.S.C. 1395ss) and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Simplification Act may be examined at during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A certified copy of the relevant portions of

§1882 (42 U.S.C. 1395ss) and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Simplification Act may be requested from the Colorado Division of Insurance for a fee.

The Health Insurance for the Aged Act, Title XVIII of the federal "Social Security Act" published by the Social Security Administration shall mean The Health Insurance for the Aged Act, Title XVIII of the federal "Social Security Act" as published on the effective date of this regulation and does not include later amendments to or editions of the Health Insurance for the Aged Act, Title XVIII of the federal "Social Security Act". A copy of the Health Insurance for the Aged Act, Title XVIII of the federal "Social Security Act"may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the Health Insurance for the Aged Act, Title XVIII of the federal "Social Security Act" may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section 226(b) of the Social Security Act published by the Social Security Administration shall mean § 226(b) of the Social Security Act as published on the effective date of this regulation and does not include later amendments to or editions of § 226(b) of the Social Security Act. A copy of § 226(b) of the Social Security Act may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of § 226(b) of the Social Security Act may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section 1882(v)(2)(B) of the Social Security Act published by the Social Security Administration shall mean § 1882(v)(2)(B) of the Social Security Act as published on the effective date of this regulation and does not include later amendments to or editions of § 1882(v)(2)(B) of the Social Security Act. A copy of § 1882(v)(2)(B) of the Social Security Act may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Section 1882(v)(2)(B) of the Social Security Act may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section1882(c)(3) of the Social Security Act published by the Social Security Administration shall mean § 1882(c)(3) of the Social Security Act as published on the effective date of this regulation and does not include later amendments to or editions of § 1882(c)(3) of the Social Security Act. A copy of § 1882(c)(3) of the Social Security Act may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of § 1882(c)(3) of the Social Security Act may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section 1851(e) of the Social Security Act published by the Social Security Administration shall mean § 1851(e) of the Social Security Act as published on the effective date of this regulation and does not include later amendments to or editions of § 1851(e) of the Social Security Act. A copy of § 1851(e) of the Social Security Act may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of § 1851(e) of the Social Security Act may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section 1851(g)(3)(B) of the Social Security Act published by the Social Security Administration shall mean § 1851(g)(3)(B) of the Social Security Act as published on the effective date of this regulation and does not include later amendments to or editions of § 1851(g)(3)(B) of the Social Security Act. A copy of § 1851(g)(3)(B) of the Social Security Act may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Section 1851(g)(3)(B) of the Social Security Act may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section 1862(b)(1)(A)(v) of the Social Security Act published by the Social Security Administration shall mean § 1862(b)(1)(A)(v) of the Social Security Act as published on the effective date of this regulation

and does not include later amendments to or editions of § 1862(b)(1)(A)(v) of the Social Security Act. A copy of § 1862(b)(1)(A)(v) of the Social Security Act may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of § 1862(b)(1)(A)(v) of the Social Security Act may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

The “Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act” adopted by the NAIC as a Model Act at its January 1993, meeting shall mean the “Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act” adopted by the NAIC as a Model Act at its January 1993, meeting as published on the effective date of this regulation and does not include later amendments to or editions of the “Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act” adopted by the NAIC as a Model Act at its January 1993, meeting. A copy of the “Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act” adopted by the NAIC as a Model Act at its January 1993, meeting may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the “Flesch reading ease test and the National Association of Insurance Commissioners (NAIC) Life and Health Insurance Policy Language Simplification Act” adopted by the NAIC as a Model Act at its January 1993, meeting may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

The “Health Insurance for the Aged Act," Title XVIII of the Social Security Act published by the Social Security Administration shall mean the “Health Insurance for the Aged Act," Title XVIII of the Social Security Act as published on the effective date of this regulation and does not include later amendments to or editions of the “Health Insurance for the Aged Act," Title XVIII of the Social Security Act. A copy of the “Health Insurance for the Aged Act," Title XVIII of the Social Security Act may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the “Health Insurance for the Aged Act," Title XVIII of the Social Security Act may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 published by the U.S. Government Printing Office, shall mean § 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 as published on the effective date of this regulation and does not include later amendments to or editions of § 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990. A copy of § 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may be requested from the Colorado Division of Insurance for a fee. A charge for certification or copies may apply.

Section 26 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 27 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocations of license, subject to the requirements of due process.

Section 28 Effective Date

This amended regulation shall be effective June 1, 2015.

Section 29 History

New Regulation 81-1 effective January 1, 1982.
Regulation 81-1 repealed and replaced by 89-7.
Regulation 89-7 repealed and replaced by 90-4, effective January 1, 1991.
Regulation 90-4 repealed and replaced by 91-18.
Regulation 91-18 repealed and replaced by 4-3-1 effective May 1, 1992.
Regulation 4-3-1 was amended effective April 1, 1996.
Regulation 4-3-1 was amended effective September 1, 1996.
Regulation 4-3-1 was amended effective April 1, 1999
Regulation 4-3-1 was amended effective January 1, 2001.
Regulation 4-3-1 was amended effective September 1, 2003.
Sections 10(E)(2), 27 and 28 were amended effective December 1, 2003
Regulation 4-3-1 was amended effective February 1, 2005.
Regulation 4-3-1 was amended effective December 1, 2005.
Regulation 4-3-1 was amended effective February 1, 2006.
Emergency regulation 08-E-8 is effective January 1, 2009.
Regulation 4-3-1 was amended effective February 1, 2009.
Regulation 4-3-1 was amended effective June 1, 2009.
Regulation 4-3-1 was amended effective January 1, 2010.
Regulation 4-3-1 was amended effective June 1, 2015.

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR
CALENDAR YEAR_____

TYPE[1]		SMSBP[2]	
For the State of:		Company Name:	
NAIC Group Code:		NAIC Company Code:	
Address:		Person Completing Exhibit:	
Title:		Telephone Number:	

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

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”

APPENDIX A (continued)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE[1]		SMSBP[2]	
For the State of:		Company Name:	
NAIC Group Code:		NAIC Company Code:	
Address:		Person Completing Exhibit:	
Title:		Telephone Number:	

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.	

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

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

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

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____

Date

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

TYPE[1] _____ SMSBP[2] _____

For the State of: _____ Company Name: _____

NAIC Group Code: _____ NAIC Company Code: _____

Address: _____ Person Completing Exhibit: _____

Title: _____ Telephone Number: _____

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

Benchmark Ratio Since Inception: (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.

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

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

TYPE[1]		SMSBP[2]	
For the State of:		Company Name:	
NAIC Group Code:		NAIC Company Code:	
Address:		Person Completing Exhibit:	
Title:		Telephone Number:	

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

Benchmark Ratio Since Inception: (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.

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

APPENDIX B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every issuer must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I, and J are no longer available for sale.

In Colorado, it is a requirement that all plans offered by [Issuer] are available to under age 65 Medicare qualified individuals.

Basic Benefits:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $[4940]; paid at 100% after limit reached	Out-of-pocket limit $[2470]; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2180] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2180]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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 issuer's name] nor its agents are connected with Medicare.

[for direct response:]

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1.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 $[1,260]	$0	$[1,260](Part A deductible)
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	$0	Up to $[157.50] a day
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints • Additional amounts	 $0 100%	 3 pints $0	 $0 $0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

* Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $[147] of Medicare Approved Amounts*	$0	$0	$147] (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 $[1,260]	$[1,260](Part A deductible)	$0
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	0	Up to $[157.50] a day
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints • Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN B

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

* Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $[147] of Medicare Approved Amounts*	$0	$0	$[147] (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 $[1,260]	$[1,260](Part A deductible)	$0
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	$Up to $[157.50] a day	$0
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints • Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN C

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

*Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts*	$0	$[147] (Part B deductible)	$0
• Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD • First 3 pints	$0	All costs	$0
• Next $[147] of Medicare Approved Amounts*	$0	$[147] (Part B deductible)	$0
• Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $[147] of Medicare Approved Amounts*	$0	$[147](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 $[1,260]	$[1,260] (Part A deductible)	$0
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day $0	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	Up to $[157.50] a day	$0
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints • Additional amounts	 $0 100%	 3 pints $0	 $0 $0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN D

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

* Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[147] of Medicare Approved Amounts*	$0	$0	$[147] (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 maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2180] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2180]. 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 $[2180] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2180] DEDUCTIBLE,**] YOU PAY

HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
•First 60 days	All but $[1,260]	$[1,260] (Part A deductible)	$0
•61st thru 90th day	All but $[315] a day	$[315] a day	$0
•91st day and after: While using 60 Lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare eligible expenses	$0***
•Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
•First 20 days	All approved amounts	$0	$0
•21st thru 100th day	All but $[157.50] a day	Up to $[157.50] a day	$0
•101st day and after	$0	$0	All costs
BLOOD •First 3 pints •Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $[147] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
[This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2180] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [2180]. 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 $[2180] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2180] DEDUCTIBLE,**]YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
• First $[147] of Medicare Approved Amounts*	$0	$[147] (Part B deductible)	$0
• Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD • First 3 pints	$0	All costs	$0
• Next $[147] of Medicare Approved Amounts*	$0	$[147] (Part B deductible)	$0
• Remainder of Medicare Approved Amounts	80%	20%	$0

CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY$[2180] DEDUCTIBLE,**PLAN PAYS	IN ADDITION TO $[2180] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $147] of Medicare approved Amounts*	$0	$[147] (Part B deductible)	$0
•Remainder of Medicare approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2180] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2180] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
•First $250 each calendar year	$0	$0	$250
•Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,260]	$[1,260] (Part A deductible)	$0
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	Up to $[157.50] a day	$0
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints • Additional amounts	$0 100%	3 pints $0	$0 $0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD • First 3 pints	$0	All costs	$0
• Next $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[147] of Medicare Approved Amounts*	$0	$0	$[147] (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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[4940] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,260]	$[630](50% of Part A deductible)	$[630](50% of Part A deductible)♦
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	Up to $[78.75] a day	Up to $[78.75] a day ♦
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints	$0 100%	50% $0	50%♦ $0

• Additional amounts			
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

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

PLAN K

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

**** Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts****	$0	$0	$[147] (Part B deductible)**** ♦
• Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
• Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4940])*
BLOOD • First 3 pints	$0	50%	50%♦
• Next $[147] of Medicare Approved Amounts****	$0	$0	$[147] (Part B deductible)**** ♦
• Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* **This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4940] per year.** However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for

paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $[147] of Medicare Approved Amounts*****	$0	$0	$[147] (Part B deductible) ♦
• Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

PLAN L

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,260]	$[945] (75% of Part A deductible)	$[315] (25% of Part A deductible)♦
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	Up to $[118.12] a day	Up to $[39.38] a day♦
• 101st day and after	$0	$0	All costs

BLOOD • First 3 pints • Additional amounts	 $0 100%	 75% $0	 25%♦ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance ♦

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

PLAN L

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

* Once you have been billed ($147) 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*
MEDICARE EXPENSES-IN OR OUT OF THE 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 $[147] of Medicare Approved Amounts****	$0	$0	$[147] (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$270])*
BLOOD • First 3 pints	$0	75%	25%♦
• Next $[147] of Medicare Approved Amounts****	$0	$0	$[147] (Part B deductible) ♦
• Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2470] per year.** However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment • First $[147] of Medicare Approved Amounts*****	$0	$0	$[147] (Part B deductible) ♦
• Remainder of Medicare Approved Amounts	80%	15%	5% ♦

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

PLAN M

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

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for sixty (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 $[1,260]	$[630](50% of Part A deductible)	$[630](50% of Part A deductible)
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	Up to $[157.50] a day	$0
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints • Additional amounts	$0 100%	3 pints $0	$0 $0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN M

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

* Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
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 N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
• First 60 days	All but $[1,260]	$[1,260](Part A deductible)	$0
• 61st thru 90th day	All but $[315] a day	$[315] a day	$0
• 91st day and after: While using 60 lifetime reserve days	All but $[630] a day	$[630] a day	$0
Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
• First 20 days	All approved amounts	$0	$0
• 21st thru 100th day	All but $[157.50] a day	Up to $[157.50] a day	$0
• 101st day and after	$0	$0	All costs
BLOOD • First 3 pints • Additional amounts	 $0 100%	 3 pints $0	 $0 $0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

* Once you have been billed $[147] 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 $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD • First 3 pints	$0	All costs	$0
• Next $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $[147] of Medicare Approved Amounts*	$0	$0	$[147] (Part B deductible)
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

Appendix C

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

[Issuer'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 or Medicare Advantage insurance and replace it with a policy to be issued by [Issuer Name]. 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 or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.

____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [Optional only for Direct Mailers.]

_____

_____

____ Other. (please specify)

_____

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions 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) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer 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.

APPENDIX D

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Issuer 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 Number	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX E

DISCLOSURE STATEMENTS

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

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits issuers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

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

Medicare generally pays for most or all of these expenses.

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

[Alternative 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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

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

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

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

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

[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 INSURANCE DUPLICATES SOME MEDICARE BENEFITS

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

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

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

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

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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

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

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

[Alternative 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

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

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

Medicare generally pays for most or all of these expenses.

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

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

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

Before You Buy This Insurance

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 health insurance assistance program (SHIP).

[Issuers: insert reference to outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.]

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2015-00144

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 04/09/2015

3 CCR 702-4 Series 4-3

LIFE, ACCIDENT AND HEALTH, Series 4-3

The above-referenced rules were submitted to this office on 04/10/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 27, 2015 13:04:55

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Disease Control and Environmental Epidemiology Division - promulgated by Colo Bd of Health

CCR number

6 CCR 1009-2

Rule title

6 CCR 1009-2 THE INFANT IMMUNIZATION PROGRAM, VACCINES FOR CHILDREN PROGRAM, AND IMMUNIZATION OF STUDENTS ATTENDING SCHOOL 1 - eff 07/01/2015

Effective date

07/01/2015

COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Disease Control and Environmental Epidemiology Division

THE INFANT IMMUNIZATION PROGRAM AND IMMUNIZATION OF STUDENTS ATTENDING SCHOOL

6 CCR 1009-2

Adopted by the Board of Health on April 15, 2015

[Publication Instructions: Replace current existing text from Section I. through Section XII. with the following new text]

I. Definitions

A. Advisory Committee on Immunization Practices (ACIP) - a group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 217a).

B. Child - any student less than 18 years of age.

C. College student - any student who is enrolled for one or more classes at a college or university and who is physically present at the institution. This includes students who are auditing classes but does not include persons taking classes by correspondence only.

D. Dose - a measured quantity of an immunizing agent; quantity and frequency of administration determined by recognized health authorities and the manufacturer of each agent. (partial, “split,” half or fractionated “doses” are not acceptable for certification.).

E. Emancipated student - any student who has reached age 18; a lawfully married child of any age; a child 15 years of age or older who is managing his/her own financial affairs and who is living separate and apart from his/her parent.

F. Immunization tracking system - a comprehensive immunization tracking system established by the Department of Public Health and Environment pursuant to Section 25-4-2403, C.R.S.

G. Indigent child - any child whose parent cannot afford to have the child immunized or if emancipated, who cannot himself/herself afford immunization and who has not been exempted.

H. Infant - any child up to twenty-four months of age or any child eligible for vaccination and enrolled under the Colorado Medical Assistance Act, Articles 4, 5, AND 6 of Title 25.5 C.R.S.

I. In-process student - a student may be considered in-process if:

1. Within fourteen days after receiving direct personal notification that the certificate is not up-to date according to the requirements of the state board of health, the parent or emancipated student submits documentation that the next required immunization has been given and a signed written plan for obtaining the remaining required immunizations. The scheduling of immunizations in the written plan shall follow medically recommended minimum intervals consistent with the U.S. Public Health Service Advisory Committee on Immunization Practices. If the student does not fulfill the plan, the student shall be suspended or expelled from school for non-compliance as noted in Section 25-4-907,

C.R.S. if the next dose is not medically indicated within fourteen days, then the medically approved minimum intervals would apply.

2. With regards to college or university students as defined in Section I Provision C and O, the student must present to the appropriate official of the school either (I) a signed written authorization requesting local health officials to administer required immunizations or (II) a plan for receipt of the required immunization or the next required immunization in a series within either 30 days or the medically approved minimum interval. If this does not occur, the college or university student will not be allowed to register for the current term or session. Such written authorizations and plans must be signed by one parent or guardian or the emancipated student or the student eighteen years of age or older.

J. Parent - the person or persons with parental or decision-making responsibilities for a child.

K. Practitioner - a duly licensed physician, advanced practice nurse, or other person who is permitted and otherwise qualified to administer vaccines under the laws of this state.

L. School - all child care facilities licensed by the Colorado Department of Human Services including: child care centers, school-age child care center, preschools, day camps, resident camps, day treatment centers, family child care homes, foster care homes, and head start programs; public, private, or parochial kindergarten, elementary or secondary schools through grade twelve, or a college or university. Schools do not include a public services short-term child care facility as defined in section 26-6-102 (6.7), C.R.S., a guest child care facility as defined in section 26-6-102 (5), C.R.S., a ski school as defined in section 26-6-103.5 (6), C.R.S., or college or university courses which are offered off-campus; or are offered to nontraditional adult students, as defined by the governing board of the institution; or are offered at colleges or universities which do not have residence hall facilities.

M. School health authority - an individual working for or on behalf of the child care facility or school who is knowledgeable about childcare/school immunizations.

N. School official - the school's chief executive officer or any person designated by him/her as his/her representative.

O. Student - any person enrolled in a Colorado school as defined in I (L).

II. Exemptions from Immunization

It is the responsibility of the parent(s) to have his or her child immunized unless the child is exempted.

A student may be exempted from receiving the required immunizations in the following manner:

A. Medical exemption - By submitting a medical exemption form with the statement of medical exemption signed by an advanced practice nurse or physician licensed to practice medicine or osteopathic medicine in any state or territory of the United States indicating that the physical condition of the student is such that immunizations would endanger his/her life or health or is medically contraindicated due to other medical conditions. This form is to be submitted once, and must be maintained on file at each new school the student attends.

B. Religious exemption - By submitting a nonmedical exemption form signed by the parent(s) or the emancipated student indicating that the parent(s) or emancipated student is an adherent to a religious belief whose teachings are opposed to immunizations.

Beginning July 1, 2016,

1. Prior to kindergarten entry, a nonmedical exemption form must be submitted at each interval in the 2015 ACIP Birth-18 years immunization schedule at which immunizations are due. The 2015 ACIP immunization schedule is incorporated in III.B. This documentation is required only for those vaccines required to prevent the diseases listed in Section III, Provision A.

2. From kindergarten through twelfth grade, a nonmedical exemption form must be submitted once per school year.

3. Beginning with college or university entry, a nonmedical exemption form must be submitted at enrollment.

C. Personal belief exemption - By submitting a nonmedical exemption form signed by the parent(s) or the emancipated student indicating that the parent(s) or emancipated student has a personal belief that is opposed to immunizations.

Beginning July 1, 2016,

1. Prior to kindergarten entry, a nonmedical exemption form must be submitted at each interval in the 2015 ACIP Birth-18 years immunization schedule at which immunizations are due. The 2015 ACIP immunization schedule is incorporated in III. B. This documentation is required only for those vaccines required to prevent the diseases listed in Section III., Provision A.

2. From kindergarten through twelfth grade, a nonmedical exemption form must be submitted once per school year.

3. Beginning with college or university entry, a nonmedical exemption form must be submitted at enrollment.

D. In the event of an outbreak of disease against which immunization is required, no exemption or exception from immunization shall be recognized and exempted persons may be subject to exclusion from school and quarantine.

E. All information distributed to the parent(s) by school districts regarding immunization shall inform them of their rights under Section II, Provisions A through C.

F. If the school chooses to use the immunization tracking system to monitor compliance with the school law, and the parent(s) or student submits an exemption, the school must submit the exemption information to the immunization tracking system.

III. Minimum Immunization Requirements

A. To attend school, a student must have an age- or grade-appropriate Certificate of Immunization. Initial certification does not exempt a student from meeting subsequent age or grade requirements. This certificate must demonstrate immunization against the following diseases:
   1. Hepatitis B
   2. Pertussis
   3. Tetanus
   4. Diphtheria
   5. Haemophilus Influenza Type B (HIB)
   6. Pneumococcal disease
   7. Polio
   8. Measles
   9. Mumps
   10. Rubella
   11. Varicella

B. The minimum number of doses required by level of school/age of student is set forth in the 2015 Birth – 18 Years Recommended Immunization Schedule or the 2015 Catch-Up Immunization Schedule of the Advisory Committee on Immunization Practices (ACIP).

1. The 2015 ACIP Birth-18 Years Recommended Immunization Schedule (Schedule) is incorporated by reference for only those vaccines required to prevent the diseases listed in Section III, Provision A. Other immunizations included in the ACIP recommendations

are not required. This schedule is posted on the Centers for Disease Control and Prevention website at: http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf, or on the Colorado Department of Public Health and Environment website at [www.coloradoimmunizations.com], and, is available for public inspection during regular business hours at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246. Copies of the recommended schedules are available from the Colorado Department of Public Health and Environment for a reasonable charge that comports with the department's record request practices. This rule does not include any later amendments or editions of the ACIP Schedule.

2. In addition, the 2015 ACIP Catch-Up Immunization Schedule is incorporated by reference for those children not fully immunized and only for those vaccines required to prevent the diseases listed in Section III, Provision A. Other immunizations included in the ACIP recommendations are not required. This recommended schedule is posted on the Centers for Disease Control and Prevention website at http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf, or on the Colorado Department of Public Health and Environment website at [www.coloradoimmunizations.com], and, is available for public inspection during regular business hours at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246. Copies of the recommended schedules are available from the Colorado Department of Public Health and Environment for a reasonable charge that comports with the department's record request practices. This rule does not include any later amendments or editions of the ACIP Catch-Up Schedule.

C. Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new college or university student residing in student housing, or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed. -

D. Two valid doses of the measles, mumps and rubella vaccine are required for all college or university students, unless the college or university student was born before 1957.

IV. Examination and Audit of Official School Immunization Records

The Department of Public Health and Environment's representative shall have the right to audit and verify records to determine compliance with the law. Discrepancies found through audits shall be corrected by school officials, and any student not in full compliance shall be suspended or expelled from school according to the following rules:

A. If the parent(s) or emancipated student was informed of the deficiencies in the student's official school immunization records pursuant to Section I, Provision I.1 of the rules, the student shall be suspended or expelled pursuant to Section 25-4-907, C.R.S.

B. If the parent(s) or emancipated student was not informed by a direct personal notification of the immunizations required and alternatives for compliance with the law, the school shall notify the parent(s) or emancipated student within 7 calendar days of the finding and the student shall: a) provide proof of immunization within fourteen days, b) continue as an in-process student, c) verify that the student is exempt, or d) the student shall be suspended or expelled pursuant to Section 25-4-907, C.R.S.

V. Denial of Attendance

A. A student who is: not in-process, not appropriately vaccinated for his/her age, or not exempt shall be denied attendance in accordance with the law.

B. If the student or child is attending a school which is not subject to the School Attendance Law, Section 22-33-101 et seq., C.R.S., the school officials shall take appropriate action to deny attendance to the student or child in accordance with that school's procedures or contract with the student; the college student will not be allowed to register for the current term or session. No

indigent child shall be excluded, suspended, or expelled from school unless the immunizations have been available and readily accessible to the child at public expense.

VI. Official School Immunization Records

A. Official school immunization records shall include:

1. An official Certificate of Immunization or an Alternate Certificate of Immunization that has been approved by the Department of Public Health and Environment shall include one of the following forms of documentation that include the dates and types of immunizations administered to a student:

    a. A paper or electronic document that includes information transferred from the records of a licensed physician, registered nurse, or public health official; or

    b. An electronic file or hard copy of an electronic file provided to the school directly from the immunization tracking system established pursuant to Section 25-4-2403 C.R.S. or from a software program approved by the Department of Public Health and Environment, or

2. An official medical exemption form with the date and vaccines exempted from, or

3. An official nonmedical exemption form with the date, type of exemption taken and the vaccines exempted from.

B. Any immunization record (original or copy) provided by a physician licensed to practice medicine or osteopathic medicine in any state or territory of the United States, registered nurse, or public health official may be accepted by the school official as proof of immunization. The information is to be verified by the school official and transferred to an official Colorado Certificate of Immunization.

C. Schools shall have on file an official Certificate of Immunization for every student enrolled. The Certificate of Immunization will be kept apart from other school records. When a student withdraws, transfers, or is promoted to a new school, the school official shall return the Certificate of Immunization to the parent(s) or emancipated student upon request or transfer it with the student's school records to the new school. Upon a college or university student's request, the Certificate of Immunization shall be forwarded as specified by the student.

VII. Reporting of Statistical Information

A. On December 1, 2016, and each year thereafter, all schools shall send aggregate immunization and exemption data by antigen to the department of public health and environment. This data shall include:

1. Total number of students and total number of kindergarten students enrolled in the school;

2. Total number of students and total number of kindergarten students who are up-to-date with immunizations as required in part III;

3. Total number of students and total number of kindergarten students who have a medical exemption for all immunizations as required in part III;

4. Total number of students and total number of kindergarten students who have a medical exemption for one or more but not all immunizations as required in part III;

5. Total number of students and total number of kindergarten students who have a religious exemption for all immunizations as required in part III;

6. Total number of students and total number of kindergarten students who have a religious exemption for one or more but not all immunizations as required in part III;

7. Total number of students and total number of kindergarten students who have a personal belief exemption for all immunizations as required in part III;

8. Total number of students and total number of kindergarten students who have a personal belief exemption for one or more but not all immunizations as required in part III;

9. Total number of in-process students and total number of in-process kindergarten students;

10. Total number of students and total number of kindergarten students not up-to-date for immunizations as required in part III, with no exemption on file, and not in-process; and

11. Total number of students and total number of kindergarten students with no immunization records.

B. The requirements delineated in provision VII.A. do not apply to a college or university. On December 1 of each year, college and university officials shall send the immunization summary report to the department of public health and environment.

********* **[Indicates omission of unaffected rules]**

XII. On-line educational module

As necessary to comply with section 25-4-903 (2.5), C.R.S., the Department of Public Health and Environment shall provide immunization information to the public. The immunization information and contents of this module shall include, but are not limited to:

A. Exemption rates in Colorado that are available to the public through the Department,

B. Evidence-based research,

C. Resources and information from credible scientific and public health organizations, and

D. Peer-reviewed studies.

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

MELANIE J. SNYDER
Chief of Staff

FREDERICK R. YARGER
Solicitor General

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Office of the Attorney General

Tracking number: 2015-00139

Opinion of the Attorney General rendered in connection with the rules adopted by the

Disease Control and Environmental Epidemiology Division - promulgated by Colo Bd of Health

on 04/15/2015

6 CCR 1009-2

THE INFANT IMMUNIZATION PROGRAM, VACCINES FOR CHILDREN PROGRAM, AND IMMUNIZATION OF STUDENTS ATTENDING SCHOOL

The above-referenced rules were submitted to this office on 04/16/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

April 27, 2015 13:07:42

Permanent Rules Adopted

Department

Department of State

Agency

Secretary of State

CCR number

8 CCR 1505-8

Rule title

8 CCR 1505-8 RULES CONCERNING LOBBYIST REGULATION 1 - eff 05/30/2015

Effective date

05/30/2015

COLORADO SECRETARY OF STATE

8 CCR 1505-8

Rules Concerning Lobbyist Regulation

Rules as Adopted – Clean
April 9, 2015

Please note the following formatting key:

Font effect	Meaning
Italic blue font text	Publication notes and annotations

[Rule 2.2.3 concerning professional lobbyists is repealed.]

Rule 3.2.2 concerning professional lobbyist disclosure:

3.2.2 Subcontractor requirements.

(a) A lobbyist or lobbying firm that subcontracts lobbying activities to another lobbyist or lobbying firm must disclose:

(1) The name of each subcontractor;

(2) The date and amount of each payment or other compensation made to each subcontractor; and

(3) The name of the client for whom the subcontractor is lobbying.

(b) A subcontractor that performs lobbying activities for another lobbyist or lobbyist firm must disclose:

(1) The name of the lobbyist or lobbying firm that engaged the subcontractor;

(2) The date and amount of each payment or other compensation received from the lobbyist or lobbying firm for lobbying; and

(3) A description of the lobbying activity, the position taken, and the name of the client for whom the subcontractor lobbies.

Rule 5.3.1:

5.3.1 A registered professional lobbyist or lobbyist firm may ask the Secretary of State to excuse or reduce an imposed fine by submitting a written request by mail, email, fax, or hand-delivery within 30 days of the imposition of fine. The request must include:

(a) The professional lobbyist's name;

(b) The request date;

(c) The due date of the delinquently filed disclosure statement;

(d) The filing date the professional lobbyist actually filed the disclosure statement;

(e) Any measures the professional lobbyist or firm has instituted or will institute to avoid future delinquencies, if applicable; and

(f) A brief summary of the reason, circumstance, or other justification of the bona fide personal emergency;

[The remainder of Rule 5.3.1 is retained unaltered]

Rule 6.2 concerning collections:

6.2 The Secretary of State will remove a registration statement restriction if a lobbyist or firm with penalties in collections is making payments and showing a good faith effort to cure the fine.

CYNTHIA H. COFFMAN
Attorney General

DAVID C. BLAKE
Chief Deputy Attorney General

MELANIE J. SNYDER
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FREDERICK R. YARGER
Solicitor General

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Office of the Attorney General

Tracking number: 2015-00141

Opinion of the Attorney General rendered in connection with the rules adopted by the

Secretary of State

on 04/09/2015

8 CCR 1505-8

RULES CONCERNING LOBBYIST REGULATION

The above-referenced rules were submitted to this office on 04/09/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 28, 2015 10:26:14

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Income Maintenance (Volume 3)

CCR number

9 CCR 2503-5

Rule title

9 CCR 2503-5 ADULT FINANCIAL PROGRAMS 1 - eff 06/01/2015

Effective date

06/01/2015

Tracking #2015-00127
FA/P 4/3/15, eff. 6/1/15

I:/14082601_Submittal.doc

(9 CCR 2503-1)

[Instructions: insert the following paragraph at the end of Statement of Basis and Purpose]

Revisions to Sections 3.510, 3.520.71, and 3.542 were final adoption following publication at the 4/3/2015 State Board meeting (Rule-making# 14-8-26-1), with an effective date of 6/1/2015. Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Enterprise Partnerships, State Board Administration.

****

(9 CCR 2503-5)

[Instructions: replace the following section title.]

3.510 DEFINITIONS [Rev. eff. 6/1/15]

===

[Instructions: replace the following.]

“Denial” means that the client was not eligible for benefits upon initial application.

“Disability Benefits Guide (Guide)” means a representative appointed to assist an individual to work with the Social Security Administration (SSA). The Guide is responsible for assisting the client with securing a protected filing date for Supplemental Security Income (SSI) within ten (10) days. The Guide must assist the client in completing and submitting a thorough application for SSI. This Guide may be selected by the client and must be:

A. Any attorney licensed in Colorado or licensed to appear in any United States federal court, in good standing who:

   1. Is not disqualified or suspended from acting as a representative in dealings with the SSA; and,

   2. Is not prohibited by any law from acting as a representative; or,

B. Any person who:

   1. Has SSI/SSDI Outreach, Access, and Recovery (SOAR) certification or is employed and endorsed by an organization that has experience in assisting with the SSI application process. Experience is determined by the county worker verifying place and type of employment; and,

2. Is not disqualified or suspended from acting as a representative in interactions with the SSA or the county department; and,

3. Is not prohibited by any law from acting as a representative.

C. If the person selected by the client meets these requirements, the county department shall notify the client verbally or in writing that the person has been approved to work with them as the Guide.

D. The county department or the SSA may refuse to recognize the person chosen by the client if the person does not meet the requirements in this section. The county department or the SSA will notify the client and the person disqualified to act as the client's Guide. If disqualified by the county department, the county department must provide written notification within three (3) days of the decision to disqualify. The client shall notify the county department within ten (10) days if he/she has selected a new Guide.

E. If a person is disqualified from acting as the Guide, and he or she wishes to dispute this decision, he or she may request a formal review through the Colorado Department of Human Services, Employment and Benefits Division. The Division will review and make decisions on the dispute.

"Discontinuation" means that the client who is currently receiving benefits is no longer eligible and his/her benefits will be stopped.

===
****

[Instructions: replace the following.]

3.520.71 Financial Eligibility Requirements [Rev. eff. 6/1/15]

A. To receive Adult Financial program assistance, the client shall meet all financial requirements in addition to all other program eligibility requirements. The client shall:

1. Have countable resources below the resource limit as outlined in Section 3.520.72; and,

2. Have income below the income limit, as outlined in Section 3.520.78; and,

3. Make reasonable attempts to pursue all available income and resources at the client's disposal.

B. The AND-SO client shall apply for Supplemental Security Income (SSI) benefits. If the client has work hours during his/her lifetime, the client shall also apply for Social Security Disability Insurance (SSDI). The client shall appeal all negative decisions regarding their SSI eligibility. Failure to appeal all negative decisions shall result in denial or discontinuation of AND benefits.

For OAP, the client shall apply for Social Security and/or SSI benefits, as follows:

1. Clients sixty (60) years of age and older who report a disability may be eligible for SSI or SSDI.

2. Clients sixty (60) years of age and older may be eligible for Social Security survivor benefits.

3. Clients sixty-two (62) years of age and older may be eligible for early Social Security retirement benefits; otherwise the client shall provide documentation from the SSA that he/she is ineligible due to insufficient work hours.

4. Clients sixty-five (65) years of age and older may be eligible for Social Security retirement benefits and/or SSI benefits when the client's income from any source is less than the SSI grant standard plus $20.00.

C. For Adult Financial programs, clients referred to the SSA to apply for any SSA related benefit shall be required to provide verification of application for such benefits within ten (10) calendar days of application for SSA benefits. Benefits shall not be approved prior to receipt of proof of application for SSA benefits, unless he/she is working with a Disability Benefits Guide (Guide) for the AND-SO program. If he/she is working with a Guide, the client will have up to two months of conditional approval from the date of the initial interview with the county department for AND-SO, unless good cause is provided for additional time.

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[Instructions: replace the following section title.]

3.542 DETERMINATION [Rev. eff. 6/1/15]

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[Instructions: replace the following.]

J. Eligibility shall begin with the date of application or the date the client meets all eligibility requirements, whichever is later. In the case of AND-SO, if the client is delayed in completing the paperwork and appointment process for SSI and/or the medical exam through no fault of their own or if he/she is working with a Disability Benefits Guide, the date of application shall be used as the date of eligibility.

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CYNTHIA H. COFFMAN
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Office of the Attorney General

Tracking number: 2015-00127

Opinion of the Attorney General rendered in connection with the rules adopted by the

State Board of Human Services: #14-8-26-1 AND-SO Changes and Disability Benefits Guide Per SB14-012

on 04/03/2015

9 CCR 2503-5

ADULT FINANCIAL PROGRAMS

The above-referenced rules were submitted to this office on 04/09/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 20, 2015 15:04:20

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY 1 - eff 05/30/2015

Effective date

05/30/2015

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Health Programs Office Benefits and Operations Division Ambulatory Surgery Center (ASC) Rule Concerning Amount, Scope and Duration of Services, Section 8.570.5
Rule Number:	MSB 15-02-11-A
Division / Contact / Phone:	HPO B&O / Ana Lucaci / x6163

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 15-02-11-A, Revision to the Health Programs Office Benefits and Operations Division Ambulatory Surgery Center (ASC) Rule Concerning Amount, Scope and Duration of Services, Section 8.570.5
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.570.5, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.570.5.A through §8.570.5.A.7 with the new text provided beginning at §8.570.5.A through the end of §8.570.5.A.8. This change is effective 05/30/2015.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Health Programs Office Benefits and Operations Division Ambulatory Surgery Center (ASC) Rule Concerning Amount, Scope and Duration of Services, Section 8.570.5
Rule Number:	MSB 15-02-11-A
Division / Contact / Phone:	HPO B&O / Ana Lucaci / x6163

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The purpose of this update is to clarify language in the Non-Covered Services section to comply with the Department's Benefit Coverage Standard (BCS).

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   §1905(a) of the Social Security Act, codified at 42 U.S.C. 1396d(a)(2); 42 CFR Section 440.230.

4. State Authority for the Rule:

   §§25.5-1-301 through 25.5-1-303, C.R.S. (2014);

Initial Review	**03/13/2015**	Final Adoption	**04/10/2015**
Proposed Effective Date	**05/30/2015**	Emergency Adoption	

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Health Programs Office Benefits and Operations Division Ambulatory Surgery Center (ASC) Rule Concerning Amount, Scope and Duration of Services, Section 8.570.5
Rule Number:	MSB 15-02-11-A
Division / Contact / Phone:	HPO B&O / Ana Lucaci / x6163

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

This rule will impact the Providers of ASC services and Medicaid Clients.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Clearly defined and updated rules will improve client access to appropriate, high quality, cost-effective and evidence-based services while improving the health outcomes of Medicaid clients. Established criteria within the rule will provide guidance to clients and providers regarding benefit coverage. Medicaid covered residents will also be better served with clear transparent description of the ASC benefit.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

This rule does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Clearly defined and updated rules increase client access to appropriate services and allow the Department to administer benefits in compliance with federal and state regulations, as well as clinical best practices and quality standards. Defining this benefit in rule will educate clients about their benefits and provide better guidance to service providers. The cost of inaction could result in decreased access to services, poor quality of care, and/or lack of compliance with state and federal guidance.

All of the above translates into appropriate cost-effective care administered by the state.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no less costly methods or less intrusive methods for achieving the purpose of this rule. The department must appropriately define amount, scope and duration of this benefit in order to responsibly manage it.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule. The Department also documents its benefit coverage policies in written coverage standards. The benefit coverage policies must be written into rule to have the force of law.

8.570.5 NON-COVERED SERVICES

8.570.5.A Non-covered services are those services that:

1. Are not commonly performed in an ASC;

2. May safely be performed in a physician's office;

3. Generally result in extensive blood loss;

4. Require major or prolonged invasion of body cavities;

5. Directly involve major blood vessels;

6. Are generally emergency or life-threatening in nature;

7. Pose a significant safety risk to clients or are expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay) when furnished in an ASC; or,

8. Are not listed in the annual ASC billing manual.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1
Rule Number:	MSB 14-02-12-A
Division / Contact / Phone:	Office of Community Living / Nora Brahe / 303-866-3566

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-02-12-A, Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Insert Section(s) affected, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.553 (COMMUNITY TRANSITION SERVICES) through the end of paragraph 8.553.5.D with the new text provided. All text indicated in blue is for clarity only and should not be changed. This change is effective 05/30/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1
Rule Number:	MSB 14-02-12-A
Division / Contact / Phone:	Office of Community Living / Nora Brahe / 303-866-3566

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule will revise Community Transition Services (CTS), a benefit of the Home and Community Based Services - Elderly, Blind and Disabled (HCBS-EBD) waiver since 2006. The revision will implement CTS as a demonstration service of the Colorado Choice Transitions (CCT) program. CTS will continue to be a benefit of the HCBS-EBD waiver. The revision will expand eligibility of CTS to individuals with intellectual disabilities, brain injuries and mental illness.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   §§25.5-1-301 through 25.5-1-303, C.R.S. (2014);

Initial Review	**03/13/2015**	Final Adoption	**04/10/2015**
Proposed Effective Date	**05/30/2015**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1
Rule Number:	MSB 14-02-12-A
Division / Contact / Phone:	Office of Community Living / Nora Brahe / 303-866-3566

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The CTS rule provides guidelines for services to elderly and disabled individuals 18 years and older residing in Medicaid skilled nursing facilities (SNFs) and adults aged 18 and older with intellectual or developmental disabilities residing in intermediate care facilities and SNFs.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The primary intent of CTS is to assist people residing in nursing homes and other long-term care facilities in Colorado who may have the desire to return to a community based living arrangement. CTS will provide supports and services to facilitate their transition to the community.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   None.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Provision of CTS services supports the successful transition of individuals from costly institutional care to less restrictive and expensive settings where they can receive home and community-based services. This impacts state Olmstead compliance, promotes the Department's strategic goal to transition institutionalized individuals and Colorado Choice Transition (CCT) ability to meet Money Follows the Person (MFP) transition goals.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly methods or less intrusive methods for achieving the purpose of the purposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

Revisions to the rule are based on input solicited from stakeholders. There were no other alternative methods identified.

8.553 COMMUNITY TRANSITION SERVICES

8.553.1 DEFINITIONS

Authorization Request (AR) means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services.

Case Management means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic assessment of such client's needs.

Case Management Agency means the organization selected to provide case management functions for person in need of long term care services.

Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence.

Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy.

Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management.

Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services.

Transition Options Team means a group of individuals, chosen by the client and/or providing services to the client, who participate in the transition assessment and planning process.

8.553.2 BENEFITS

8.553.2. A. CTS shall only be available to clients currently residing in a skilled nursing facility or an Intermediate Care Facility-Individuals with Intellectual Disabilities (ICF-IID) who are eligible for adult Home and Community- Based Services (HCBS) waivers except the Spinal Cord Injury Waiver.

8.553.2. B. CTS includes transition coordination services and funds to assist the client to set-up a household.

8.553.2. C. CTS shall be provided by Transition Coordinators who are employed by Transition Coordination Agencies certified by the Department.

8.553.2. D. CTS shall be provided using procedures and guidelines provided in the Department transition coordination and intensive case management training.

8.553.2. E. The CTS household set-up assistance shall only be for the benefit of the client to set up a less restrictive living arrangement and may include the following:

1. Security deposits that are required to obtain a lease on a residence.

2. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.

3. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items.

4. Moving expenses required to occupy a community-based residence.

5. Health and safety assurances including a one-time pest eradication and one-time cleaning prior to occupancy.

6. A one-time purchase of food not to exceed $100.

7. Purchase of a cell phone to be used for safety monitoring.

8. First month rent.

9. Bus pass for period that covers the time period from referral to CTS to 30 days past the date of discharge from a facility described at 10 C.C.R. 2505-10, Section 8.553.2.A.

10. Computer that is determined to be medically necessary to sustain a less restrictive living arrangement. (Client is required to complete computer training prior to receiving computer).

11. Clothing that is appropriate for the community.

8.553.2. F. The cost of CTS shall not exceed the established amount per client unless otherwise authorized by the Department.

8.55.3.2. G. Items purchased through CTS, returned security deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.a. and returned deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.b. shall be the property of the client. The client may take the property with him or her in the event of a move to another residence.

8.553.3 NON-BENEFITS

8.553.3. A. CTS shall not include the following:

1. Monthly rental expenses or other ongoing periodic residential expenses.

2. Recreation, entertainment or convenience items.

3. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when already provided through other means.

4. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when provided for the benefit of persons other than the client.

5. Monthly cell phone expenses.

6. Monthly bus pass expenses not described in 10 C.C.R. 2505-10, Section 8.553.2.E.i.

8.553.4 TCA QUALIFICATIONS

8.553.4. A. A TCA shall conform to all certification standards and procedures described in 10 C.C.R. 2505-10, Section 8.487 for HCBS-EBD Provider Agencies.

8.553.4. B. A TCA shall meet all requirements as set forth in 10 C.C.R. 2505-10, Section 8.553.5.

8.553.5 TCA RESPONSIBILITIES

8.553.5. A. TCAs shall administer the CTS benefit.

8.553.5. B. The TCA shall perform administrative functions, including supervision of Transition Coordinators, attendance at required meetings, timely reporting, compliance with transition procedures defined by the Department with input from stakeholders, community coordination and outreach, client monitoring and on-site visits.

8.553.5. C. Staffing Requirements

1. The TCA shall ensure and document that each Transition Coordinator has completed the required Department Transition Coordinator training and has received a satisfactory proficiency rating.

2. The TCA shall ensure that each Transition Coordinator has received training in the following:

    a. Knowledge of populations served by the TCA and the target population served by waivers.

    b. Client interviewing and assessment skills.

    c. Intervention and interpersonal communication skills.

    d. Knowledge of available community resources and public assistance programs.

    e. Team coordination skills.

    f. Meeting facilitation skills.

3. The TCA supervisor(s), at a minimum, shall have two years supervisory experience and meet all qualifications for a Transition Coordinator.

4. The TCA supervisor shall complete the Department transition coordination supervision training.

5. Supervision of Transition Coordinators shall include, but not be limited to, the following activities:

    a. Arrangement and documentation of training or skills validation testing.

    b. Review of transition assessments and plans and risk mitigation plans.

    c. Oversight of transition coordination activities.

    d. Assessment of client's satisfaction with services.

    e. Investigation of complaints regarding provision of CTS.

    f. Counseling with staff on difficult cases.

    g. Oversight of recordkeeping by staff.

6. Training shall be completed prior to the delivery of CTS.

8.553.5. D. The Transition Coordinator shall conduct transition activities in accordance with training, policies and procedures defined by the Department.

8.553.5. E. The Transition Coordinator shall, in collaboration with the client's Transition Options Team, complete a Department-approved assessment to determine the client's preferences, desires, and needs for housing, services and items necessary to establish a community-based residence.

8.553.5. F The Transition Coordinator shall work with the client and the Transition Options Team to create and implement a transition plan that meets the client's preferences, desires and needs identified on the transition assessment. The Transition Coordinator and the client shall sign the transition plan to signify agreement.

1. The Transition Coordinator shall submit the completed transition assessment, transition plan and risk mitigation plan to the Department Transitions Administrator (TA) for review prior to implementation of both plans.

    a. The transition plan shall include the items needed for the client to transition to a community-based residence.

8.553.5. G. The Transition Coordinator shall work with the client and Transition Options Team to create and implement a risk mitigation plan that identifies known risk factors and a strategy to mitigate each factor.

8.553.5. H. The Transition Coordinator shall work with the client to obtain a residence and any items necessary to establish a community-based residence.

8.553.5. I. The Transition Coordinator shall conduct a minimum of four visits of the residence to ensure all essential furnishings, utilities, community resources and services are in place.

8.553.5. J. If the Transition Coordinator finds any of the supports to be insufficient for the client to live successfully in the community, the Transition Coordinator shall work with the case manager to correct the deficiencies.

8.553.5. K. The Transition Coordinator shall perform on-site visits to the client's community-based residence at the following intervals:

1. Prior to the client's discharge from the skilled nursing facility.

    a. If possible, the client shall accompany the Transition Coordinator during the on-site visit prior to discharge.

    b. If the client is unable to participate in the on-site visit, the Transition Coordinator shall document the reason in the client's file.

2. The day of the move to ensure that the client's belongings and medications are moved from the facility; that all required services are in place; and that the necessary household set-up is complete.

3. One week after the transition to ensure that the supports and services identified on the transition assessment and plan are being provided and received.

4. One month after the transition to ensure the client has the proper supports to continue successfully living in the community.

5. The Transition Coordinator shall complete a transition report after the last on-site visit.

8.553.6 CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.553.6. A. The case manager shall participate in the Transition Options Team meetings.

8.553.6. B. The case manager shall conduct service brokering for Medicaid services, including HCBS and state plan benefits, such as behavioral health services and home health. Service brokering includes determining whether services that meet the client's needs are available in the community where the client wants to live.

8.553.6. C. The case manager shall authorize CTS services.

8.553.6. D The case manager shall provide joint monitoring with the transition coordinator of the client during the 30 day post-discharge period.

8.553.7 AUTHORIZATION REQUESTS

8.553.7. A. The TCA shall submit the CTS AR form to the case management agency to authorize payment for CTS and for any purchases or deposits after client discharges from the facility.

1. The AR shall include copies of cancelled checks and copies of receipts detailing the items purchased and the cost.

2. Any expenses submitted on the CTS AR for items that are not included in the approved transition plan shall be considered non-allowable expenses and shall not be reimbursed.

3. The case manager shall complete a review of the AR and shall notify the TCA of approval or denial of the AR and, if applicable, any non-allowable expenses on the cost report within ten business days of receipt.

4. The TCA shall submit the AR for Transitional Case Management once the client has discharged from the facility.

a. The case manager shall verify that the client is established in a community-based residence.

b. The case manager shall complete a review of the AR and shall notify the TCA of approval or denial within ten business days of receipt.

c. The case manager shall notify the TCA of approval of any non-allowable expenses on the cost report, if applicable.

d. Incomplete ARs shall be returned to the TCA for correction within 10 business days of receipt by the case management agency.

8.553.7. B. If after the transition plan has been reviewed the Transition Coordinator determines additional purchases are required, the Transition Coordinator shall submit a revised AR to the case management agency.

8.553.7. C. Approval of the AR by the case manager shall authorize the TCA to submit claims to the Department's fiscal agent. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures.

8.553.8 REIMBURSEMENT

8.553.8. A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R. 2505-10, Section 8.487.200 Provider Reimbursement.

8.553.8. B. Payment for CTS shall be the lower of the billed charges or the maximum rate of reimbursement.

8.553.8. C. The cost of transitional coordination services shall be reimbursed by one unit of service completed when the client is established in a community-based residence as verified by the case manager.

8.553.8. D. Reimbursement for household set-up shall be made only for items listed on the transition plan with an accompanying receipt. The cost of household set-up shall be reimbursed at one unit of service completed when the client is established in a community-based residence as verified by the case manager.

8.553.9 CONFLICT- FREE TRANSITION COORDINATION

8.553.9. A. TCAs shall separate transition coordination from direct service provision. Examples of this separation are separate staff, intake lines, office space and client files.

1. Transition Coordinators who are involved in the determination that a transition is feasible are required to do so distinctly so that there is not an incentive to increase business for their organization.

2. In circumstances when one entity is responsible for providing transition coordination and service delivery, appropriate safeguards and firewalls shall exist to mitigate risk of potential conflicts of interest and to ensure that consumer choice and control are not compromised. The safeguards and firewalls shall be submitted to the Department for approval.

3. In circumstances where the TC is an employee of an agency providing other services, the TC shall comply with safeguards and firewalls established to mitigate conflict of interest and to ensure client choice and control.

8.553.9. B. Determination that a transition is feasible is made by the Transition Options Team.

8.553.9. C. Transition Coordinators shall not be related to the parent, child, spouse, sibling, grandparent, niece, nephew, uncle or aunt of any of the individual's caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3
Rule Number:	MSB 15-02-06-A
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 303-866-3239

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 15-02-06-A, Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.4.G.3, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: April 2015
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

At §8.100.1 insert a new unnumbered paragraph that begins with "MAGI equivalent is the resulting standard . . .". This paragraph is inserted immediately following the unnumbered paragraph that reads "Modified Adjusted Gross Income (MAGI) refers to the methodology . . ." and immediately before the paragraph that reads "MIA - Monthly Income Allowance is the amount . . .".

Replace current text at §8.100.4.G.3 and §8.100.4.G.4 with new text provided. Remove current text at §8.100.4.G.3.a.

All text indicated in blue is for context only and should not be changed. This revision is effective 05/30/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3
Rule Number:	MSB 15-02-06-A
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 303-866-3239

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of the rule change is to make a revision to the current policy regarding MAGI Parent/Caretaker Relatives Federal Poverty Level (FPL) changing from 100% FPL to 60% MAGI-converted. The state will be updating the Colorado Benefits Management System (CBMS) to be in alignment with our federal regulations effective April 1, 2015. This rule also needs to be updated to ensure the state is in compliance with federal regulations..

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   Section 1902(e)(14)(E) of the Social Security Act

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);

Initial Review		Final Adoption	**04/10/2015**
Proposed Effective Date	**07/01/2015**	Emergency Adoption	

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3
Rule Number:	MSB 15-02-06-A
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 303-866-3239

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rule will impact those currently enrolled on the Parent/Caretaker Relatives category. Changing the Federal Poverty Level (FPL) percent to 60 % MAGI-converted will transition a number of adults from MAGI Parents/Caretaker Relatives category to the MAGI Adult category. Also, individuals who do not meet the FPL percentage of 60 % MAGI-converted and who currently have Medicare will no longer be eligible for Medicaid. The benefit from the proposed rule is more adults will be eligible for MAGI Adult category.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The proposed rule will transition a number of adults from Parent/Caretaker Relatives to MAGI Adult category. Those affected are adults who do not meet the FPL percentage of 60 % MAGI-converted and who are on Medicare will no longer be eligible for Medicaid.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   A small number of clients could lose eligibility as a result to this change, but the Department assumes that the majority of the clients in this small population could be eligible in other aid categories. Consequently, the actual fiscal impact is anticipated to be nominal.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Action is needed for compliance with federal regulation; inaction is not an option.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There is no alternative action available to achieve federal compliance.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There are no alternative methods for the proposed rule that were considered.

8.100.1 Definitions

Modified Adjusted Gross Income (MAGI) refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act. These MAGI groups include Parents and Caretaker Relatives, Pregnant Women, Children, and Adults. For a more complete description of the MAGI categories and pursuant rules, please refer to section

MAGI-equivalent is the resulting standard identified through a process that converts a state's net-income standard to equivalent MAGI standards.

MIA - Monthly Income Allowance is the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MSP - Medicare Savings Program is a Medical Assistance Program to assist in the payment of Medicare premium, coinsurance and deductible amounts. There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLIMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals – 1 (QI-1s).

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance.

    a. Medical Assistance eligibility is guaranteed for 12 continuous months from the application month regardless of changes in income or household size.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 60% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household receiving Medical Assistance.

4. Effective January 1, 2014, Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage must be provided regardless of changes in the woman's financial circumstances.

6. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for Medical Assistance if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.3. This population is referenced as Legal Immigrant Prenatal.

7. A child born to a woman receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This provision also applies in instances when the woman received Medical Assistance to cover the child’s birth through retroactive Medical Assistance. To receive Medical Assistance under this category, the individual need not file an application nor provide a social security number or proof of application for a social security number for the newborn. Anyone can report the birth of the baby verbally or in writing. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time. Once reported, a newborn meeting the above criteria shall be added to the Medical Assistance case according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes. This population is referenced as Eligible Needy Newborn.

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Office of the Attorney General

Tracking number: 2015-00138

Opinion of the Attorney General rendered in connection with the rules adopted by the

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

on 04/10/2015

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY

The above-referenced rules were submitted to this office on 04/10/2015 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

April 20, 2015 14:00:23

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Department

Department of State

Agency

Secretary of State

STATE OF COLORADO
Department of State
1700 Broadway
Suite 200
Denver, CO 80290

Wayne W. Williams
Secretary of State

Suzanne Staiert
Deputy Secretary of State

Help Shape Colorado's Election Rules

Topic: Rules to implement legislative changes and clean up revisions

May 8, 2015

What is this about?

Secretary Williams is considering amendments to Colorado's Rules Concerning Elections (8 CCR 1505-1). The changes are intended to improve the administration and enforcement of Colorado election law[1] and to increase transparency and security in the election process.

The main goals of the proposed rulemaking are to:

- Ensure proper administration of legislation;
- Establish uniformity in the administration of current law;
- Organize existing rules for clarity;
- Eliminate obsolete provisions;
- Simplify the language of existing rules; and
- Remove language that is duplicative of statute.

We invite you to share your thoughts and recommendations as we develop a preliminary draft of the proposed rules. Please review the attached working draft. Please note that if an existing rule is not included in the proposed draft, we are not proposing amendments to that rule.

Why does the Secretary need my help?

The Secretary values your feedback and we would very much like to hear your thoughts. We need your help to identify necessary revisions or additional guidance in order to propose a constructive and comprehensive draft rule for consideration during the rulemaking proceedings. Overall, we invite your opinions and recommendations to help shape Colorado's Election Rules.

How do I submit my comments and what is the deadline?

You may email your comments to SOS.Rulemaking@sos.state.co.us. To ensure consideration of your comments before we issue the proposed draft, we must receive your comments by 5:00 p.m. on May 15, 2015.

[1] Article VII of the Colorado Constitution, Title 1 of the Colorado Revised Statutes, and the Help America Vote Act of 2002 ("HAVA"), P.L. No. 107-252.

Will my comments become part of the official record for the anticipated rulemaking?

Yes, we will incorporate your comments into the official record when we commence with formal rulemaking. Our office will identify your comments as information received in anticipation of rulemaking to support the development of the proposed draft rule. Please note that you will have an additional opportunity to provide testimony and/or written comments regarding the proposed rule during the rulemaking proceeding.

To promote transparency and to help generate discussion, our office will post a copy of your comments on the Secretary of State's website. We appreciate privacy concerns and will redact personal contact information that may appear in your comments prior to posting (including your home address, personal email address, and telephone number). To view the comments that we receive, please visit: http://www.sos.state.co.us/pubs/rule_making/ruleComments.html.

Working Draft of Proposed Rules

Office of the Colorado Secretary of State
Election Rules
8 CCR 1505-1

May 8, 2015

Disclaimer:

The following is a working draft concerning the Election Rules. The Secretary values your input and is seeking feedback about the proposed revisions before a formal notice of rulemaking.

Please send your feedback by May 15, 2015. Please reference the specific page and line number in your comments. We will consider all comments submitted by this date for inclusion in the official rulemaking draft.

Please note the following formatting key:

Font effect	Meaning
Sentence case	Retained/modified current rule language
SMALL CAPS	New language
~~Strikethrough~~	Deletions
Italic blue font text	Annotations

Amendments to 8 CCR 1505-1 follow:

Amendments to Rule 1.1.46(a):

1.1.46 "Watcher" has the same meaning as in section 1-1-104(51), C.R.S.

(a) A watcher may be appointed for a recall election in the same manner as in a primary election. A RECALL ISSUE COMMITTEE MAY ALSO APPOINT A WATCHER.

[The remainder of Rule 1.1.46 is retained unaltered]

Amendments to Rule 2.3 through 2.5:

2.3 When an elector registers to vote, the elector must provide a verifiable driver's license or state identification card number, or last four digits of his or her social security number. If THE ELECTOR PROVIDES A NUMBER THAT DOES NOT VERIFY OR the elector states that he or she does not have a driver's license, state identification card number, or social security

number, the county clerk must register the elector and mark the registration record "ID required".

2.3.1 A COUNTY MUST PROCESS THE HELP AMERICA VOTE VERIFICATION FILE ON A MONTHLY BASIS FOR VERIFYING SOCIAL SECURITY NUMBERS AND REMOVE THE "ID REQUIRED" FLAG FOR THOSE NUMBERS THAT ARE VERIFIED.

~~2.3.1~~ 2.3.2 As used in section 1-1-104(19.5), C.R.S., government document means a document issued by a city, county, state or federal government.

[The remainder of New Rule 2.3.2, formerly Rule 2.3.1, is retained unaltered]

~~2.3.2~~ 2.3.3 As used in section 1-1-104(19.5)(a)(VII), C.R.S., current means that the date of the document is within 60 days of the date submitted for identification purposes unless the document states a longer billing cycle.

~~2.3.3~~ 2.3.4 Documents issued under section 42-2-505, C.R.S., are not acceptable forms of identification for any purpose under the Uniform Election Code of 1992 and these rules.

2.4 Treatment of NEW REGISTRATION applications where the elector fails to provide required information

[The remainder of Rule 2.4 is retained unaltered]

2.5 Changes to an elector's EXISTING voter registration record

2.5.1 If an elector submits a change to his or her voter registration record and fails to include the information required by sections 1-2-216 or 1-2-219, C.R.S., the county clerk ~~must~~ MAY not make the requested change unless the county clerk can ~~confidently identify the voter~~ ESTABLISH MINIMUM MATCHING CRITERIA. ~~The~~ IF THE county clerk CANNOT ESTABLISH MINIMUM MATCHING CRITERIA, THE COUNTY CLERK MAY NOT CHANGE THE ELECTOR'S STATUS AND must notify the voter of the additional information that is required to process the request.

[The remainder of Rule 2.5 is retained unaltered]

Amendments to Rule 2.7.1:

2.7 Minimum matching criteria

2.7.1 Except as provided in section 1-2-302.5, C.R.S., the county clerk must not transfer, consolidate, or cancel a voter registration record unless the APPLICABLE minimum matching criteria as set forth in sections 1-2-603 ~~and~~ OR 1-2-604, C.R.S., are met. If the minimum matching criteria are not met the county clerk must send a letter to the voter requesting confirmation of the missing or non-matching information in order to transfer, consolidate, or cancel the record.

[The remainder of Rule 2.7 is retained unaltered]

Amendments to Rule 2.10:

2.10 ~~20-day applicants~~ NEW VOTER NOTIFICATION under section 1-2-509(3), C.R.S.

2.10.1 When a county clerk deems an applicant "not registered" upon receipt of an undeliverable new voter notification in accordance with section 1-2-509(3), C.R.S., the county clerk must mail a confirmation card. The confirmation card must meet the requirements of section 1-1-104(2.8), C.R.S.

2.10.2 If the applicant returns the signed confirmation card within 90 days the county clerk must register the applicant using the date of the original application.

2.10.3 During the 22 days before an election, the county clerk must defer processing undeliverable ~~20-day~~ NEW VOTER notifications. After the election is closed, the clerk must deem an applicant "not registered" under section 1-2-509(3), C.R.S., only if the applicant did not vote in the election.

~~2.12.1~~ 2.10.4 ~~When~~ IF AFTER THE 20-DAY PERIOD OUTLINED IN SECTION 1-2-509(3), C.R.S, EXPIRES the United States Postal Service returns a new voter notification ~~or confirmation card~~ to the county clerk as undeliverable, or provides the clerk with a postcard notice of mail forwarding, the county clerk must mark the voter's record "Inactive – returned mail" and mail a confirmation card. ~~Where a confirmation card sent under this Rule is returned as undeliverable, the county is not required to mail another card.~~

[Current Rule 2.12.1 is amended and recodified as New Rule 2.10.4]

Amendments to Rules 2.12 and 2.13:

2.12 List Maintenance under section 8 of the National Voter Registration Act of 1993

~~2.12.1 When the United States Postal Service returns a new voter notification or confirmation card to the county clerk as undeliverable, or provides the clerk with a postcard notice of mail forwarding, the county clerk must mark the voter's record "Inactive – returned mail" and mail a confirmation card. Where a confirmation card sent under this Rule is returned as undeliverable, the county is not required to mail another card.~~

[Current Rule 2.12.1 is amended and recodified as New Rule 2.10.4; subsequent rules are renumbered as follows:]

~~2.12.2~~ 2.12.1 The Secretary of State will provide monthly National Change of Address (NCOA) data under section 1-2-302.5, C.R.S., to the county clerk by the fifth of each month.

[The remainder of New Rule 2.12.1, formerly Rule 2.12.2, is retained unaltered]

~~2.12.3~~ 2.12.2 In accordance with section 1-2-605(7), C.R.S., no later than 90 days following a General Election, the county clerk in each county must cancel the registrations of electors:

[The remainder of New Rule 2.12.2, formerly Rule 2.12.3, is retained unaltered]

~~2.12.4~~ 2.12.3 The county must process all records designated for cancelation by the Secretary of State within 21 days of receipt.

~~2.12.5~~ 2.12.4 The county must process and mail all confirmation cards using SCORE so that the elector's voter registration record audit log shows the date on which the county printed or extracted the confirmation card.

~~2.12.6~~ 2.12.5 To the extent a county has records of confirmation cards it has generated and sent outside of SCORE, the county must retain those records as election records under section 1-7-802, C.R.S.

2.13 Voter registration at a voter service and polling center

2.13.1 A person registering voters or updating voter registration information in a voter service and polling center must:

(a) Be a permanent or temporary county employee, state employee, or temporary staff hired by the county clerk;

~~(b) Successfully pass the criminal background check described in Rule 6.5;~~ and

~~(c)~~ (B) Complete a training course provided by the Secretary of State.

[Current Rule 2.13.2 is retained unaltered]

Amendments to Rule 6.4 and repeal of Rule 6.5:

6.4 A supervisor judge in a voter service and polling center must~~:~~

~~6.4.1 Successfully pass the criminal background check described in Rule 6.5. Any person who has been convicted of an election offense or an offense with an element of fraud is prohibited from handling voter registration applications or conducting voter registration and list maintenance activities.~~

~~6.4.2 Complete~~ COMPLETE a training course provided by OR APPROVED BY the Secretary of State.

~~6.5 The county clerk must arrange for a criminal background check on a supervisor judge and each staff member conducting voter registration activities.~~

~~(a) The criminal background check must be conducted by or through the Colorado Bureau of Investigation, the county sheriff's department in accordance with section 24-72-305.6(3), C.R.S., or similar state or federal agency.~~

~~(b) A person convicted of an election offense or an offense containing an element of fraud may not:~~

~~(1) Handle voter registration applications or conduct voter registration and list maintenance activities; or~~

~~(2) Have access to a code, combination, password, or encryption key for the voting equipment, ballot storage area, counting room, or tabulation workstation.~~

Repeal of Rule 7.2.3(c) concerning ballots and ballot packets:

~~(c) In coordinated elections, the county clerk must mail ballots to all active eligible electors of each political subdivision.~~

Amendments to Rules 7.2.5 through 7.2.7:

7.2.5 ~~Effective January 1, 2015, each~~ EACH mail ballot return envelope and mail ballot instruction must include a statement informing voters that it is a violation of law to drop off more than ten ballots in any election.

7.2.6 Effective ~~January 1, 2015~~ JANUARY 1, 2016, each mail ballot return envelope must include the following: "~~For third party delivery:~~ I am voluntarily giving my ballot to (name and address) for delivery ON MY BEHALF. ~~I have marked and sealed my ballot in private and have not allowed any person to observe the marking of the ballot, except for those authorized to assist voters under state or federal law.~~"

7.2.7 A COUNTY CLERK WHO USES A THIRD PARTY VENDOR TO MAIL BALLOTS IS CONSIDERED TO BE IN POSSESSION OF THE BALLOTS FOR PURPOSES OF SECTION 1-5-403(1), C.R.S., WHEN THE VENDOR HAS PREPARED THE BALLOTS FOR MAILING.

Amendments to Rule 7.5.1:

7.5 Receipt and processing of ballots

7.5.1 ~~All~~ THE COUNTY CLERK MUST ADEQUATELY LIGHT ALL drop-off locations ~~must be monitored by~~ AND USE EITHER an election official or A video security surveillance recording system~~,~~ as defined in Rule ~~20~~ 1.1.42 TO MONITOR EACH LOCATION.

[The remainder of Rule 7.5.1 and Rules 7.5.2 through 7.5.4 are retained unaltered]

Amendments to Rule 7.5.5:

7.5.5 Election officials must record the number of ballot packets returned as undeliverable AND RECEIVE THE BALLOT PACKETS IN SCORE upon receipt.

Amendments to Rule 7.7:

7.7 Missing signature.

~~7.7.1~~ If a mail or provisional ballot return envelope lacks a signature, ~~the election official must contact the elector in writing no later than two calendar days after election day.~~ THE ELECTION OFFICIAL MUST FOLLOW THE PROCEDURES FOR DISCREPANT SIGNATURES OUTLINED IN SECTION 1-7.5-107.3(2)(A), C.R.S. The designated election official must use the letter and form prescribed by the Secretary of State and keep a copy as part of the official election record. Nothing in this Rule prohibits the designated election official from calling the elector, but a phone call may not substitute for written contact. If the designated election official calls any elector he or she must call all electors whose affidavits are unsigned.

[Sections 1-7.5-107.3 and 1-8.5-105(3)(a), C.R.S.]

~~7.7.2 The letter must inform the elector that the elector must sign the affidavit and return the form in person or by mail, fax, or email, and that the county must receive the form no later than eight calendar days after the election.~~

~~7.7.3 The election official must use the letter and the signature verification form approved by the Secretary of State. The letter and missing signature affidavit form does not violate section 1-13-801, C.R.S.~~

Amendments to Rule 7.9.3:

7.9.3 ~~Voter check-in at the voter service and polling center~~

~~(a) Each voter service and polling center must include an adequately staffed designated voter check-in table or area.~~

~~(b) The check-in judge must verify each elector's registration information, including address.~~

~~(c) If an elector has moved or is not registered, the check-in judge must direct the elector to the registration area. If the elector is registered and has no updates, the check-in judge must direct the elector to the voting table.~~ COUNTY CLERKS MUST CONFIGURE VOTER SERVICE AND POLLING CENTERS, AND PROVIDE SUFFICIENT ELECTION JUDGES, SCORE WORK STATIONS, VOTING EQUIPMENT, BALLOTS, AND OTHER SUPPLIES, IN ORDER TO ASSIST REGISTRANTS AND ELECTORS EFFICIENTLY.

Amendments to Rule 7.11:

7.11 Voter service and polling center connectivity

7.11.1 The county must have real-time access to SCORE AND WEBSCORE at every voter service and polling center designated by the county clerk.

7.11.2 THE COUNTY CLERK MUST INSTRUCT ELECTION JUDGES AND, IF APPROPRIATE, ELECTION STAFF, TO:

(A) USE WEBSCORE TO REGISTER VOTERS; UPDATE EXISTING VOTER REGISTRATIONS; ISSUE AND REPLACE MAIL BALLOTS; AND ISSUE, SPOIL, AND REPLACE IN-PERSON BALLOTS.

(B) OFFER AN IN-PERSON VOTER THE OPPORTUNITY TO OBTAIN A REPLACEMENT MAIL BALLOT RATHER THAN A PROVISIONAL BALLOT IN THE EVENT THE VOTER SERVICE AND POLLING CENTER LOSES CONNECTIVITY TO WEBSCORE BUT RETAINS CONNECTIVITY TO SCORE.

~~7.11.2~~ 7.11.3 At no time may an election official open SIMULTANEOUS SESSIONS OF both ~~the~~ SCORE ~~voter registration screen~~ and ~~the voting module~~ WEBSCORE on a single workstation.

~~7.11.3~~ 7.11.4 Every voter service and polling center designated by the county clerk must meet the minimum security procedures for transmitting voter registration data as outlined in section 1-5-102.9, C.R.S., and Rule 2.16.

Amendments to Rule 11.1.3 concerning voting system access:

11.1.3 In accordance with section 24-72-305.6, C.R.S., all permanent and temporary county staff and all vendor staff who have access to the voting system or any voting or counting equipment must pass ~~the~~ A criminal background check ~~described in Rule 6.5~~. A PERSON CONVICTED OF AN ELECTION OFFENSE OR AN OFFENSE CONTAINING AN ELEMENT OF FRAUD MAY NOT HAVE ACCESS TO A CODE, COMBINATION, PASSWORD, OR ENCRYPTION KEY FOR THE VOTING EQUIPMENT, BALLOT STORAGE AREA, COUNTING ROOM, OR TABULATION WORKSTATION.

Current Rule 16.1.5, concerning voting by military and overseas electors, is repealed and subsequent rules are renumbered as follows:

~~16.1.5 In accordance with sections 1-8.3-111 and 1-8.3-113, C.R.S., all ballots cast must be voted and mailed or electronically transmitted no later than 7:00 p.m. MT on election day, and received by the county clerk or the Secretary of State no later than the close of business on the eighth day after election day.~~

~~16.1.6~~ 16.1.5 Ballots received by the Secretary of State

[The remainder of New Rule 16.1.5, formerly Rule 16.1.6, is retained unaltered]

~~16.1.7~~ 16.1.6 The county clerk must send a minimum of one correspondence no later than 60 days before the Primary Election to each elector whose record is marked "Inactive." The correspondence may be sent by email or mail and, at a minimum, must notify the electors of:

[The remainder of New Rule 16.1.6, formerly Rule 16.1.7, is retained unaltered]

~~16.1.8~~ 16.1.7 No later than 45 days before an election, the county clerk must report to the Secretary of State the number ballots transmitted to military and overseas electors by the 45-day deadline.

~~16.1.9~~ 16.1.8 Failure to meet the 45-day ballot transmission deadline in section 1-8.3-110, C.R.S.

[The remainder of New Rule 16.1.8, formerly Rule 16.1.9, is retained unaltered]

Amendments to Rule 16.2.1(c), concerning electronic transmission:

(c) In accordance with section 1-8.3-113(1), C.R.S., an elector who chooses to receive his or her unvoted ballot by ~~online ballot delivery~~ ELECTRONIC TRANSMISSION may return his or her ballot by fax or email ONLY IF THE ELECTOR DETERMINES THAT A MORE SECURE METHOD, SUCH AS RETURNING THE BALLOT BY MAIL, IS NOT AVAILABLE OR FEASIBLE. "NOT FEASIBLE" MEANS CIRCUMSTANCES WHERE THE ELECTOR BELIEVES THE TIMELY RETURN OF HIS OR HE BALLOT BY MAIL IS NOT CERTAIN.

Amendments to Rule 16.2.3:

16.2.3 The self-affirmation must include the standard oath required by the Uniformed and Overseas Citizen Voting Act (42 U.S.C sec. 1973ff(b)(7) and 1(a)(5)), the elector's name, date of birth, signature, and the following statement: I also understand that by returning my voted ballot by electronic transmission, I am voluntarily waiving my right to a secret ballot AND THAT COLORADO LAW REQUIRES THAT I RETURN THIS BALLOT BY A MORE SECURE METHOD, SUCH AS MAIL, IF AVAILABLE AND FEASIBLE. (~~Section~~ SECTIONS 1-8.3-113 AND 1-8.3-114, C.R.S.)

Amendments to Rule 20.4:

20.4 Individuals with access to keys, door codes, and vault combinations

20.4.1 For employees with access to areas addressed in Rule 20.4.3, the county must state in the security plan each employee's title and the date of the criminal background check WAS performed ~~under Rule 6.5~~. [Section 24-72-305.6, C.R.S.]

[Current Rule 2.4.2 is retained unaltered]

20.4.3 Employee access. The county may grant employees access to the codes, combinations, passwords, and encryption keys described in this Rule in accordance with the following limitations:

(a) Access to the code, combination, password, or encryption key for the voting equipment, ballot storage areas, counting room, or tabulation workstations is restricted to employees who have successfully passed ~~the~~ A criminal background check ~~described in Rule 6.5~~. Any person who has been convicted of an election offense or an offense with an element of fraud is prohibited from having access to a code, combination, password, or encryption key for the voting equipment, ballot storage areas, counting room, or tabulation workstations.

[*Current Rules 20.4.3(b), 20.4.3(c), and Rule 20.4.5 are retained unaltered]*

Amendments to Rule 20.5.2(f), concerning internal controls for the Voting System:

(f) If any component of the voting system is equipped with Wi-Fi capability or a wireless device, the county must disable the wireless capability or device UNLESS OTHERWISE APPROVED BY THE SECRETARY OF STATE.

Amendments to Rule 20.9.1(c), concerning transportation of equipment, memory cards, ballot boxes, and ballots:

(c) Transportation by contract. If a county contracts for the delivery of equipment to remote voting locations, each individual delivering equipment must successfully pass ~~the~~ A criminal background check ~~described in Rule 6.5~~. Any person who has been convicted of an election offense or an offense with an element of fraud is prohibited from handling or delivering voting equipment. Two election officials must verify, sign, and date the chain-of-custody log upon release of the equipment to the individual(s) delivering the equipment.

New Rule 23:

RULE 23. COMMISSIONS

23.1 BIPARTISAN ELECTION ADVISORY COMMISSION

23.1.1 THE SECRETARY OF STATE RECOGNIZES THAT OPEN DISCUSSION ABOUT THE ADMINISTRATION AND CONDUCT OF ELECTIONS IN COLORADO IS NECESSARY TO ENSURE THAT EVERY ELIGIBLE CITIZEN HAS THE OPPORTUNITY TO PARTICIPATE IN FAIR, ACCESSIBLE, AND IMPARTIAL ELECTIONS, AND HAS THE ASSURANCE THAT ELECTIONS ARE CONDUCTED WITH INTEGRITY AND HIS OR HER VOTE WILL COUNT. IN LIGHT OF THE COLORADO GENERAL ASSEMBLY SUNSETTING THE COLORADO VOTER ACCESS AND MODERNIZED ELECTION COMMISSION, THE SECRETARY OF STATE WILL ESTABLISH A BIPARTISAN ELECTION ADVISORY COMMISSION (THE COMMISSION) TO IDENTIFY PROCESSES FOR IMPROVEMENT AND WORK TO OBTAIN BIPARTISAN SUPPORT IN THE ADMINISTRATION OF ELECTIONS. THE COMMISSION WILL MAKE RECOMMENDATIONS TO THE SECRETARY OF STATE REGARDING THE DEVELOPMENT AND ADOPTION OF BEST PRACTICES, ADMINISTRATIVE RULES AND LEGISLATIVE CHANGES.

23.1.2 MEMBERSHIP OF THE COMMISSION

(A) THE SECRETARY OF STATE WILL APPOINT AT LEAST 13 MEMBERS TO THE COMMISSION. THE COMMISSION MAY INCLUDE:

(1) A REPRESENTATIVE OF AN ORGANIZATION THAT ADVOCATES ON BEHALF OF PEOPLE WITH DISABILITIES;

(2) A MEMBER OF THE EXECUTIVE BRANCH AND AT LEAST ONE LEGISLATOR FROM EACH PARTY;

(3) TWO COUNTY CLERK AND RECORDERS REPRESENTING THE COLORADO COUNTY CLERKS ASSOCIATION PRESIDENTIAL LINE OF LEADERSHIP;

(4) IF BOTH CLERKS IN (3) ARE FROM THE SAME PARTY OR IF NOT ALL COUNTIES ARE MEMBERS OF THE CCCA, ADDITIONAL CLERKS MAY BE APPOINTED;

(5) TWO REPRESENTATIVES OF ORGANIZATIONS THAT ADVOCATE ON BEHALF OF LOCAL GOVERNMENTS, INCLUDING COUNTIES, MUNICIPALITIES, AND SPECIAL DISTRICTS;

(6) CHAIR, PARTY OFFICER, OR LEGAL COUNSEL FOR EACH MAJOR POLITICAL PARTY; AND

(7) TWO MEMBERS WITH EXPERTISE ON VOTING RIGHTS AND/OR ELECTION INTEGRITY.

(B) THE SECRETARY OF STATE OR HIS OR HER DESIGNEE, WILL BE A MEMBER AND SERVE AS CHAIR THE COMMISSION.

(C) THE SECRETARY OF STATE'S OFFICE WILL PROVIDE STAFF SUPPORT TO THE COMMISSION AS MAY BE DIRECTED BY THE SECRETARY OF STATE.

23.1.3 MEETINGS

(A) THE COMMISSION WILL MEET NO FEWER THAN THREE TIMES ANNUALLY.

(B) THE MEETINGS WILL BE HELD AT THE OFFICE OF THE SECRETARY OF STATE OR REGIONAL LOCATIONS THROUGHOUT THE STATE AS THE COMMISSION DEEMS APPROPRIATE.

(C) MEETINGS WILL COMPLY WITH COLORADO OPEN MEETINGS LAW AND WILL PERMIT AN OPPORTUNITY FOR PUBLIC COMMENT.

(D) NOTICES, RECORDS OF MEETINGS, WRITTEN COMMENTS, AND DOCUMENTS SUBMITTED TO THE COMMISSION WILL BE PUBLISHED ON THE OFFICIAL WEBSITE OF THE SECRETARY OF STATE. HOWEVER, DOCUMENTS THAT ARE OTHERWISE PUBLICLY AVAILABLE NEED NOT BE POSTED. ANY SUBMISSION CONTAINING INFLAMMATORY OR OTHERWISE INAPPROPRIATE CONTENT WILL NOT BE POSTED, INCLUDING ANY MATERIAL THAT IS DEFAMATORY, IRRELEVANT, DUPLICATIVE, OR OBSCENE.

Calendar of Hearings

Hearing Date/Time	Agency	Location
06/01/2015 09:00 AM	Public Utilities Commission	Colorado Public Utilities Commission Hearing Room, 1560 Broadway, Suite 250, Denver, CO 80202
06/01/2015 10:00 AM	Division of Motor Vehicles	1881 Pierce Street, Lakewood, CO. 80214, Rm 110 Boards/Commissions Mtg Room
06/02/2015 01:30 PM	Division of Insurance	1560 Broadway, Ste 850, Denver CO 80202
06/02/2015 01:30 PM	Division of Insurance	1560 Broadway, Ste 850, Denver CO 80202
06/05/2015 10:00 AM	Division of Oil and Public Safety	633 17th Street; Denver, CO 80202
06/05/2015 10:00 AM	Social Services Rules (Staff Manual Volume 7; Child Welfare, Child Care Facilities)	Colorado Department of Human Services, 1575 Sherman Street, 8th Floor C-Stat Room, Denver, CO 80203
06/05/2015 10:00 AM	Social Services Rules (Staff Manual Volume 7; Child Welfare, Child Care Facilities)	Colorado Department of Human Services, 1575 Sherman Street, 8th Floor C-Stat Room, Denver, CO 80203
06/05/2015 11:30 AM	Behavioral Health	Colorado Department of Human Services, 1575 Sherman Street, 8th Floor C-Stat Room, Denver, CO 80203
06/08/2015 10:00 AM	Water Quality Control Commission (1002 Series)	Florence Sabin Conference Room, CDPHE, 4300 Cherry Creek Drive South, Denver, CO 80246
06/12/2015 09:00 AM	Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)	303 East 17th Avenue, 7th Floor, Denver, CO 80203
06/17/2015 10:00 AM	Hazardous Materials and Waste Management Division	Sabin-Cleere Conference Room, Colorado Department of Public Health and Environment, Bldg. A, 4300 Cherry Creek Drive, South, Denver, CO. 80246
06/17/2015 10:00 AM	Health Facilities and Emergency Medical Services Division (1011, 1015 Series) - by Colo Bd of Health	Sabin-Cleere Conference Room, Colorado Department of Public Health and Environment, Bldg. A, 4300 Cherry Creek Drive, South, Denver, CO. 80246
06/18/2015 10:00 AM	Division of Banking	Division of Banking, 975 Conference Room, 1560 Broadway, Suite 975, Denver, CO 80202
06/30/2015 09:30 AM	Water Quality Control Commission (1003 Series)	Sabin Conference Room, CDPHE, 4300 Cherry Creek Drive South, Denver, CO 80246